

## Runacres v The Coroners Court of Victoria [2024] VSC 304

# **Quigley J**

### I EXECUTIVE SUMMARY

On 11 June 2024, in the Trial Division of the Supreme Court, Quigley J dismissed an appeal by Dr Sean Runacres against specific findings made by Coroner Simon McGregor ('the Coroner') of the Coroners Court of Victoria in the inquest into the passing of Veronica Marie Nelson.

## **Background:**

- Veronica, a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman, passed away whilst in the State's custody on 2 January 2020 at the Dame Phyllis Frost Centre.
- Veronica's death constituted a 'reportable death' pursuant to section 4 of the *Coroners Act 2008* (Vic) ('Coroners Act'). On 30 January 2023, the Coroner published his findings into the death with inquest into the passing of Veronica Marie Nelson ('the Coroner's report').
- Per section 67 of the Coroners Act, the Coroner made a considerable number of statutory findings relating to several matters connected with Veronica's death.
- This included specific adverse findings against the appellant, Dr Sean Runacres, who conducted the
  initial medical assessment ('reception medical assessment' or 'RMA') of Veronica when she arrived
  at DPFC on 31 December 2019.
- At the time of Veronica's death, the appellant, a registered medical doctor, was employed by Correct Care Australia ('CCA'), the private entity which provided primary health services at DPFC.

# The appeal:

- The appellant brought an appeal under section 83(1) of the Coroners Act, seeking to quash specific adverse findings made against him by the Coroner with respect to the circumstances of Veronica's death, including:
  - o At [528] of the findings, that the appellant did not physically examine Veronica on 31 December 2019;
  - At [520] of the findings, that the appellant recorded Veronica's weight inaccurately in the Medical Assessment Form ('MAF'); and
  - O At [541] of the findings, that the appellant set in motion a chain of events in which Veronica's medical treatment and care was inadequate in an ongoing way.
- The appellant contended that the Coroner erred in finding that certain findings of fact were 'not open' to him, that the Coroner failed to weigh the evidence in accordance with the applicable evidentiary standard, and/or that the findings were against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made such findings.

### Conclusions as to the grounds of appeal:

- The Court found that the Coroner correctly understood the evidentiary standard applicable to him and he properly weighed the evidence in accordance with it. The Court found that the findings at [528] and [520] were open to the Coroner on the evidence before him, and were not against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made them.
- The Court found that the statement at [541] is not an appealable statutory finding for the purposes of the Coroners Act. Rather, it was found to be a preliminary conclusion forming part of the continuum of analysis which underpinned a separate statutory finding at [542].



#### II DETAILED SUMMARY

# The appeal:

- The appeal was limited to the *findings* of the Coroner, as opposed to the Coroner's comments or recommendations (s 83(2) Coroners Act).<sup>1</sup>
- Per section 87A of the Coroners Act, the appeal is limited to a question of law. As such, the success of the appeal was dependent on whether the appellant could identify an error of law in the Coroner's findings.<sup>2</sup>
- The Court granted leave to intervene in the proceeding to Aunty Donna Nelson, Veronica's mother, and James Leonard ('Percy') Lovett, Veronica's longtime partner. Written and oral submissions were made by the intervenors on the substance of the appeal.<sup>3</sup>

# The findings being challenged by the appellant:

- The appellant sought to set aside three specific findings found at [528], [520] and [541] of the Coroner's report. Further, if set aside, the appellant sought to make consequential amendments to other paragraphs of the Coroner's report.<sup>4</sup>
- The finding at [528]:
  - On the basis of the evidence canvassed above, I find that a physical examination of Veronica was not conducted on 31 December 2019, although three examinations were recorded as having been undertaken in the MAF and Initial Appointment Notes by Dr Runacres.'5
- The finding at [520]:
  - On the basis of Dr Baber's 47 evidence, I find that Veronica weighed around 33kg at the time of her reception medical assessment and that the weight recorded by Dr Runacres in the MAF was inaccurate.'6
- The finding at [541]
  - O 'Dr Runacres was the health professional responsible for identifying at reception whether Veronica was fit to be held in an unobserved cell. The reception medical assessment is to be a comprehensive health assessment and offered the best opportunity in the prison reception process for the extent of Veronica's unwellness to be identified, recorded, treated and escalated. Dr Runacres' failure to properly utilise this opportunity set in motion a chain of events in which her medical treatment and care was inadequate in an ongoing way.'<sup>7</sup>

# The grounds of appeal:

The notice of appeal raised six questions of law or alleged errors by the Coroner in his assessment of evidence upon which he made the specific findings challenged. This included:<sup>8</sup>

- 1) whether the Coroner erred in finding that it was 'not open' to him to reach his conclusion at [526] of the Report.
- 2) in reaching his findings at [528] and [520], whether the Coroner failed to apply the *Briginshaw* standard in weighing all available evidence, bearing in mind the gravity of that finding against the appellant and the inherent unlikelihood of the conduct found; and

<sup>2</sup> [16-[18]

<sup>&</sup>lt;sup>1</sup> [13]-[14]

<sup>&</sup>lt;sup>3</sup> [27]-[29]

<sup>4 [53]</sup> 

<sup>&</sup>lt;sup>5</sup> [54]

<sup>&</sup>lt;sup>6</sup> [56]

<sup>7.5503</sup> 

<sup>&</sup>lt;sup>7</sup> [58]

<sup>8 [60]</sup> 



3) whether the findings at [528], [520] and [541] are wrong in law in that they are 'against the evidence and the weight of the evidence' to the extent that no reasonable coroner could have made

#### **Conclusions as to Ground 1:**

Ground 1 related to whether the Coroner erred in law in determining at [526] of the Coroner's Report that it was 'not open' to him to find that the appellant could have conducted physical examinations of Veronica in the reception cell. Paragraph [526] was a conclusion on the evidence upon which the finding at [528] was based.

