IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2023 004999**

IN THE MATTER OF THE INQUEST INTO THE DEATH OF CHRISTOPHER KEISLER

RULING NO 2 REGARDING USE OF SAPSE DOCUMENTS

BACKGROUND

1. On 7 September 2023, Christopher Keisler (hereinafter referred to as '**Chris**') was 44 years of age when he died following an incident involving the attendance of emergency services at his home in Point Cook, which was a supported residence funded under the auspices of the National Disability Insurance Scheme.

2. Upon the arrival of emergency services personnel at his address, Chris appeared to be experiencing an incident of acute mental ill health, and was highly agitated. With the assistance of police and paramedics, he was restrained and administered with sedating medications. Unexpectedly, and very sadly, Chris deteriorated and went into cardiac arrest *en route* to hospital, where he was pronounced deceased.

3. Following Chris's death, Ambulance Victoria (**AV**) conducted an internal review of the care and management provided to Chris. Chris's death was classified as a 'serious adverse patient safety event' (**SAPSE**) within the meaning of s 3(1) of the *Health Services Act 1988* (Vic) (the ***Health Services Act***) and reg 3B of the *Health Services (Quality and Safety) Regulations 2020* (Vic).

4. On 15 May 2024, in response to a request from the Court for *'any reports of any internal reviews regarding the death of Christopher Keisler*', Ambulance Victoria (**AV**) provided the Court with four documents:

   a) 'SAPSE review report: Review of an event meeting sentinel event criteria, Ambulance Victoria', inclusive of Parts A, B and C, signed off on 28 December 2023;

   b) 'SAPSE review report: Review of an event meeting sentinel event criteria, Ambulance Victoria', Part D (Recommendation Monitoring Report), signed off on 28 March 2024;

c) Appendix 1 ('Linear Timeline') and Appendix 2 ('Cause and Effect'); and

d) Patient Safety Incident Management Serious Adverse Patient Safety Event In-depth Case Review Report dated 11 September 2023.

(collectively referred to as the '**SAPSE Documents**').

5. AV submits that the SAPSE Documents fall into two categories of document. The first category – documents a) to c) – constitute a SAPSE review report prepared pursuant to section 128T of the *Health Services Act*, referred to collectively as the '**SAPSE Report**'. The second category – document d) – is an In-Depth Case Review (**IDCR**) report into Chris's death, referred to by AV in these proceedings as the '**SAPSE Materials**'. I adopt that descriptor for it for the purposes of this ruling in the interests of clarity, without necessarily accepting that it is an accurate descriptor.

6. On 1 November 2024, AV applied to the Court ('**the Application**') seeking that:

a) I refrain from including the SAPSE Report in the coronial brief and/or admitting it into evidence in the inquest into Chris' death; and

b) I disregard the SAPSE Materials on the basis that the document had been provided to the Court in error and was a document protected from being compelled to be produced to and used by the Coroner pursuant to s 128U(1)(b) and (2) of the *Health Services Act*.

7. On 14 March 2025, I delivered a Ruling which sets out my determination in relation to the use of the SAPSE Report in this proceeding ('**Ruling No 1**').[1] I reserved my determination in relation to use of the SAPSE Materials pending receipt of further evidence to support AV's submission that the SAPSE Materials constituted a document under s 128U(1)(b) or s 128U(2) of the *Health Services Act*.

8. This Ruling sets out my determination in relation to use of the SAPSE Materials in this proceeding and should be read in conjunction with Ruling No 1.

[1] Ruling regarding use of SAPSE documents, available on the website of the Coroners Court of Victoria here.

PROCEDURAL HISTORY

9. The procedural history of the Application is set out in Ruling No 1, and I do not propose to recount that history here, save to note that in that Ruling:

    a) I refused AV's Application insofar as it related to the use of the SAPSE Report and ordered that the SAPSE Report be included in the coronial brief and be admissible evidence during or at the conclusion of the inquest into the death of Christopher Keisler as part of the coronial brief; and

    b) I indicated that I did not consider that AV had established as a matter of evidence that the SAPSE Materials constituted a document falling within s 128U(1)(b) or s 128U(2) of the *Health Services Act.* I reserved my determination in respect of this aspect of the Application and directed AV to provide further submissions or evidence in in support of its position on the use of the SAPSE Materials in these proceedings.[2]

10. On 11 April 2025, AV filed further evidence and submissions in support of its position that the SAPSE Materials should not have been provided to the Court and that this document is inadmissible in any action or proceeding before the Court. This included an affidavit of Debra Riseley, Acting Director of Patient Safety and Experience at Ambulance Victoria, affirmed on 11 April 2025 ('**Riseley Affidavit'**).

11. I subsequently became aware that in another investigation before me, AV had produced to the Court a document entitled 'Patient Safety Incident Management Serious Adverse Patient Safety Incident In Depth Case Review Report' without any claim that the report was protected under Division 8 of Part 5A of the *Health Services Act*. This report appeared identical in form to that contained in the SAPSE Materials, having the same general form of content, structure and headings, save for the case being referred to as an 'incident' rather than an 'event'.

12. Accordingly, on 17 June 2025, I asked AV to clarify its use of In Depth Case Review reports (**IDCR reports**) in its review of adverse patient safety events, and to explain any distinction in the permitted use or legal basis of an IDCR report between the relevant cases. I further requested AV to confirm whether it maintained the view that an IDCR as a class of document ought to be considered inadmissible for the reasons outlined in the Riseley Affidavit.

[2] Ruling No 1, [94-96], [98].

13. On 3 July 2025, AV provided further written submissions to the Court which sought to make a distinction between, on the one hand, the permitted use and legal basis of an IDCR report prepared for the purpose of a SAPSE review under Division 8 of Part 5A of the *Health Services Act*, and on the other hand an IDCR report prepared in accordance with Victorian Duty of Candour Guidelines under Division 9 of Part 5A of the *Health Services Act*.

14. I invited further written submissions from any Interested Party, at their discretion, on the use of the SAPSE Materials in this proceeding in light of the additional material filed by AV. No party sought to be heard on the issue. However, in considering this Application, I have had regard to written submissions previously filed by AV and Chris's family in relation to the use of the SAPSE Documents,[3] as well as to the oral submissions made at the Directions Hearing on 9 December 2024 by Counsel Assisting and the parties.

15. Before turning to the evidence and submissions of AV in relation to the SAPSE Materials, it is necessary for me to first set out the applicable legal framework regarding the conduct of SAPSE reviews and Duty of Candour, given their relevance to the preparation of IDCR reports. While some of these provisions are discussed in Ruling No 1, given the distinctions in the nature of the documents under consideration in the separate rulings, I consider it appropriate to set out those provisions here.

