CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Heather Winchester
Hearing dates:	2 February 2022
Date of judgment:	20 March 2022
Place of judgment:	Coroners Court of NSW, Lidcombe
Judgment of:	**Deputy State Coroner, Magistrate David O'Neil**
Catchwords:	CORONIAL LAW – notice of motion – issues lists – Inquest not yet commenced – challenge to an issues list
File number:	2019/304802
Representation:	1) Counsel assisting on the application: Ms Kirsten Edwards of Counsel, instructed by Mr J Herrington of the NSW Crown Solicitor's Office 2) Christian Congregation of the Jehovah's Witnesses Australasia Limited: Mr Adam Casselden SC and Mr Eric Engwirda of Counsel instructed by Ms Stacey Leeke 3) The Hunter New England Health District: Ms Karen Kumar of Counsel instructed by Mr Scott Sherwen of Makison D'Apice Lawyers 4) The Winchester Family: Ms Epstein of Counsel instructed by Ms T Woods

Introduction

1. Mrs Heather Winchester died on 27 September 2019 at John Hunter Hospital Newcastle. Mrs Winchester had undergone surgery to treat a vaginal haematoma that had occurred as a result of surgery conducted at Maitland Hospital two days earlier.

2. The inquest into Mrs Winchester's death was listed to commence on 28 November 2022.

3. On 16 November 2022, the Christian Congregation of the Jehovah's Witnesses Australasia Limited ("CCJW", "applicant") forwarded a Notice of Motion to the Crown Solicitors Office ("CSO") seeking that the hearing date be vacated and that the motion ("application") be heard on 28 November 2022.

4. On 18 November 2022, the inquest set down for 28 November 2022 was vacated. The matter was mentioned on 28 November 2022. At that mention a new date was set for the inquest and a timetable was set down in relation to the application. The inquest is now listed to commence on 8 May 2023. The application was heard on 2 February 2023.

5. I now set out some detailed background to the application.

Background to the Application

6. As part of its role in assisting the coroner the CSO had written to Mr Patrick Coetsee, solicitor, who acted for the Jehovah's Witness Church, on 12 May 2022 seeking information in relation to "apparent anomalies between the various documents signed by Mrs Winchester". The correspondence contained questions and asked for a number of documents. The correspondence requested a statement from an appropriately authorised person addressing the matters raised.[1]

7. A seven-page response under the hand of Tom Pecipajkovski on behalf of the Public Information Department, Jehovah's Witnesses Australasia, was sent to the CSO on 10 June 2022.[2] The correspondence included some background information to provide context to Mr Pecipajkovski's response to the various

[1] See Exhibit A6.
[2] see Exhibit A7.

issues raised. The background included a focus upon Jehovah's Witnesses beliefs and sought to clarify "common misconceptions". Mr Pecipajkovski then, in answer to questions concerning Jehovah's Witnesses and blood products indicated congregants are directed to "lesson 39 in the Enjoy Life Forever book" and also noted that that congregants are advised to "speak with their physician, surgeon and/or anaesthesiologist well in advance of any surgery…"

8. On 18 July 2022 the applicant was advised that it was now a person with sufficient interest in the subject matter of the inquest and that, whilst no final view had been formed, it was possible that Jehovah's Witnesses Australasia (JWA) and/or some of its members may be the subject of adverse comment.[3] It was also raised that the JWA may want to be represented at the inquest. In the correspondence the JWA was also asked to provide the name of an individual who was authorised by JWA to provide further evidence and or information.

9. On 3 August 2022, Ms Stacey Leeke wrote to the CSO in response to the 18 July 2022 correspondence. That correspondence clarified the proper legal entity on behalf of Jehovah's Witnesses to be the CCJW, confirmed Ms Leeke's firm had authority to act on behalf of that entity, set out relevant law as to the rights of an individual as to whether they receive blood transfusions and pointed out her client's position that the religious beliefs of Mrs Winchester and the Jehovah's Witnesses are irrelevant to and outside of the Coroner's jurisdiction.

10. Ms Leeke also confirmed that Mr Matthew Kemertzis is authorised to provide any further evidence if required.

11. On 18 August 2022, the CCJW appeared at a directions hearing and was granted leave to appear and be represented at the inquest.

12. Subsequently, the CSO prepared a draft issues list[4] that was forwarded to persons with sufficient interest including the CCJW. An extract of that issues list is as follows:

> *<u>In Relation to the manner of death:</u>*
>
> *2. The adequacy and appropriateness of the care provided to Mrs Winchester, including:*

[3] Exhibit A8.
[4] Exhibit A4.

a. whether Mrs Winchester should have been offered the surgery in the first place;

b. whether the risks of the surgery and any available alternatives were adequately explained to Mrs Winchester;

c. the nature and extent of her consent, including her refusal of [some] blood products and whether the paperwork and other documentation provided to her by her Church (the Christian Congregation of Jehovah's Witnesses (Australasia - "the Church"), was sufficiently detailed to allow Mrs Winchester to properly inform her doctors of her wishes consistent with her faith, and for her treating doctors to comply with them;

d. whether Mrs Winchester was provided with appropriate advice by members of the Church, including whether she and/or her treating doctors were able to clarify any uncertainties about which blood products she could and could not accept, consistent with her faith;

e. whether appropriate contingencies were put in place to manage Mrs Winchester should she suffer a bleed during or after her operation noting her refusal of [some] blood products

f. whether the initial surgery conducted by Dr Naseem was conducted competently; and

g. whether the decision to conduct the second operation at Maitland hospital before transferring Mrs Winchester to John Hunter Hospital was appropriate.