LEGAL FRAMEWORK

I. *Health Services Act*

16. Part 5A of the *Health Services Act* governs the conduct of quality and safety reviews undertaken by health service entities, including ambulance services. In addition, AV is also subject to the *Ambulance Services Act 1988* (Vic) ('***Ambulance Services Act***'), which contains duplicate provisions regarding AV's duty of candour obligations.

17. These provisions are relatively new statutory requirements and were introduced by the *Health Legislation Amendment (Quality and Safety) Act 2022*, which came into operation on 30 November 2022.

[3] Submissions on behalf of the Senior Next of Kin dated 3 December 2024, in particular at [12-14]; Submissions on behalf of Ambulance Victoria dated 1 November 2024, in particular at [4.1-4.5].

i. *SAPSE reviews*

18. Division 8 of Part 5A of the *Health Services Act*, is entitled 'SAPSE reviews' and establishes a protected review process for a SAPSE review panel appointed by the health service entity to undertake a review of a serious adverse patient safety event. Such a review is referred to as a '**SAPSE review**'. A SAPSE review conducted in accordance with the requirements of this Division provides certain protections for participants in the SAPSE review and for the SAPSE review panel members, as well as limitations on access to and use of certain materials.

19. A review that is not conducted pursuant to the requirements of Division 8 is not a SAPSE review for the purposes of the *Health Services Act* and those protections and limitations will not apply.

20. A SAPSE review conducted under Division 8 must:[4]

    a) establish the facts of the SAPSE, including any relevant surrounding context;

    b) identify the factors that may have led or contributed to the SAPSE, including, but not limited to:

        i. any relevant factors that are external to the health services entities involved in the event;

        ii. organisational and management factors relating to the health services entities involved in the event;

        iii. working environment factors, including the assignment and performance of tasks, technology used by the health service entities, team management and staffing allocation;

        iv. factors relating to the patients to whom health services were provided by the health service entities involved in the event; and

    c) identify any remedial measures that may be taken in relation to the SAPSE, and any measures to prevent similar events from occurring in future and improve the quality and safety of the health services provided by the health service entities involved in the event.

[4] *Health Services Act*, s 128O.

21. After completing its investigation, the SAPSE review panel must prepare and produce a report for the health service entities that appointed it (**SAPSE report**).[5]

22. A SAPSE report must contain one or more of the following elements, as considered appropriate by the SAPSE review panel:[6]

    a) a description of the SAPSE;

    b) analysis identifying why the event happened and any factors that contributed to the event;

    c) any recommendations about changes or improvements in policy, procedure or practice relating to the provision of a health service that are intended to reduce the likelihood of, or prevent, the same type of event happening again.[7]

23. Section 128T(3) of the *Health Services Act* provides that a SAPSE report must not contain the name or address of a person involved in providing the relevant health service, a person who received the relevant health service, a member of the SAPSE review panel,[8] or the name and address of a person who has provided information to the SAPSE review panel.[9] As noted by Counsel for AV, *"It's an anonymised report. Everyone either gets pseudonyms or they get referred to by way of a general word: the patient, the paramedic."*[10]

24. With limited exceptions, section 128U(1) provides that no person may be compelled to produce:

    a) a SAPSE report; or

    b) any document created for the sole purpose of providing information in the course of conducting a SAPSE review and provided in the course of conducting a SAPSE review by or on behalf of that person.[11]

[5] *Health Services Act*, s 128T(1).
[6] *Health Services Act*, s 128T(2).
[7] In addition, section 128T(2)(d) provides for other matters or requirements to be prescribed. There are currently no prescribed matters or requirements in the *Health Services (Quality and Safety) Regulations 2020*.
[8] *Health Services Act*, s 128T(3)(a).
[9] Prescribed under the *Health Services (Quality and Safety) Regulations 2020*, reg 3E, pursuant to s 128T(3)(b) of the *Health Services Act*.
[10] Transcript of Directions Hearing on 9 December 2024, Counsel for AV, T-7.
[11] *Health Services Act*, s 128U(1)(b).

25. Section 128U(2) further provides that evidence of any other information or reports obtained by or in the possession of a SAPSE review panel in the course of conducting a SAPSE review; or evidence about a SAPSE report or related documents, is not admissible in court.

26. However, under s 128U(3), a SAPSE report may be produced to a Coroner and/or to the Coroners Court for an investigation or inquest.

27. Access to a SAPSE report must also be offered to the patient, a person nominated by the patient, or if the patient has died, their immediate family, carer or next of kin,[12] as part of the statutory duty of candour process, discussed further below.

ii. Duty of Candour

28. Separate to the SAPSE review process, AV is required to comply with statutory duty of candour obligations under Division 9 of Part 5A of the *Health Services Act* and s 22I of the *Ambulance Services Act 1986* (Vic).

29. Under Division 9, Part 5A of the *Health Services Act* and s 22I of the *Ambulance Services Act 1986* (Vic), where a patient suffers a SAPSE in the course of receiving services from an ambulance service, the ambulance service responsible for providing those services owes a duty of candour to the patient and is required to comply with the steps set out in the Victorian Duty of Candour Guidelines (**'Duty of Candour Guidelines'**).

30. The Duty of Candour Guidelines set out nine requirements that health service entities (including ambulance services) must follow in the statutory duty of candour process. These include a requirement that the health service entity complete a review of the SAPSE and produce a report outlining what happened and any areas identified for improvement. If the SAPSE is classified as a sentinel event, they are required to notify Safer Care Victoria and outline in their review report clear recommendations from the review findings.[13]

31. Access to a report created following a statutory duty of candour process must be offered to the patient, a person nominated by the patient, or if the patient has died, their immediate family, carer or next of kin,[14] as is required where a SAPSE report is prepared.

[12] *Health Services* Act, s 128V(3).
[13] Guidelines, Requirement 6.
[14] Guidelines, Requirement 7.

32. A review of a SAPSE for the purposes of the statutory duty of candour process will only attract the protections within Division 8 of Part 5A of the *Health Services Act* if it is conducted in accordance with those provisions.

II. Coronial jurisdiction

33. The Coroners Court is a specialist inquisitorial court established for the purposes of independently investigating certain deaths ('reportable deaths') to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[15] The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice, both through the observations made in the investigation findings and by the making of recommendations by coroners.[16]

34. Coroners have broad powers under the *Coroners Act 2008* (Vic) to investigate deaths. These powers include gathering evidence, obtaining information and documents from individuals and organisations relevant to the investigation, and summoning witnesses to give evidence at inquest.[17] As noted in *Priest v West* (2012) 40 VR 521, in investigating a death, the coroner must pursue all reasonable lines of enquiry, be an active investigator and discover all they can about the circumstances surrounding the death.[18]

35. The role of the coroner is to establish the facts, not to lay or apportion blame.[19] Coroners are not empowered to determine any criminal or civil liability arising from a reportable death, and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[20]

36. The coronial system should operate in a fair and efficient manner.[21] Consistent with this:

[15] *Coroners Act*, preamble, s 67.
[16] *Coroners Act*, preamble, s 1(a)-(c).
[17] *Coroners Act,* ss 42, 55, 64.
[18] At [3], [4] (per Maxwell P and Harper JA), and [167] per Tate JA.
[19] *Keown v Khan* (1999) 1 VR 69.
[20] *Coroners Act*, s 69(1).
[21] *Coroners Act 2008* (Vic), s 9.

a) coroners are required to liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations, and to expedite the investigation of deaths and fires;[22] and

b) when exercising a function under the Act, coroners are to have regard, as far as possible in the circumstances, to the notion that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[23]

37. Coroners have been afforded broad powers to fulfil their statutory functions to investigate and make findings as to the cause and circumstances of a reportable death. This includes powers to compel production of documents[24] or to authorise entry, search, inspection and seizure of material relevant to an investigation.[25]

THE APPLICATION AND SUBMISSIONS

I. AV's Application in respect of the SAPSE Materials

38. AV's present Application concerns the SAPSE Materials – a document entitled the 'Patient Safety Incident Management Serious Adverse Patient Safety Event In-depth Case Review Report' – which was prepared by AV in respect of Chris's death.

39. It is appropriate for me to provide a broad description of the SAPSE Materials, without revealing the specific contents or findings, as they are highly pertinent to this Ruling and my statutory functions in investigating and making findings as to the cause and circumstances in which Chris' death occurred.

40. The SAPSE Materials comprise a de-identified report dated 11 September 2023 which:

a) captures key information about the events on 7 September 2023 as they relate to AV's involvement, as well as relevant surrounding context including analysis of Chris' prior AV interactions, and details of Chris's reaction to ketamine administered during an attendance in early 2023.

[22] *Coroners Act 2008* (Vic), s 7.
[23] *Coroners Act 2008* (Vic), s 8.
[24] *Coroners Act 2008* (Vic), s 42.
[25] *Coroners Act 2008* (Vic), s 39.

b) includes a detailed analysis of events on 7 September 2023 as they unfolded by reference to applicable clinical practice guidelines, including findings concerning the clinical care provided to Chris, findings on factors which may have contributed to the event, and opinion as to potential missed opportunities in management of the event.

c) identifies relevant factors that may have led or contributed to the event, including in relation to: patient factors; policies, guidelines and decision support; physical environment; and workforce/organisational factors. The report also draws attention to multiple learning points and improvement opportunities which may lead to systems improvements.

41. AV submits that the document constituting the SAPSE Materials:

a) was created for the sole purpose of providing information in the course of conducting a SAPSE review, and was provided in the course of conducting a SAPSE review by or on behalf of that person. Accordingly, it falls within the definition of s 128U(1)(b) of the *Health Services Act* and should not have been provided to the Court;

b) is evidence of any other information or reports obtained by or in the possession of a SAPSE review panel in the course of conducting a SAPSE review and evidence of or about a document to which s 128U(1) applies, and is therefore not admissible in any action or proceeding before the Coroners Court pursuant to s 128(2)(a) and (b) of the *Health Services Act*; and

c) ought not be added to the coronial brief or otherwise relied upon by the Court.[26]

i. Evidence in support of AV's application

42. AV relies on:

a) The Riseley Affidavit; and

b) AV's Patient Safety Incident Management Procedure PRO/QBE/003 approved 30 June 2023 (**Incident Management Procedure**).

[26] As noted in paragraph 15 of Ruling No 1, I note here for completeness that the SAPSE Materials were provided to Interested Parties in November 2024 for the purposes of making submissions on AV's application with respect thereto, and the document is thus in their possession.

43. As Acting Director of Patient Safety and Experience for the period March 2025 to May 2025, Ms Riseley was responsible for implementing and overseeing processes for the conduct of SAPSE reviews and SAPSE reports at AV.

44. Ms Riseley's substantive position at AV (to which she has since returned) is Patient Review Support Manager, a role she has held for over 18 years.[27] The responsibilities of the Patient Review Support Manager are set out in the Incident Management Procedure, and include relevantly, to oversee, monitor and report progress on all incident reviews, maintain and monitor the Recommended Actions Register, and coordinate all patient safety incident information for patient safety incident reviews.[28]

45. The Riseley Affidavit details (as discussed further below):

    a) AV's 'usual' process for conducting SAPSE reviews and preparing SAPSE Reports;

    b) the process adopted by AV in reviewing Chris's death; and

    c) Ms Riseley's opinion as to the consequences that would arise if IDCR reports like the SAPSE Materials were distributed and included on coronial briefs.

46. The Incident Management Procedure sets out AV's procedure for the end-to-end patient safety incident management process and assists staff in understanding their responsibilities in delivering and supporting this process.[29] This document was last updated in 30 June 2023,[30] approximately three months prior to Chris's death and six months after the commencement of the *Health Legislation Amendment (Quality and Safety) Act 2022*.[31]

47. Relevantly, the Incident Management Procedure provides that:

    a) AV staff have a responsibility to report patient safety incidents, participate in the investigation and review of incidents as required, respond to requests for incident reports

[27] Riseley Affidavit, [1.1], [4.2].
[28] AV's Incident Management Procedure, p 4.
[29] AV's Incident Management Procedure, p 1.
[30] AV's Incident Management Procedure, p 19.
[31] The *Health Legislation Amendment (Quality and Safety) Act 2022* commenced on 30 November 2022, and made relevant amendments to the *Health Services Act* to provide for the conduct of SAPSE Reviews under Division 8, Part 5A, and statutory duty of candour obligations under Division 9, Part 5A amongst other matters.

in a timely manner, and learn from the findings and outcomes of incident reviews and participate in continuous improvement efforts.[32]

b) Clinical Support Officers (**CSOs**) conduct and document IDCRs as required, supported by Patient Review Specialists.[33]

c) Where a patient safety incident is identified as having an incident severity rating of ISR 1 (severe/death) – as occurred in Chris's case – a Root Cause Analysis (**RCA**) must be undertaken. Notification must also be made to Safer Care Victoria, and an RCA panel will be convened by the Patient Review Specialist Lead supported by local CSO and management.[34]

d) As part of the RCA process, an IDCR will be undertaken and provided to the RCA panel to inform the analysis. The IDCR "*captures information from a range of perspectives about an incident to ensure that the complete nature of the incident, including causative, contributory and preventative factors, are documented and understood. The information obtained through the review supports the development of recommended actions and individual support programs*."[35]

e) The IDCR process includes:

i. information gathering and confirmation of facts;

ii. interviews of those involved or who witnessed the incident to understand what happened and identify findings, and will be structured to facilitate supported engagement;

iii. production of a timeline of the incident; and

iv. identification of causal and/or contributing factors and potential root cause(s).[36]

f) The RCA panel will review the information and confirm what occurred during the incident, review what could have or should have occurred and determine the cause(s) of the incident. Following this review, the Patient Review Specialist Lead will complete an RCA report