3. The adequacy of the systems in place at Maitland Hospital to identify and resolve any uncertainties in relation to the consent provided by Mrs Winchester including:

a. whether Dr Naseem was aware of the apparent anomalies in which blood products Mrs Winchester had consented to receive before she commenced the initial surgery; and

b. whether the relevant policies were adequate in dealing with what appears to be conflicting forms of consent, and if so, were they followed.

13. On 30 September 2022, the applicant emailed the CSO submitting that the draft issues 2(c) and 2(d) do not involve matters with sufficient connection to Mrs

Winchester's death and requested that consideration be given to removing the matters from the issues list.[5]

14. On 14 October 2022, Ms Leeke emailed the CSO advising that in the event that those assisting the Coroner did not agree to remove issues 2(c) and 2(d) from the issues list her client had instructed her to bring an application as to the scope of the inquest consistent with the terms of the 30 September 2022 letter. Ms Leeke further set out:

> *To avoid a vacation of the hearing of the inquest any application as to scope will need to be heard and determined by the Coroner expeditiously to enable any aggrieved party to seek judicial review in the Supreme Court of NSW before 21 November 2022.*

15. On 16 November 2022, a second draft issues list was distributed to the persons with sufficient interest by the CSO.[6] The following changes were made to issues 2(c) and 2(d):

> 2. The adequacy and appropriateness of the care provided to Mrs Winchester, including:
>
> > c. [changed to] the nature and extent of her consent, including her refusal of [some] blood products and including whether she and/or her treating doctors were able to clarify any uncertainties about which blood products she could and could not accept;
> >
> > d. [deleted]

16. On the same day, the applicant wrote to the CSO indicating that it remained of the view that issue 2(c) as currently drafted is not within scope. It was further submitted that the subpoena issued to Mr Kemertzis be set aside. An amended Notice of Motion of the same date was enclosed, which sought the following orders:

> 1. *The hearing date for the inquest of 28 November 2022 to 1 December 2022 be vacated;*
> 2. *This application be listed for hearing on 28 November 2022;*

[5] Exhibit A3, annexure SL1.
[6] Exhibit A5.

> 3. *Issues 2(c) ~~and 2(d)~~ be removed from the Coroner's <u>draft</u> Issues List dated <u>16 November 2022</u> as ~~they~~ <u>it</u> do<u>es</u> not involve matters with sufficient connection to the manner and cause of Heather Winchester's death and ~~are~~ <u>is</u> therefore beyond the scope of the Coroner's jurisdiction; and*
> 4. *<u>The Subpoena to Matthew Kemertzis dated 16 November 2022 be set aside</u>;*
> 5. *Any further order the Court deems fit.*

17. Before turning to consider the issues raised on the application it is appropriate to look at aspects of the legislation that empower a Coroner to hold an inquest.

Legislation

18. The role and function of a Coroner are set out in the Coroners Act (2009) ("the Act").

19. The objects of the Act are set out in s.3 which relevantly provides:

> c) *to enable coroners to investigate certain kinds of deaths…in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths,*
>
> d) *to enable coroners to make recommendations in relation to matters in connection with an inquest.*

20. Sections 81 and 82 of the Act make the objects operational.

21. Section 81 requires findings as to identity, date, place, manner, and cause of the identified person's death and for those findings to be recorded in writing. Section 82(1) allows for recommendations to be made in relation to any matter connected with the death that is subject to inquest.

22. Section 82(2) specifies without limiting s.82(1), that public health and safety are matters that can be the subject of recommendations as well as recommendations that a matter be reviewed by a specified person or body.

23. Sections 81 and 82 Act as the principal limiting factors on the scope of an inquest.

Background Facts

24. On the hearing of the application the full brief of evidence was tendered, in its current form,[7] as well as some affidavit material, the amended notice of motion and some correspondence. In addition, the parties' written submissions were marked as MFIs,[8] together with a bundle provided by counsel assisting.[9]

25. I now set out some of the relevant facts to provide some context and background to the application. In determining the application, I have had regard to the entirety of the material before me:

    i. On 5 July 2018, Mrs Winchester filled in and signed 'Worksheet 1' and 'Worksheet 2' indicating which blood products and treatments she would receive.[10] On the worksheets Mrs Winchester had indicated that she would accept albumin and haemoglobin.[11] "A church senior" was involved in discussing the worksheets with Mrs Winchester,[12] worksheets 1 and 2 are available on a publication closely connected to the CCJW being, "The Watchtower".[13]

    ii. On 14 August 2018, Mrs Winchester filled in an Advance Care Directive indicating that "I direct that NO TRANSFUSIONS of whole blood, red cells, platelets or plasma be given to me under any circumstances" and "I might accept haemoglobin if it is a constant flow and not plasma from another person." This form is signed by her and witnessed by Terrance Gill and Andrew Child.[14]

    iii. On 31 May 2019, Mrs Winchester attended Dr Azra Naseem's room for a consult with symptoms of a uterovaginal prolapse.

    iv. On 5 July 2019, Mrs Winchester returned to see Dr Naseem and advised her that she wanted to go ahead with surgery and accepted the use of a ring pessary while awaiting surgery.[15] A Request for medical treatment form was filled out by Mrs Winchester and Dr

[7] Exhibit A1.
[8] MFI A, Applicant's Submissions "AS" and MFI B, Counsel assisting submissions "CAS".
[9] MFI C.
[10] Medical records John Hunter Hospital (tab 24) pp. 117 – 118.
[11] Annexure B to statement of Dr Daniel Chilton (Tab 11).
[12] Statement of Dr Daniel Chilton (Tab 11), paragraphs 12 and 13.
[13] Counsel assisting's unchallenged written submission at [16] and footnote 1.
[14] Medical records from John Hunter Hospital (Tab 24), p.119.
[15] Statement of Dr Azra Naseem (Tab 9), paragraph 2.