[32] AV's Incident Management Procedure, p 2.
[33] AV's Incident Management Procedure, pp 3-4.
[34] AV's Incident Management Procedure, p 7.
[35] AV's Incident Management Procedure, p 10.
[36] AV's Incident Management Procedure, p 9.

for endorsement by the AV Executive and CEO prior to submission to Safer Care Victoria.[37]

g) Staff are provided with feedback on the findings, learning and recommended actions and improvement following an incident. The RCA report or IDCR report is used to inform this feedback to promote openness and transparency in communication with staff to support a just and learning culture.[38]

h) AV ensures that its review processes are focussed on systemic issues and improvement opportunities, rather than individual fault.[39]

48. The Incident Management Procedure does not include any mention of SAPSEs, or protected review processes conducted under Division 9, Part 5A of the *Health Services Act*, but does refer to requirements for open disclosure and Statutory Duty of Candour.[40]

ii. AV's process for conducting a SAPSE review generally

49. The Riseley Affidavit sets out AV's usual process for conducting SAPSE reviews under Division 8, Part 5A of the *Health Services Act*. Ms Riseley states that:

a) following a patient incident, a multi-disciplinary team at AV determines whether the incident satisfies the definition of a SAPSE, as outlined in the *Health Services Act* and reg 3B of the *Health Services (Quality & Safety) Regulations 2020*.

b) where an incident is classified as a SAPSE, the multi-disciplinary team, on delegation from the Chief Executive Officer of AV, will determine whether a SAPSE review should be conducted pursuant to Division 8 of Part 5A of the *Health Services Act*.

c) if a SAPSE review is to be conducted in accordance with this Division, the Patient Review Specialist Lead under delegation from the Director of Patient Safety and Experience, appoints a SAPSE review panel.[41]

[37] AV's Incident Management Procedure, p 10.
[38] AV's Incident Management Procedure, p 16.
[39] AV's Incident Management Procedure, p 16.
[40] AV's Incident Management Procedure, pp 1, 9, 19.
[41] The SAPSE review panel comprises at least three members, which may include the Patient Review Specialist Lead, AV subject matter experts, an external subject matter expert and a consumer representative, in accordance with the requirements of the *Health Services Act*.

d) the SAPSE review panel, via the Patient Review Specialist Lead, nominates a CSO or other senior specialist (‘**the interviewer’**) to interview the relevant AV staff members involved in the incident (**‘the participants’**) and prepare an IDCR report for the panel.

e) in preparing the IDCR report for a SAPSE review:

i. the interviewer is responsible for conducting a confidential interview with each participant and may tailor the interview having regard to the individual participant and incident.

ii. participants are notified that they will be interviewed in relation to an incident that has involved moderate or severe harm to a patient. However, they will <u>not</u> generally be informed specifically that the incident has been classified as a SAPSE, is the subject of a SAPSE review, or that the SAPSE review is subject to protections under the Act.

iii. participants are not formally directed to attend an interview. However, it is expected that they will participate in accordance with AV’s Incident Management Procedure.

iv. after completing the interviews, the interviewer prepares an IDCR report which is given to the SAPSE review panel, so they can consider the information contained within the report for the SAPSE review.

v. the IDCR report is prepared for the sole purpose of guiding the SAPSE review panel in the course of its review of the SAPSE. The report is kept confidential and only provided to the SAPSE review panel members.

f) upon receipt of the IDCR report, the SAPSE review panel meets to review and consider the IDCR report, together with any other relevant information such as policy documents, clinical practice guidelines, training materials, event chronology and cardiac monitor data. The review panel does not interview participants directly but relies on the IDCR report to give them important information from the participants.

g) the SAPSE review panel then formulates its findings and recommended actions and prepares the SAPSE report. Once finalised, the SAPSE report is provided to the AV Executive for consideration and endorsement, before being submitted to Safer Care Victoria. A copy of the SAPSE report is also disclosed to the patient and/or their family.

iii. Use and confidentiality of IDCR Reports

50. Ms Riseley's evidence on affidavit is that the IDCR Report prepared in relation to Chris's death (that is, the SAPSE Materials) was:

    a) written by the CSO for the sole purpose of providing information to the SAPSE review panel in the course of its review of Chris' death;

    b) not created for any other purpose; and

    c) was not intended to be provided to or used by anyone other than the SAPSE review panel and was to be kept confidential.[42]

51. I note that Ms Riseley was not the author of the SAPSE Materials. Nor does it appear Ms Riseley had any direct substantive involvement in the review of Chris's death. Ms Riseley states that "during the case of Mr Christopher Keisler" (which I take to mean at the time of AV's review of his care and management), she held the positions of Patient Review Support Manager and Patient Review Co-ordinator.[43] Neither of these positions appear to have responsibilities in assigning, directing or leading the preparation of an IDCR report.[44] Accordingly, it is unclear whether her evidence on this point is drawn from her own knowledge or based on information and belief.

52. Ms Riseley states that:

    a) in her opinion, IDCR reports need to be treated as sensitive and strictly confidential, and that the SAPSE Materials should not have been forwarded to the Court, and that this was done in error;[45]

    b) based on her experience, if IDCR reports were distributed and included on coronial briefs, it would *"disincentivise AV workers, including paramedics, from participating in the interviews and SAPSE reviews (or from participating in as forthright a manner as they would otherwise"*; and

[42] Riseley Affidavit, [3.5].
[43] Riseley Affidavit, [1.1].
[44] The Incident Management Procedure specifies that the primary investigator and responsibility for reviewing an ISR 1 incident is the RCA Panel, convened by the Patient Review Specialist Lead supported by local Clinical Support Officer and management group, p 7. CSOs are responsible for conducting in-depth case reviews as required and documenting these in the patient safety system.
[45] Riseley Affidavit, [4.1].

c) in turn, this may also limit the ability of the multi-disciplinary team to undertake as robust and comprehensive an IDCR review as it might otherwise be able to do.[46]

53. In its subsequent written submissions, AV explained that an IDCR report may be prepared for reviews other than for a SAPSE review under Division 8, Part 5A of the *Health Services Act*. That is, an IDCR report may be prepared by AV for the purpose of undertaking a statutory duty of candour process in accordance with the Victorian Duty of Candour Guidelines. AV submitted that the relevant protections and confidentiality requirements under Division 8 of Part 5A of the *Health Services Act* for SAPSE reviews would not apply in these circumstances.[47]

54. The distinction between an IDCR report prepared as part of the SAPSE review process and one prepared for other purposes was not addressed in the Riseley Affidavit, and I am reliant on the submissions provided on behalf of AV by their legal representatives. I accept for the purposes of this ruling that the factual assertions made in those submissions could have been the subject of affidavit evidence from Ms Riseley and I do not place any less weight on those assertions by reason of their being contained in submissions rather than in an affidavit.

iv. AV's review of Chris's death

55. Ms Riseley's evidence is that AV's review of Chris's death was completed in accordance with the process for SAPSE reviews outlined at paragraph [49] above.[48] She has provided dates for relevant events that occurred during the review process.