Naseem. Mrs Winchester indicated that she did not consent to a blood transfusion if needed and signed the form.[16]

v. On 11 September 2019, Mrs Winchester attended the Anaesthetic Clinic and was seen by Dr Daniel Chilton (Anaesthetic Registrar). He was presented with Worksheets 1 and 2. He asked Mrs Winchester twice if she was happy to receive red blood cells and twice she replied with the words "I *have gone through this document with a church senior, whatever I have ticked, I am happy with.*"[17]

vi. On 25 September 2019, Mrs Winchester signed a 'Consent for medical procedure/treatment' form. Under the question 'I refuse consent to have the following aspects of the recommended treatment' she wrote 'Jehovah's Witness.' Below this, she ticked a box which stated 'I do not consent to a blood transfusion if needed.'[18]

vii. On the same date, Jasmine Moore (Endorsed Enrolled Nurse) completed the 'Adult Pre-Procedure' checklist' with Mrs Winchester prior to her surgery. Mrs Winchester acknowledged her consent to packed cells and platelets and this column of the checklist was ticked.[19]

viii. At 12:30pm on the same day, Dr Chilton asked Mrs Winchester, during a "Group and Screen", whether she was happy to receive packed red blood cells but did not want to receive plasmapheresis, she said that was correct.[20]

ix. At 3:24pm on 25 September 2019, Mrs Winchester underwent her first surgery which involved a hysterectomy and an anterior and posterior repair.

x. As a consequence of the surgery Mrs Winchester was found to have suffered a 95mm vaginal haematoma.[21]

xi. Later that evening, Mrs Winchester indicated to Dr Searle that she did not want to receive haemoglobin if it could be received only by packed

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[16] Medical records from John Hunter Hospital (Tab 24), p.127.
[17] Statement of Dr Daniel Chilton (Tab 11), paragraphs 12 and 13.
[18] Medical records from John Hunter Hospital (Tab 24), p.123.
[19] Statement of Jasmine Moore (Tab 21), paragraph 9; Medical records from John Hunter Hospital (Tab 24), p.189.
[20] Statement of Dr Daniel Chilton (Tab 11), paragraph 27.
[21] Statement Dr Naseem dated 20 May 2020 (Tab 9), paragraph 21

red blood cells and that this was her wish even if the result would be her death.[22]

xii. At 12:40am on 26 September 2019, a further surgery was undertaken at Maitland Hospital to repair a ruptured blood vessel and evacuate the haematoma. Mrs Winchester's total blood loss was estimated to be 1000ml..

xiii. At 3:50am, Mrs Winchester was transferred to the Intensive Care Unit of John Hunter Hospital via ambulance.[23]

xiv. At John Hunter Hospital Mrs Winchester underwent a third surgery. Whilst Mrs Winchester was at John Hunter Hospital issues surrounding Mrs Winchester's conflicting instructions were the source of ongoing consideration as the clinicians sought to determine what blood products Mrs Winchester could receive.[24]

Is the question raised on the application justiciable?

26. In accordance with the timetable referred to above the application was heard on 2 February 2023.

27. The applicant's primary contention, as set out in its amended notice of motion, is that the revised issue ("impugned issue", "revised issue") does not involve matters with sufficient connection to the manner and cause of Mrs Winchester's death and is therefore beyond the scope of the coroner's jurisdiction.

28. The operative part of the amended notice of motion reads:

> Issues 2(c) ~~and 2(d)~~ be removed from the Coroner's draft Issues List dated 16 November 2022 as ~~they~~ it does not involve matters with sufficient connection to the manner and cause of Heather Winchester's death and ~~are~~ is therefore beyond the scope of the Coroner's jurisdiction;

29. The application raises the question as to whether the revised issue is beyond the scope of permissible inquiry.

[22] Statement of Dr Searle (Tab 10), paragraphs 21 and 22.
[23] Medical records from John Hunter Hospital (tab 24), p.123.
[24] See below at [64] for more detail in relation to Mrs Winchester's care at John Hunter Hospital.

30. In her written submissions in response to the application, counsel assisting submitted that the question raised is not justiciable.

31. In considering the justiciability issue it is helpful to first refer to the nature and role of an issues list.

What is an issues list?

32. There was no dispute in the proceedings as to the following "core principles" relating to an issues list:

    i. An issues list does not have any legal or statutory status; it is a document circulated prior to an inquest to foreshadow issues that might be explored by counsel assisting in the course of an inquest.

    ii. An issues list does not delimit the scope of an inquest and it can neither enlarge nor restrain a coroner's jurisdiction.

    iii. Issues may rise or fall away as evidence unfolds during the course of the inquiry, even at a late stage of proceedings.

    iv. An issues list is distributed as a matter of procedural fairness to advise participants of matters that may arise on the evidence.[25]

33. In the inquest into the death of Kumanjayi Walker,[26] there have recently been instructive observations in relation to the role of an issues list:

> "[9] Unlike in civil or criminal proceedings the only 'issues' in an inquest are whether, and, if so, in what terms, a Coroner may or must make a finding, comment or recommendation under ss 26, 34, and/or 35 of the Coroners Act. The 'subject matters' of those provisions have been held to be 'broad…with indefinite boundaries.' This can create practical difficulties in inquests such as this, 'given the size and complexity of the inquest brief'.
>
> [10] As a result, a practice has developed, particularly in large or complex inquests, of Counsel Assisting producing an 'issues list.' Although there is no requirement for it, the practice has been held to be

[25] See MFI B at [64].

[26] Inquest into the death of Kumanjayi Walker (*Ruling No. 2*) [2022] NTLC 017.

‘entirely appropriate’. As I noted in an earlier ruling, Counsel Assisting’s ‘issues’ list was ‘designed to encourage discussion among the Coronial team and the parties’ and in that way to ‘give some structure to the inquest’. It contains ‘indicative questions of a kind that are anticipated [by Counsel Assisting] to arise on the evidence’. The list has never purported to be ‘determinative of the scope of … the inquest’ because an issues list can neither enlarge, nor constrain, the jurisdiction of a Coroner.

> [11] In this case, Counsel Assisting distributed that document early in their preparation for this inquest, in good faith, and as a courtesy to the parties. It was also thought that it would assist in explaining to the family and community of Kumanjayi Walker likely areas of inquiry. In spite of these intentions, given the level of disagreement it has generated, Counsel Assisting ultimately joined a number of the interested parties in submitting yesterday that it was inappropriate that I rule in an abstract way on the disputed ‘issues’ or ‘questions’. Instead, Counsel Assisting and these interested parties submitted that I should rule on any objections if and when an objection is actually taken to identified items or classes of evidence. No interested party submitted to the contrary.”

34. At [12], her Honour noted:

> “…at this early stage of this lengthy and complex inquest, it is impossible to know whether a number of the ‘issues’ or ‘questions’ anticipated to arise on the evidence by my Counsel Assisting team (and the interested parties) will ultimately be relevant to, or necessary under ss 26, 34, and/or 35 of the Act.”

35. In developing her submissions, on this application, counsel assisting stressed the following: the nature of an inquest; the inquest has not yet started; there has been no opening by counsel assisting; no evidence in chief has been taken; and no cross examination conducted. Counsel assisting also pointed to the fact that the inquest is an evolving factual inquiry during which both the issues list and the witness list may change.

36. It is uncommon, if indeed it has ever previously occurred in the NSW coronial jurisdiction, for there to be a Notice of Motion, brought by a person with sufficient interest, seeking to have an issue removed from a draft issues list in advance of an inquest.

37. I was not taken in oral or written submissions to any instance in NSW, or any other state or territory, of an issues list, draft or otherwise, being challenged prior to an inquest commencing, and that challenge being ruled upon by the coroner in advance of the inquest.

38. There are examples from other states of superior courts being asked to rule on issues a coroner was considering, during the currency of the proceedings.[27]

39. In NSW, during the inquest into the deaths of persons in the Lindt Café siege, State Coroner Barnes received argument and ruled upon a challenge as to whether issues relating to Mr Man Monis' bail were within the State Coroner's jurisdiction.[28] That application proceeded some four months after the inquest had commenced.

40. What is clear in relation to these authorities is that in each instance the impugned issue/s were expressed with specificity. In Lindt,[29] the impugned issues were clearly identified through three questions counsel assisting proposed to explore. In *Harmsworth*,[30] the appellant sought declarations that the Coroner had exceeded his jurisdiction by admitting into evidence matters relating to prison administration and operations. The issues had been divided into "grounds" of the appeal which set out in detail what the Coroner had been inquiring into or in some instances proposed to inquire into.

41. In each of these matters the appeal Court was able to rule on the impugned issues because of the specificity with which the issues were identified.

42. In answer to counsel assisting's submission that the question raised on the application is not justiciable, the applicant posed what it suggested was a rhetorical question: "what is a party to do when it has a genuine concern about the scope of an inquiry, when is it to agitate that? Does it sit mute until a first

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[27] See for example *Harmsworth* [1989] VR 989; *Thales Australia Limited v The Coroners Court of Victoria* [2011] VSC 133; *Doomadgee v Clements* [2005] QSC 357.
[28] Inquest into deaths arising from the Lindt Café Siege, 5 June 2015.
[29] Op cit 5 June 2015 pp.1,2.
[30] Op cit pp.997,998.

witness is called and then stand up and object and wish to argue scope and possibly interrupt the good order and management of your Honour's inquiry?.......my client took the view that it is better to agitate sooner rather than later so that all the parties, most importantly your Honour, knows what is going to be an issue for exploration."[31]

43. The answer to the applicant's question in my view is that the most appropriate time to consider the issue would be when it becomes apparent that the issue will be explored and, if so, how it is to be explored.

44. In bringing the application at this stage of the Coronial proceedings the applicant relies upon its assessment as to the course of the inquest, firstly assessing what matters under issue 2(c) will be explored, and then speculating as to how they will be explored.

45. The applicant's contention in this regard emerges from its written submission that the revised issue suffers the same defect as the original issues[32] and that there is no practical distinction between the original issues and the revised issue so far as the matters of inquiry are concerned.[33]

46. The applicant suggests that Messrs Gill, Child and Kemertzis remaining as witnesses to be called at the hearing is evidence of the preservation of the scope.[34] The applicant also submits "there remain no limits on the scope of the inquiry into the nature and extent of Mrs Winchester's consent".[35]

47. The submission as to there being no limits to the scope of the inquiry can be quickly disposed of, given an issues list cannot and does not determine the limits of an inquiry. The limits of the inquiry will be determined by the questions at inquest.

48. The "original issues" (2)(c) and (d)) referred to "paperwork and other documentation" as having been "provided to [Mrs Winchester] by her Church" and also referred to "members of the Church providing advice" to Mrs Winchester and the "appropriateness" of that advice.

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[31] Transcript "T" at p.45 l.47 to p.46 l.8.
[32] AS [9].
[33] AS [17].
[34] AS [18].
[35] AS [17].

49. Inferentially the applicant's argument is that the inquiry will include consideration of the various documents completed by Mrs Winchester, whether those documents were provided to Mrs Winchester by the church, whether advice was provided by the church and or church members, to Mrs Winchester, in relation to blood products, and the appropriateness of any advice that was provided.