56. The Riseley Affidavit does not list the events relevant to the review of Chris's death in a strict chronological order.[49] As it is important for the Court to understand the precise chronology of the process that was followed by AV in their review of Chris's death, I have looked to the source documents from which Ms Riseley extracted the dates on which relevant events occurred.

[46] Riseley Affidavit, [4.2].
[47] Letter from HWL Ebsworth on behalf of AV, to the Coroners Court dated 3 July 2025.
[48] Riseley Affidavit, [3.1]
[49] In setting out the events that occurred in the review of Chris' death, the Riseley Affidavit first refers to events which occurred on 12 September 2023 concerning the appointment of the SAPSE review panel, before referring to the events five days earlier, on 8 September 2023, at which time a CSO was assigned to conduct a IDCR.

57. Those source documents demonstrate that the review of Chris's death occurred chronologically as follows:

a) On 8 September 2023, a CSO was assigned to be the interviewer and prepare an IDCR report.[50] The CSO interviewed the relevant staff involved in the care of Chris and prepared an IDCR report (that is, the document constituting the SAPSE Materials).[51] The report appears to have been completed on 11 September 2023, as it bears this date[52] and no evidence has been provided to me to indicate otherwise. Debriefs had occurred with all relevant staff between 7 and 11 September 2023 (that is, prior to the appointment of the SAPSE review panel), with additional debriefs with two of the staff members recorded as occurring on 14 and 17 September 2023.[53]

b) On 12 September 2023, a multi-disciplinary team assessment was conducted to consider the care and management provided to Chris. Only at this point was his death classified as a SAPSE and referred for SAPSE review, and a SAPSE review panel was thereafter appointed.[54] No evidence has been provided as to what material was considered by the multi-disciplinary team at the time of their assessment and review of the care and management provided to Chris. It is unclear whether the multi-disciplinary team had access to or considered the findings of the IDCR report at the time of its assessment and recommendation that a SAPSE review be conducted.

c) On 19 September 2023, the CSO provided the IDCR report to the SAPSE review panel for its consideration in the course of its review. The SAPSE review panel accepted it as part of the review process.[55]

d) On 11 December 2023, the SAPSE Report was finalised, and the findings and recommendations were endorsed and accepted by the AV Executive and Chief Executive and submitted to Safer Care Victoria.[56]

[50] Riseley Affidavit, [3.3].
[51] Riseley Affidavit, [3.4-5].
[52] Patient Safety Incident Management Serious Adverse Patient Safety Event In Depth Case Review Report dated 11 September 2023.
[53] SAPSE Materials, In depth case review check list, p 29.
[54] Riseley Affidavit, [3.2].
[55] Riseley Affidavit, [3.6]
[56] Riseley Affidavit, [3.7]; This is confirmed in the Sign-off-Part A and B, at p 28 of the SAPSE Report.

e) On 12 December 2023, AV provided a copy of the SAPSE Report to Chris's family in accordance with the *Health Services Act*.[57]

58. As will be discussed further below, I am not satisfied that the review process in relation to Chris's death followed the strict chronological sequence of events for a SAPSE review conducted in accordance with the requirements of Division 8 of Part 5A of the *Health Services Act*, as would ordinarily be undertaken by AV as set out in paragraph [49] above. This is relevant to whether the SAPSE Materials can be said to be a document to which the provisions of that Division apply.

iii. AV Submissions

59. AV submits that Division 8 of Part 5A of the *Health Services Act* prohibits production to, or use by, the Coroner of the SAPSE Materials (being the IDCR Report prepared in relation to Chris' death). This is on the basis that:

a) a person must not be compelled to produce any document created for the sole purpose of providing information in the course of conducting a SAPSE review, or any documents provided in the course of conducting a SAPSE review, pursuant to s 128U(1)(b) of the *Health Services Act*.

b) evidence of any other information or reports obtained by or in possession of a SAPSE review panel is not admissible in any action or proceedings before any court, tribunal, board, agency or other person, pursuant to s 128U(2) of the *Health Services Act*.[58]

60. AV submits that the documents created for the sole purpose of providing information in the course of conducting a SAPSE review – such as *"notes, materials, drafts, file notes, summaries, opinions, expert reports, transcripts or recordings"* which underpin a SAPSE report – are exempt from production to any court, tribunal or person without exception.[59] AV's submission is that the SAPSE Materials document falls within this category.

61. In its further submissions to the Court regarding the use of IDCR reports, AV acknowledges there may be confusion between an IDCR report prepared for the purposes of a SAPSE review (subject to relevant protections under Division 8 of Part 5A of the *Health Services Act*), and a similar report created for a statutory duty of candour process in accordance with the Victorian

[57] Riseley Affidavit, [3.8].
[58] Letters from HWL Ebsworth, on behalf of AV, to the Coroners Court dated 1 November 2024, and 11 April 2025.
[59] Transcript of Directions Hearing on 9 December 2024, Counsel for AV, p 12-13.

Duty of Candour Guidelines. However, AV maintain that while these reports *"appear similar and share the same name… they are actually fundamentally different types of documents created under different legislative provisions for different purposes"*.[60]

62. To avoid confusion arising in the future, AV has committed to reviewing its internal processes and implementing clear labelling to distinguish between the two types of IDCR reports to ensure all parties can readily distinguish between these instruments and understand their respective legislative foundations, purposes and whether they are admissible or inadmissible documents in Court proceedings.[61]

II. Counsel Assisting and Family Submissions

63. No other party sought to make further submissions on the Application insofar as it relates to the SAPSE Materials. However, in considering this Application, I have had regard to earlier submissions made by Counsel Assisting and on behalf of Chris' family, insofar as they are relevant to the issues for consideration, and which are detailed further in Ruling No 1.

RULING ON SAPSE MATERIALS

64. In ruling on the Application in respect of the SAPSE Materials, I have considered applicable legislation,[62] as well as the evidence and submissions of AV, and, broadly, previous submissions made by Counsel Assisting and Counsel on behalf of the Senior Next of Kin concerning the Application. I have also taken into account the evidence as it is currently known regarding the cause and circumstances of Chris's death, and the review process conducted by AV in relation to Chris's death.

Relevance of the SAPSE Materials to the coronial investigation

65. As noted by Counsel Assisting during a hearing on this issue, the care provided by paramedics, including decisions made about sedation and how Chris was monitored, is a relevant matter for the coronial investigation into Chris's death, having regard to my obligation to make findings about the cause and circumstances of the death.[63] This will necessarily involve examination of

[60] Letter from HWL Ebsworth, on behalf of AV, to the Coroners Court dated 3 July 2025.
[61] Letter from HWL Ebsworth, on behalf of AV, to the Coroners Court dated 3 July 2025.
[62] Including Part 5A, Division 8 of the *Health Services Act*, s 22I of the *Ambulance Services Act*, and relevant provisions of the *Coroners Act*, including in particular ss 1, 7, 8, 9, 55 and 69.
[63] Transcript of Directions Hearing dated 9 December 2024, T-3.

the training, tools, practices and resources available to paramedics for responding to and managing patients with acute behavioural disturbance.

66. Further, having regard to my role in contributing to the reduction of the number of preventable deaths,[64] and identifying preventative measures, my investigation will examine the factors that contributed to Chris' death and opportunities to learn from these events to improve patient safety.

67. Having reviewed the contents of the SAPSE Materials, it is evident to me that the document contains highly pertinent information relevant to my inquiry, not otherwise available in other material before the Court, which will assist me in discharging my functions to investigate what happened on 7 September 2023, to understand how it happened, and to identify what systems improvements could preclude similar events from recurring.

68. In this respect, the SAPSE Materials provides helpful information and detailed analysis concerning:

a) the nature and volume of past AV attendances involving Chris in the period preceding his death, including:

i. the proportion of past attendances involving co-response with Victoria Police,

ii. the circumstances where rapport was able to be established with Chris by responding services without requiring use of physical or chemical restraints,

iii. the circumstances of Chris's penultimate involvement with AV in early 2023, where he experienced an unexpected adverse reaction to chemical sedation (information which was not known to the paramedics responding to the subject event).

b) the phases of AV's response to this event evaluated from a clinical perspective, including steps taken and treatment provided by the attending paramedics, decision making processes, and relevant clinical practice guidelines.

c) factors which may have contributed to the event, and identification of potential areas for systems improvement in multi-agency responses to welfare checks which may improve patient care and safety in the future.

[64] *Coroners Act 2008* (Vic), s 1(c).

69. The SAPSE Materials document therefore has the potential to be of considerable assistance to my investigation and in the discharge of my statutory functions to make findings as to the cause and circumstances of the death. Further, its contents are also of potential relevance to s 72, which deals with the power of the coroner to make recommendations to any Minister, public statutory authority or entity on any matter connected with a death which the coroner has investigated, including relating to public health and safety.

70. Accordingly, I am satisfied that the SAPSE Materials is a relevant document which would, absent any statutory prohibition, appropriately form part of the coronial brief and be admitted during the Inquest proceedings.

71. Having so established, I now turn to the appropriate characterisation of the SAPSE Materials.

Characterisation of the SAPSE Materials

72. The relevant question that arises for my determination is how the SAPSE Materials document is to be characterised in the context of AV's review into Chris's death. That is, whether (as submitted by AV), the SAPSE Materials document is:

    a) a document that was created for the sole purpose of providing information in the course of conducting a SAPSE review and provided in the course of conducting a SAPSE review by or on behalf of that person; and/or

    b) evidence of any other information or reports obtained by or in possession of a SAPSE review panel in the course of conducting a SAPSE review.

73. If I am satisfied that the SAPSE Materials document falls within either of these categories, I accept that the document would not be admissible in the Inquest into Chris's death, regardless of its relevance, and could not be included in the coronial brief, or otherwise admitted into evidence during or at the conclusion of the inquest.

74. Having perused the SAPSE Materials and considered the evidence and submissions provided by AV in support of their Application, I am **not** satisfied that this document constitutes a document as described under s 128U(1)(b) or s 128U(2) of the *Health Services Act*.

75. For the reasons that follow, I consider the SAPSE Materials is a document eligible for inclusion in the coronial brief, together with the SAPSE Report, and that it may be admitted into evidence during or at the conclusion of the inquest into Chris's death.

(i) The SAPSE Materials is not a document created for the sole purpose of a SAPSE review under Division 8 of Part 5A of the *Health Services Act*

76. In evaluating the evidence of Ms Riseley and considering the extent to which I can be persuaded that, on the evidence, the SAPSE Materials document was prepared for the sole purpose of providing information to the SAPSE review panel, I have considered the potential for AV to have called more detailed evidence from a more immediate source in accordance with the principle in *Blatch v Archer*.[65]

77. That is, to the extent AV asserts that the SAPSE Materials document was prepared by the CSO for the *"sole purpose of providing information to the SAPSE review panel"*, and *"not created for any other purpose….[nor] intended to be provided to or used by anyone other than the SAPSE review panel"*, it bears the onus of producing adequate material to prove that issue on the balance of probabilities. No evidence has been produced by AV from the author of the SAPSE Materials that may have dealt directly with that issue. Nor has any explanation been proffered by AV regarding the absence of such evidence. As I have noted, the source documents provide a different chronology from the one apparent in the Riseley Affidavit. I have drawn an inference that the SAPSE Materials document was prepared on the date it bears. If there were direct evidence available to AV of it being prepared on a different date, or as to its purpose, it would have been for AV to provide that evidence.

78. Having considered the evidence which has been provided, I am not satisfied that the SAPSE Materials document was written for the *'sole purpose of providing information to the SAPSE review panel in the course of their review of Chris's death'* for the following reasons:

    a) A review of a SAPSE will only be protected if it is conducted in accordance with the specific requirements of Division 8, Part 5A of the *Health Services Act*. This Division

[65] (1774) 1 Cowp 63 at 65, per Lord Mansfield, that "*all evidence is to be weighed according to the proof which it was in the power of one side to have produced, and in the power of the other to have contradicted*." This principle was aptly elucidated in *Australian Securities and Investments Commissioner v Hellicar* (2012) 247 CLR 345, [256]: "*The underlying rationale for this principle can be simply put: a party with the burden of proof is expected to meet the requisite proof. If a party provides limited evidence when further evidence was available, a tribunal of fact is entitled to consider that failure when assessing whether the party has produced evidence to satisfy the standard of proof.*" (per Heydon J).

requires a SAPSE review panel to be appointed in accordance with sections 128P and 128Q of the *Health Services Act*.