50. Whilst it is clear that consideration of Mrs Winchester's consent will result in consideration of the various documents, there is nothing in the revised issue that suggests the other matters will be considered. To that extent the applicant's position can be seen as somewhat speculative.

51. The revised issue is currently widely drawn. Given the nature of an issues list there is no requirement for it to be any more specifically drawn.

52. Bearing in mind that the application has been brought at a time when the inquest has not yet commenced; there has not been an opening by counsel assisting; no oral evidence has been given; no cross- examination has taken place; the impugned issue is a draft issue; and the legal position that an issue on an issues list cannot enlarge a coroners jurisdiction, there are powerful reasons to consider that the issue raised is not justiciable.

53. Whilst the application can only be determined by consideration of the (draft) revised issue, as currently drawn, it is clear, on the face of the revised issue, that the paperwork and other documentation (signed by Mrs Winchester) will be considered in the context of her consent. There is a clear connection between the applicant and the paperwork which will come under consideration.

54. The applicant has argued that inquiry into the issues it has assessed as arising from the revised issue is beyond jurisdiction. It is an extremely serious step to refuse to hear an applicant in relation to a jurisdictional challenge. The challenge would have to be clearly or demonstrably without basis for such a step to be taken. Whilst aspects of the application are, as I have suggested, speculative, I accept that, at least in part, the applicant challenges an issue, which, on the face of the revised issue, is to be inquired into. In those circumstances I propose to deal with the application on its merits.

Outline of competing arguments on the application

55. There are two distinct aspects to the applicant's arguments as to why the revised issue is outside scope.

56. The first aspect relates to the "papers and other documents". The second relates to the suggested maintenance of the other aspects of the original issues.

57. In relation to the papers and documents, in written submissions the applicant put its case this way;

> "It cannot be said that 'the paperwork and other documentation' had any causal connection to Mrs Winchester's death. Irrespective of any written instructions, Mrs Winchester had unequivocally communicated her refusal to accept a blood transfusion"[36]

58. In oral submissions the matter was put as follows:

> There is no causal link between Dr Chilton's understanding, erroneous as we have submitted (it) was, and Mr's Winchester's ultimate death.[37]

59. As the applicant's argument was developed, through a series of posed questions,[38] it was submitted that Mrs Winchester, under no legal disability, and fully informed by medical advice, died because of her personal choice to refuse a blood transfusion, and that, "to explore lines of inquiry, beyond those posed questions, in relation to issue 2(c) would be both unreasonable, irrational and beyond the scope of your Honour's jurisdiction when one applies a *March v Stramere*[39] test of causation. It is just too tenuous we submit, too remote".[40]

60. The applicant emphasised throughout its oral submissions that there had to be a causal link between the issue inquired into and the death of Mrs Winchester for the issue to be within scope.[41]

61. In response to the applicant's causation submission, counsel assisting submitted that there did not need to be a causal connection between issues explored and the death being inquired into and pointed to the examples of a Coroner inquiring into a death during a police shooting where it is clear that the deceased died from

[36] AS [19,37].
[37] T p.11 L.19 and following.
[38] T p.8 L.20.
[39] *(1991) 177 CLR*.
[40] T p.8 L.45 – T p.9 L.5.
[41] T p.11 L.15-33; p.15 L.30; p.16 L.26-28.

a gunshot wound whilst threatening police with a knife and yet consideration of the arrest and the circumstances of the arrest are not issues beyond jurisdiction. Similarly, in a death in custody inquest, the deceased prisoner may be known to have died from cancer and yet inquiries into the deceased's care, treatment and surrounding circumstances are not beyond scope.

62. As a further prong to its contention that inquiry into the issue of Mrs Winchester's consent is beyond scope the applicant submits that "any perceived ambiguity in relation to Mrs Winchester's consent was unequivocally resolved no later than 9:55pm on 25 September 2019 by Mrs Winchester's explicit instructions to Dr Searle".[42]

63. There is no doubt that in her statement, Dr Searle sets out clearly that Mrs Winchester indicated she did not want to be transfused.

64. Counsel assisting submits, as with all witnesses, Dr Searle should be examined on oath or affirmation and be available for cross-examination. Further, counsel assisting notes, the instructions to Dr Chilton appear to have been as firm as were the instructions to Dr Searle.

65. The applicant pressed its contention in oral submissions, stressing that in the minds of the relevant clinicians there was no confusion in relation to Mrs Winchester's consent after 9:55pm on 25 September 2019.[43] This is a matter of some dispute. The evidence of the ongoing issues and concerns in relation to Mrs Winchester's instructions is set out in MFI "C" provided by counsel assisting and entitled "aide memoire of some documents relating to Mrs Heather Winchester's consent to blood products". The aide notes that:

    a. At 5:00am, on 26 September Mrs Winchester arrived at John Hunter Hospital. An admission summary indicates "…because of being JW, refuses Rbcs, she received onlly (sic) Albumin 350 ml + Crystalloid + aramine >> retrieved intubated to JHH" and that the reason for her admission was "post vaginal hysterectomy bleeding in Jehovah's witness patient."