b) On a proper review of the chronology of events, a SAPSE review panel had not been appointed at the time the SAPSE Materials document was prepared. The evidence before me confirms a CSO was first assigned to interview relevant AV staff and prepare an IDCR report on 8 September 2023 (the day after Chris' death), with the report subsequently completed on 11 September 2023. This was the day prior to the multi-disciplinary team assessment being conducted to consider the care and management provided to Chris on 12 September 2023. It was not until 12 September 2023 that Chris's death was classified as a SAPSE, and his case referred for SAPSE review and appointment of a SAPSE review panel. The SAPSE Materials was provided to the review panel a week later.

c) Contrary to AV's 'usual process' for conducting a SAPSE review in accordance with the protected process under Part 5A, Division 8 of the *Health Services Act* (outlined in the Riseley Affidavit), the SAPSE review panel did not nominate the CSO to interview relevant AV staff members and prepare an IDCR report for it in relation to Chris' death. The CSO had been assigned to conduct the review and had completed their report – the SAPSE Materials – prior to the panel's appointment.

d) A document created prior to the appointment of a SAPSE review panel cannot properly be said to have been created for the 'sole purpose' of a protected SAPSE review process under Division 8, Part 5A of the *Health Services Act* in circumstances where such a review had not yet come into existence, and it was not yet known whether it would take place.

e) It appears to me that the SAPSE Materials document was created in the first instance to comply with AV's Incident Management Procedure and statutory duty of candour obligations. Following its completion, it might have been used in one of two ways – for use in the statutory candour process, or in the protected SAPSE review process. If the multidisciplinary team reviewing Chris's care had determined **not** to conduct a protected SAPSE review under Division 8, Part 5A of the *Health Services Act*, the SAPSE Materials would have been used in the statutory duty of candour process and disclosed to Chris's family in accordance with open disclosure requirements, without any attendant protections.

79. Accordingly, I am not satisfied the SAPSE Materials is a document within the meaning of s 128U(1)(b) of the *Health Services Act*. It could not have been created for the sole purpose of

providing information in the course of conducting a SAPSE review, as no such review had commenced at the time it was prepared. The fact that a protected SAPSE review process was subsequently commenced cannot operate to retrospectively limit the use of the SAPSE Materials or any similar IDCR report by the Coroner.

(ii) The protections that apply to documents under s 128U(1)(b) are not unlimited in scope

80. It was submitted on behalf of AV at the hearing in December 2024 that documents captured by the protections under s 128U would include: *'notes, materials, drafts, file notes, summaries, opinions, expert reports, transcripts or recordings, all of those materials that are created for the sole purpose of a SAPSE review and provided to the SAPSE panel, all of those documents that underpin or feed the SAPSE report'*.[66]

81. While noting that counsel for AV was providing helpful examples that might assist the Court in determining the relevant issues, I consider this latter formulation (underlined above) to be too wide an interpretation of the protections that apply to materials considered by a SAPSE Review Panel in the course of conducting a protected review process.

82. It may of course be supposed – and is indeed indicated at various points in the SAPSE Report – that certain materials would be available to the Panel including patient care records, and applicable policies and procedures or guidelines.

83. In this regard, the protections in s 128U(1)(b) are limited to those documents created specifically by (or for) a SAPSE review panel for the purposes of providing information in the course of conducting a SAPSE review. They do not apply to primary source documents such as medical records and corporate records of the health service entity that are not developed to inform the SAPSE review.

84. Notes or transcripts of interviews with participants for the purposes of a SAPSE review (where such a review has commenced) would not be compellable because they would be prepared for the purpose of providing information. However, this first-hand material from clinicians is to be distinguished from the subsequent analysis of the information gathered in the course of the review and the conclusions reached as to prevention opportunities – as is the case in the SAPSE Materials.

[66] Submissions of Counsel for AV, T-12 line 22 to T-13 line 2 (emphasis added).

85. On my review of the SAPSE Materials, it is clear that this report goes beyond being raw evidence or information gathered for the purpose of a review (however that review is characterised). It is self-evident from my description of the SAPSE Materials that the author of this report has engaged in a comprehensive analysis of the information compiled during the IDCR process, including from interviews with relevant staff members and review of applicable policies and procedures, and has conducted a careful evaluation of the relevant events, drawing on their clinical expertise, identifying relevant contributing factors and opportunities for system improvements.

86. In this respect, in my view, the SAPSE Materials document is so closely intertwined with the SAPSE Report that – had it been prepared after the protected review process had been commenced – it would be more properly characterised as part of the SAPSE Report rather than as a document prepared for the purposes of providing information to the SAPSE review, noting that:

a) it follows the exact scope of a SAPSE review conducted under Division 8, Part 5A of the *Health Services Act*,[67] namely, by:

   i. establishing the facts (in detail) of the SAPSE and relevant surrounding context;

   ii. identifying factors that may have led to or contributed to the SAPSE; and

   iii. identifying any remedial measures that may be taken to prevent similar events from occurring in the future and improve the quality and safety of health services provided.

b) the SAPSE Materials document contains all relevant elements required to be contained in a SAPSE report, including a description of the SAPSE, analysis identifying why the event happened and any factors which contributed to the event, and any recommendations about changes or improvements in a policy, procedure or practice relating to the provision of a health service that are intended to reduce the likelihood of, or prevent, the same type of event happening again.[68]

[67] Pursuant to s 128O, *Health Services Act*.
[68] As required under s 128T, *Health Services Act*.

c) the SAPSE Materials is an entirely anonymised report (save for the name of the review lead), with all relevant persons involved in providing or receiving the health service being referred to by way of a pseudonym or general word. As noted by Counsel for AV, this is a requirement specific to SAPSE reports.[69]

87. Accordingly, I do not consider that it is a document to which section 128U(1)(b) would apply. It is part of the review analysis, not a document prepared for the purposes of a review as that term is used in the *Health Services Act*.

iii. Section 128U(2) applies to evidence about information or reports before a panel conducting a protected SAPSE review, and not to the documents themselves

88. Further, I do not accept AV's submission that the SAPSE Materials document is inadmissible on the basis that it falls within s 128U(2) of the *Health Services Act*.

89. Sections 128U(2)(a) and (b) preclude evidence of the following from being admissible in any action or proceeding:[70]

a) any other information or reports obtained by or in the possession of a SAPSE review panel in the course of conducting a SAPSE review, or

b) a SAPSE report, or any document created for the sole purpose of providing information in the course of conducting a SAPSE review and provided in the course of conducting a SAPSE review, being the documents to which s 128U(1) applies.

90. On a plain reading of these provisions, this means that no evidence can be admitted in any action or proceeding as to what matters were taken into account by a SAPSE review panel in conducting their review or in preparing their Report.

91. These provisions do not, and cannot be said to, render inadmissible a document in and of itself, which has been obtained by or is in the possession of a SAPSE review panel, unless otherwise protected from production under s 128U(1)(b). To accept such an interpretation would otherwise result in an absurdity in:

[69] Transcript of Directions Hearing on 9 December 2024, Counsel for AV, T-7, referring to s 128T(3), *Health Services Act* and reg 3E, *Health Services (Quality and Safety) Regulations 2020*.