[42] AS [32].
[43] T p.7 L.7, p.7 L.25-28; p.11 L.42-44: p.12 L.5-7: p.13 L.9-10.

b. At 5:54am, Mrs Winchester is examined and given Albumin 350ml + Crystalloid + aramine.

c. On 27 September 2019 at 7:30am, Dr Simon Ellis (Anaesthetics Registrar) at John Hunter Hospital noted that Mrs Winchester was a Jehovah's Witness and did not consent to some blood products, including red blood cells and that there were multiple directives which had differing information regarding her wishes. As a result, he and Dr Tracey Tay (duty anaesthetist) sought clarification and documented the same in the medical records.[44]

d. Further on the same day at 11:30am, Dr Hyde discussed the 2018 and 2019 documents with Mrs Winchester's family, the differences in the documents and discussed the advice he had received from the hospital management on the interpretation of the forms. Dr Hyde explained that they were seeking legal advice from NSW Health on how to interpret "multiple signed and disagreeing documents and verbal statements that Mrs Winchester has made"[45].

e. After 11:30am a lengthy discussion was held between Dr Jeram Hyde, NUM Chislett, NUM Styles, Dr. Healey (ICU acting director) to help clarify which blood products, if any, Mrs Winchester would consent to based on the available information. They escalated this to Debbie Bradley (Hospital GM), Julie Tait (Critical Care Service Manager) and Karen Barry (HNE Legal Counsel) for clarification. A note was made that "In the meantime Mrs Winchester rapidly deteriorated from noon onwards…[46]"

f. At 2:00pm, an investigation conducted by OTIO anaesthetist on whether Mrs Winchester could have platelets as it was recorded in the handover from ICU that she "would have anything except red blood cells."[47] The Jehovah's Witness advisor (Alan) was contacted by the anaesthetist and (the anaesthetist) was told that the 'current templates were confusing

[44] Statement Dr Ellis Tab 20 para 1.8.
[45] Statement Dr Hyde (Tab 16) at 1.20.
[46] JHH Notes (Tab 24), p.360.
[47] Statement Dr Choi (Tab 34) [30].

(tick boxes)' and 'it is up to individuals to make decisions.' A further note states 'Advised OTIO Anaesthetist NO platelets[48].'

g. At 3:41pm, a family meeting was held and the family was told that Mrs Winchester was deteriorating and would likely not survive.

h. At 4:30pm, Mrs Winchester passed away.

66. Another submission of the applicant is that there was no ambiguity in relation to whether Mrs Winchester would receive packed red blood cells.[49] An aspect of the applicant's submission is that to the extent there was any confusion in relation to the Work Sheets it was caused by Dr Chilton's erroneous conclusions.[50] As such, it is argued there is no need to inquire into the issue of Mrs Winchester's consent.

67. The second aspect of the applicant's case relates to the contention that the revised issue preserved the scope of the inquest.

68. The only submissions made in relation to this contention related to Messrs Gill, Child and Kemertz being witnesses and reference to the paperwork and other documentation not being causative of Mrs Winchester's death.[51]

69. The applicant, in written submissions, notes that Mr Gill and Mr Child signed the advanced health directive,[52] and in oral submissions posed the question as to what they (Mr Gill and Mr Child) can say "on the nature and extent for [sic] Mrs Winchester's consent when they had had no interactions with her".[53]

70. Counsel assisting submitted that the family may want to explore or test the statements by Mr Gill and Mr Child including the assertion that there was no further discussion.[54]

71. In relation to Mr Kemertzis, it was submitted he had never met Mrs Winchester.[55] As I have observed, there was no development beyond these submissions as to the relevance of the applicant's contention as to scope having been preserved.

[48] JHH Notes pp. 418,419.
[49] AS [25-29].
[50] AS [25-29]; T p.5 L.28 - T p.6 L.5.
[51] AS [15,16,19].
[52] AS [15], L.18.
[53] T p.14, L.8-12.
[54] T p.22, L.45.
[55] T p.14 L.15

Principles and authorities relating to the scope of the inquiry into manner and cause of death

72. As set out above, s.81 of the Act requires findings as to identity, date, place, manner, and cause of the identified person's death.

73. It is recognised that cause of death" focuses upon the physiological cause or causes of death.[56]

74. It is considered important to distinguish between the terminal cause of death and the "real" or "actual" cause of death.[57]

75. It is also clear that consideration of "manner" involves different content to consideration of "cause." The difference between manner and cause was clearly explained by Justice Mullens in *Atkins v Morrow*[58] in the Queensland Supreme Court wherein his Honour explained that the death is the actual event and the cause of it is the process or happening which brought the death about, whereas the "circumstances" covers a much wider area of inquiry as the word itself conveys.

76. The relevant terminology in the NSW Coroners Act is "manner of death". In *Conway v Jerram*[59] *,* after reviewing the authorities, Barr J concluded that:

    > "manner of death should be given a broad construction so as to enable the coroner to consider by what means <u>and in what circumstances the death occurred."</u> (emphasis added)

77. So far as the extent of the inquiry into manner is concerned, *Harmsworth*[60] confirms that inquiries must be directed to the making of the statutory findings and cautioned against embarking on an inquiry that might never end and that might never enable coherent and concise findings to be made. In *R v Doogan*,[61] the Full Court of the Australian Capital Territory Supreme Court warned against conducting a "roving royal commission".

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[56] Dillon and Hadley 'The Australasian Coroners Manual' 2015 p.112.
[57] Waller's Coronial Law and Practice 4th ed. at 81.21.
[58] *Atkins v Morrow 2005 QSC 92* [29].
[59] *(2010) 78 NSWLR 689.*
[60] *Harmsworth v The State Coroner* [1989] VR 989.
[61] *R v Doogan* (2005) 158 ACTR 1.

78. Whilst these authorities make clear that the scope of an inquest is not unlimited, Waller notes that it is important that “manner of death” not be too narrowly construed.[62]

79. What is a permissible scope will turn on the facts of each inquest. Consideration of authorities is instructive as to what has been found to be within scope.