[70] NB: These provisions are subject to the exception under s 128U(3), which provides that a SAPSE report may be produced to a coroner or the Coroners Court for the purposes of an investigation or inquest under the Coroners Act in respect of a death. This exception is discussed in Ruling No 1.

a) rendering inadmissible relevant records created outside the review process that would ordinarily be expected to be considered by a SAPSE review panel in conducting their review, such as patient records and clinical guidelines or health service policies; and

b) defeating the purpose of maintaining the confidentiality of the protected review process by requiring disclosure of the information or reports considered by the SAPSE review panel in order to determine whether such documents are inadmissible in proceedings.

92. The SAPSE Materials as a document in and of itself, does not provide evidence of information or reports considered by a SAPSE review panel in the course of conducting its review. It is an in-depth case review of the serious adverse patient safety event, separate from the SAPSE review process. It does not provide any evidence of what information or reports may have been provided to or obtained by the SAPSE review panel in the course of their review. In my view, the type of document which may fall within the scope of s 128U(2) would be a schedule of information or reports considered by the SAPSE review panel in conducting its review, rather than the documents themselves.

93. Accordingly, I do not accept AV's submission that the SAPSE Materials as a document is inadmissible pursuant to s 128U(2) of the *Health Services Act*.

iv. There is no evidence to suggest use of the SAPSE Materials in this case, or more generally, would create a 'chilling effect' on frank participation in review processes

94. A consistent theme in AV's submissions in the Application in respect of both the SAPSE Materials and IDCRs more generally, is what it says would be the 'chilling effect' of the Court's use of these types of reports in coronial investigations. I consider it relevant to address this issue as it has been claimed by AV that, if IDCR reports were distributed and included on coronial briefs it "*would disincentivise AV workers, including paramedics, from participating in the interviews and SAPSE reviews (or from participating in as forthright a manner as they would otherwise*".[71]

95. No direct evidence has been provided in support of this assertion. No examples have been provided in the Riseley Affidavit of such effects ever having occurred, been threatened, or anticipated as likely in the review process. Indeed, I note that on the evidence IDCR reports are routinely prepared for review of adverse patient safety events without the protections under

[71] Riseley Affidavit, p 4.

Division 8 of Part 5A of the *Health Services Act*, and in accordance with statutory duty of candour processes and AV's internal review procedures.

96. While it may be accepted that effects of that kind are theoretically possible, it is unclear how such concerns would arise in circumstances where:

    a) IDCR reports do not include any identifying information about clinicians or patients involved in the relevant event;

    b) IDCR reports are provided to the Court in relation to other reviews conducted under statutory duty of candour processes; and

    c) there is no evidence that participants are told of any relevant protections applicable to a SAPSE review at the time of interview.[72]

97. Further, I do not accept the submission that use of an IDCR Report like the SAPSE Materials in coronial proceedings may "*limit the ability of the multi-disciplinary team to undertake as robust and comprehensive an IDCR review as it might otherwise be able to do*".[73] As highlighted in Ruling No 1,[74] the legislative amendments made in 2022 to the *Health Services Act* included a new statutory duty of candour on health services – the fundamental purpose of which was to engender a culture of honesty and openness in health services, and to improve the quality of health care, with a focus on safety and person-centredness. Parliament has contemplated the need for frankness on the part of participants as a precondition of such processes and has provided for it through the existing protections in legislation. I do not accept that provision of an IDCR report to the Coroner will undermine that focus on frankness.

98. To the contrary, I consider that health workers are typically frank and candid in provision of information through both formal and informal review processes, and in providing statements to assist the Court in fulfilling its statutory functions to find the cause and circumstances of a reportable death and identify prevention opportunities. This is reflected in commentary within the SAPSE Materials which noted *"All five paramedics involved in this case were active*

[72] Indeed, the Riseley Affidavit indicates that participants are "*generally not informed…that the incident…is the subject of a SAPSE review, or that the SAPSE review is subject to protections under the [Health Services] Act*", at [2.8(b)].
[73] Riseley Affidavit, p 4.
[74] Ruling No 1, [88]-[89].

participants in the review process and demonstrated significant insight in their critical reflections. This reflects positively on their professionalism as registered paramedics"[75].

99. I agree with this assessment – having the benefit of not only the SAPSE Materials, but also statements from the paramedics involved, which were provided to the Court during the coronial investigation and are included in the coronial brief. Notably, the paramedics actively participated in the review process without being compelled to do so, or in reliance on any protections under the *Health Services Act.* I consider this to be commendable, noting that this is of assistance to my investigation and may assist in narrowing the scope of my inquiry and potentially obviate the need to call these witnesses to give *viva voce* evidence at inquest.

Conclusion regarding application

100. As noted in Ruling No 1 in relation to the SAPSE Report, I accept AV made this Application in relation to the SAPSE Materials having given genuine and anxious consideration to the way in which SAPSE and other internal review reports may be disseminated, and in circumstances where there has not yet been any judicial determination of the precise meaning and scope of relevant provisions under Part 5A of the *Health Services Act*, particularly in relation to Division 8, SAPSE Reviews.

101. I further acknowledge that AV, along with all other health services in this State, is navigating new processes in the context of existing review procedures and refining its implementation of these processes and procedures in light of relatively new legislative provisions. AV is to be commended for its work in reviewing its internal processes to implement clearer labelling to distinguish between the types of review reports and applicable legislative foundations, purposes and provisions, which will serve to create greater certainty for AV and for its individual staff.

102. However, having considered AV's arguments and evidence provided in support, I do not accept its characterisation of the SAPSE Materials in this case. I consider the SAPSE Materials document is properly before me and would have been a compellable document if not voluntarily provided to the Court. It is not a document to which the SAPSE Review provisions of the *Health Services Act* apply.

103. The Application made on behalf of AV in relation to the SAPSE Materials is therefore refused.

[75] SAPSE Materials, p 7.

ORDERS AND DIRECTIONS

104. I order that the SAPSE Materials, more particularly and precisely described as the Patient Safety Incident Management Serious Adverse Patient Safety Event In-depth Case Review Report dated 11 September 2023 (**IDCR Report**) be included in Version 2 of the coronial brief for **COR 2023 004999 - Christopher Keisler**.

105. The IDCR Report may thereafter be admitted into evidence during or at the conclusion of the inquest into the death of Christopher Keisler, as part of the coronial brief.

106. I direct that a copy of this ruling be distributed to Interested Parties and published on the Coroners Court website in accordance with the *Coroners Court Rules 2019*.

Signature:

INGRID GILES

CORONER

Date: 29 August 2025