80. In *Atkinson v Morrow*,[63] the deceased (Mr O’Sullivan) had captured police attention when he had complained that persons hiding in trees had a gun trained on him. Police attended and transported the deceased from the area where his complaint had been made, and later dropped him off in a Queensland country town, known as a place where long haul trucks picked up persons who wanted transportation to other parts of the state. The deceased was not seen alive again. The Queensland Court of Appeal confirmed that it was within permissible scope for a Senior Police Officer to be required to give evidence in relation to dealing with situations similar to that which had eventuated in relation to the death of Mr O’Sullivan.

81. In *Thales Australia Limited v The Coroners Court [2011] VSC 133*,[64] in an inquest that had become fragmented due to the manner in which Thales had made submissions, the Coroner had made findings as to cause and circumstances whilst at the same time indicating the inquest would be continued for further inquiry into occupational health and safety issues. On appeal Beach J was satisfied that it was open to his Honour to consider evidence on these issues.

82. In *Harmsworth*,[65] it was clear the deceased died in a fire in a prison following some prisoners barricading themselves and ultimately one of the prisoners starting a fire. On appeal, Nathan J accepted that an inquiry into the cause of each deceased prisoner’s frustration would be a permissible area for inquiry, as would whether the levels of frustration and anger induced by the relevant incarceration required extra diligence and care by the Department of Corrections.

83. In *Doomadgee v Clements*,[66] Muir J, whilst acknowledging that the power to comment was ancillary to the duty to make the statutory findings, expressed the

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[62] Waller, Coronial Law and Practice, 4th Ed., 81.19.
[63] *[2005] QCA 353*.
[64] See [63-66]
[65] *Harmsworth v The State Coroner* [1989] VR 989.
[66] *Doomadgee v Clements* (2006) 2 Qd R 352 at 360, [28].

view that the scope of an inquest is not confined to evidence directly relevant to the statutory findings.

84. In *Doogan*,[67] the Coroner was inquiring into bushfires that had caused death and widespread damage in the Canberra area. In the course of its judgment on a question of apprehended bias, the Full Court of the ACT Supreme Court observed, by way of example, that consideration of the "circumstances in which the fire occurred" could have extended to referring to Australia Day traffic hampering the deployment of firefighting units.

85. Finally, in relation to authority I will refer to some comments of superior Courts in relation to the role of a Coroner.

86. In *R v Doogan,*[68] in ruling that the application was premature the Court observed that it was neither necessary nor appropriate to go through either the evidence or issues list with a view to making rulings as to the relevance of each of the issues identified

87. In *Bauwens*,[69] the Northern Territory Supreme Court noted that a Coroner's Court fulfils the "important public function" of investigating the cause and circumstances of reportable deaths and that it is "generally…. inappropriate to interfere with the gathering of evidence by a coroner" or "to seek from a coroner a ruling that one piece of evidence or another is inadmissible or irrelevant as if the coroner were conducting a civil or criminal trial".

Ruling

88. It clearly emerges from the principles and authorities referred to above that an issue does not need to be causative of the death to be within the permissible scope of an inquest. The authorities make clear that "manner" has different content to "cause" and, in appropriate circumstances the exploration of manner may go beyond exploration of causative matters.

89. This is consistent with the wording of the Act, and the Coroner's obligation to conduct a thorough investigation and pursue reasonable lines of inquiry to

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[67] R v Doogan [2005] ACTSC 74 at [36].
[68] *R v Doogan* (2005) 158 ACTR 1.
[69] *Bauwens & Anor v The Territory Coroner* 2022 NTSC 92 at [62,64]

determine in what circumstances the death occurred. There is a significant public interest in the Coroner conducting a thorough public inquiry.

90. Revised issue 2 (c) makes no mention of the CCJW. The focus of issue 2 (c) is to inquire into aspects of Mrs Winchester's consent, including her attitude to the receipt of blood products.

91. The applicant contends that any ambiguity in relation to Mrs Winchester's attitude to receipt of packed red blood cells emerged solely because of Dr Chilton's misunderstanding and that any confusion was resolved for clinicians by 9:55pm on the 25th of September 2019. Counsel assisting submitted otherwise.

92. On the face of the notes from John Hunter Hospital set out in MFI "C" there was significant confusion amongst treating clinicians as to what blood products Mrs Winchester would and would not receive, on 26 and 27 September 2023 up until the time of her death. Further, that confusion cannot be accurately described as being solely due to any view Dr Chilton held. The confusion arose because of what were observed to be "multiple signed and disagreeing documents and verbal statements that Mrs Winchester has made" and "multiple directives which had differing information regarding her wishes".

93. In relation to the worksheets, the CCJW contact (through John Hunter Hospital), "Alan", was quoted as saying that "the current templates are confusing (tick boxes)".[70]

94. In relation to matters prior to 9:55 pm on 25 September 2019, contrary to the applicant's submissions, Dr Chilton's discussions with Mrs Winchester were not limited to discussions on 11 September 2019.[71] Mrs Winchester also provided verbal instructions to Dr Chilton on 25 September 2019, pre-operatively.[72] The differing instructions on 25 September 2019 to Dr Chilton (pre-operatively) and Dr Searle (post-operatively) together with the content of the checklist document completed by Nurse Moore[73], raise issues to be inquired into as part of the inquiry into Mrs Winchester's attitude to the receipt of blood products in general and packed red blood cells in particular.

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[70] JHH records (Tab 24), p.418.
[71] T p.14 l.35-45.
[72] Statement of Dr Daniel Chilton (Tab 11), paragraph 27.
[73] JHH notes (Tab 24), p.189.

95. The disputed contentions in relation to events prior to and post 9:55pm on 25 September 2019 are to be resolved at inquest when witnesses give evidence on oath or affirmation and are subjected to cross-examination.

96. What is clear however is that on the information currently available in the brief of evidence, the nature and extent of Mrs Winchester's consent and the clarification of what blood products she would accept, were, as counsel assisting submitted, inextricably linked to the circumstances of her death. Whilst no blood products were required in the first surgery, blood products were required as a result of complications arising from the first surgery and which blood products could be received during subsequent attempts to treat Mrs Winchester remained an issue for her treating clinicians up until the time of her death.

97. I am satisfied inquiry into the nature and extent of Mrs Winchester's consent, as explained above, including consideration of the documents she signed and the verbal instructions she gave, relating to her receipt of blood products, is within permissible scope and as such within jurisdiction. Inquiry into the circumstances in which Mrs Winchester's death occurred would be incomplete without consideration of these matters

98. As noted above, limited submissions were made by the applicant in relation to the asserted "preservation of the scope of the inquest."

99. A consequence of the applicant making its application at this stage of the coronial proceedings, in circumstances where the revised issue is widely drawn, is that there is no specificity as to what the questioning of Messrs Gill and Child will be. The need to examine Messrs Gill and Child, and, if they are examined, the content of the examination may not be determined until consent issues have been inquired into with other relevant witnesses, including Drs Naseem, Chilton, Searle, Woods, Jaaback and Choi.

100. Having accepted that the documentation signed by Mrs Winchester and her verbal instructions are inextricably linked to the circumstances of her death and accepting there is evidence currently available that Mrs Winchester's instructions, not only varied, but that the variations created confusion amongst treating doctors, I am of the view that exploration of the circumstances in which

each verbal instruction was given, and each document was signed is within scope.

101. Messrs Gill and Child witnessed the signing of the Advanced Care Directive; interested parties are entitled to examine Mr Gill and Mr Child under oath or affirmation and test the content of their statements and examine the circumstances of the signing.

102. The applicant's contention that Messrs Gill and Child will say that they did not have any discussions with Mrs Winchester is no answer to the right of interested parties to test the content of the statements of Messrs Gill and Child.

103. The applicant has not put forward any argument in relation to the asserted "preservation of the original scope" that would cause me to remove the revised issue from the draft issues list.

104. Finally, in relation to Mr Kemertzis there is little force to the application for the subpoena served upon him to be set aside.

105. Mr Kemertzis was nominated by the applicant as authorised to provide further evidence and information on behalf of the applicant.

106. Entities regularly assist coroners through individuals who have had no contact with the deceased or other persons involved in the circumstances of the death.

107. The purpose of such involvement is well established and well known. It is to assist the coroner, on behalf of the interested party, in relation to topics in which the coroner is interested.

108. In this inquest, there will be examination of documents provided by the CCJW to Mrs Winchester. There will also be examination of the circumstances in which those documents were completed. In addition, there is material indicating the CCJW directed congregants to a "lesson", relating to the receipt of blood products. In these circumstances it appears that Mr Kemertzis, being the person nominated by the CCJW is likely to be able to give material evidence at inquest (*s.66 of the Act*). I decline to set aside the subpoena to Mr Kemertzis dated 16 November 2022.

The power to make recommendations

109. The confusion and uncertainty as to Mrs Winchester's instructions was a most regrettable situation. The risk of such confusion occurring in the future should be minimised, so far as this can be achieved. There is a clear public health interest in the associated risk to health being reduced. Correspondence from the CCJW highlights the need for cooperation between hospitals and patients and confirms the need for the swift application of protocols for patients who do not accept blood products. In this regard the CCJW wrote to the CSO in the following terms:[74]

> "As you would appreciate, the way in which hospitals respectfully co-operate with patients who do not accept allogenic blood transfusion and swiftly apply effective protocols has a bearing on the more than 20,000 active Jehovah's Witnesses living in New South Wales, in addition to the growing number of patients who refuse allogenic blood transfusion based on the medical risks."

110. The need to take steps to minimise the risk of confusion, uncertainty and delay, in future clinical settings, brings into focus what I consider to be a separate basis for finding that consideration of the matters raised by the revised issue is within jurisdiction. That is, the recommendation power under s.82 of the Act. The recommendation power is secondary to the duty to make findings. Nevertheless, it is an important power as making recommendations with an aim to reducing future risk, is a fundamental function of Coroners.

111. In *Conway v Jerram*[75] at paragraph [63] Justice Barr noted:

> "The power of a coroner to make recommendations about matters of public health and safety seems apt to enable the coroner to consider matters outside the scope of what may be considered necessary to determine the manner and cause of death."

112. In dismissing an application for leave to appeal, the Court of Appeal[76] noted Justice Barr held that "before the power to make recommendations became exercisable, there first had to be proper grounds for holding an inquest".

113. Section 82 of the Act authorises recommendations in relation to any matter connected with the death with which an inquest is concerned. There is no doubt

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[74] Exhibit A7 (last paragraph).
[75] Conway v Jerram (2010) NSWLR 689.
[76] Conway v Jerram [2011] NSWCA 319 [42,46]

that Mrs Winchester's consent, including her attitude to the receipt of blood products and the confusion created by her varying verbal and written instructions are all matters connected with her death. Additionally, there is no dispute that there are proper grounds for holding an inquest into the death of Mrs Winchester. The applicant does not argue otherwise, and no other interested party takes any objection to any aspect of the draft issues list.

114. I have determined the revised issue raises matters to be inquired into which are clearly within permissible scope and within jurisdiction. Separately, and additionally, s.82 enables consideration of the revised issue, within jurisdiction, with a view to making appropriate recommendations.

Orders

115. The application is dismissed.

Magistrate David O'Neil

Deputy State Coroner
Coroners Court New South Wales
20 March 2023