Quigley J was not satisfied that the Coroner erred in law in finding that it was not open to him to find that the appellant conducted a physical examination while in the reception cell. 10 Quigley J stated 'that such a foundational component of the assessment could be undertaken in one minute and 37 seconds (which is the time shown on the CCTV footage) is of itself inherently unlikely and illogical.'11

This conclusion was reinforced when considering the context of evidence before the Coroner, including that:12

- The appellant did not give positive evidence that he did in fact conduct the RMA in holding cell 2.
- The appellant's evidence was entirely reconstructed from his notes (which he ultimately conceded he did not take care to ensure were accurate, he had no independent recollection of any interaction with Veronica and he could not say what he did in holding cell 2.
- There was no direct evidence from any other witness who said the appellant did in fact undertake a physical analysis in holding cell 2.

## Conclusions as to Grounds 2 and 3:

Ground 2 related to whether, in finding that the appellant did not physically examine Veronica on 31 December 2019, the Coroner failed to apply the Briginshaw standard in weighing all available evidence bearing in mind the gravity of the findings against the appellant and the inherent unlikelihood of the conduct found. 13

Ground 3 related to whether the finding that the appellant did not physical examine Veronica on 31 December 2019 is wrong in law in that it is against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made. 14

Quigley J was not satisfied that the Coroner erred in law in the manner which he weighed all of the available evidence in finding at [528] that the appellant did not physically examine Veronica on 31 December 2019. This finding was not 'against the evidence and the weight of the evidence' to such an extent that no coroner could have made it and the evidence relied upon was competent according to the *Briginshaw* standard. <sup>15</sup>

Quigley J noted that the Coroner was required to make findings as to the circumstances of Veronica's death in a context where the evidence was 'hotly disputed'. The Coroner carefully resolved inconsistencies by weighing the evidence in accordance with their cogency and credibility. <sup>16</sup>

<sup>10</sup>[175]

<sup>&</sup>lt;sup>9</sup> [62]

<sup>&</sup>lt;sup>11</sup> [178]

<sup>&</sup>lt;sup>12</sup> [176]

<sup>&</sup>lt;sup>13</sup> [65]

<sup>&</sup>lt;sup>14</sup> [69]

<sup>&</sup>lt;sup>15</sup> [277]

<sup>&</sup>lt;sup>16</sup> [280]



Quigley J held that the weight of the evidence was in favour of the finding made by the Coroner and it was entirely reasonable for the Coroner to reach it notwithstanding the evidence to the contrary. Quigley J held that the Coroner's reasoning was 'entirely intelligible' and his justification for his findings was evident across the Report.

### Conclusions as to Grounds 4 and 5:

Ground 4 related to whether, in finding that the appellant inaccurately recorded the weight of Veronica in the MAF, the Coroner failed to apply the *Briginshaw* standard in weighing all available evidence bearing in mind the gravity of the findings against the appellant and the inherent unlikelihood of the conduct found.<sup>17</sup>

Ground 5 related to whether the finding that the appellant inaccurately recorded the weight of Veronica in the MAF is wrong in law in that it is against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made. 18

The Coroner found that on the basis of Dr Baber's evidence that Veronica weighed around 33 kg at the time of the RMA and that the weight recorded by the appellant in the MAF was inaccurate.<sup>19</sup>

Dr Runacres recorded Veronica's weight as 40.7 kg on 31 December 2019.<sup>20</sup> Dr Baber, who performed the autopsy on Veronica on 6 January 2020, reported her body weight at 33 kg. The evidence from Dr Baber was that no weight loss which would 'register in terms of kilograms' would occur post mortem and it would not be possible for a living person to lose 7.7 kg (or even 5 kg) in body weight in 36 hours.<sup>21</sup> The Medical Conclave also formed a negative view of the appellant's assessment and care, including record keeping.<sup>22</sup> Evidence of others as to her physical appearance corroborated that Veronica was exceptionally thin. The Coroner found that there were many errors in Veronica's medical file, including as to her weight.<sup>23</sup>

Quigley J was not satisfied that the conclusions drawn from the evidence available were wrongly formed. The finding that Veronica weighed about 33 kg at the time of her RMA was a finding open to him on the evidence of Dr Baber.<sup>24</sup>

Quigley J found that, consistently with the *Briginshaw* standard, the Coroner weighed the evidence carefully in accordance with its cogency, and inferences were guided by corroborating evidence.<sup>25</sup> Furthermore, Quigley J was also satisfied that the weight of the evidence before the Coroner was in favour of his ultimate finding and therefore it could not be described as 'against the evidence and the weight of the evidence' to such an extent that no reasonable coroner would have made it.<sup>26</sup>

## **Conclusions as to Ground 6:**

Ground 6 related to whether the findings that the appellant set in motion a chain of events in which Veronica's medical treatment and care was inadequate in an ongoing way, is wrong in law in that it is against the evidence and the weight of the evidence to such an extent that no reasonable Coroner could have made it.

In accordance with the Coroners Act, the appeal was limited to the statutory findings of the Coroner and there is not such right of appeal against a coroner's comments or recommendations in respect of a death.<sup>27</sup>

<sup>17 [71]
18 [73]
19 [301]
20 [294]
21 [298]
22 [302]
23 [303]
24 [305]
25 [314]
26 [315]
27 [321]</sup> 



Quigley J held that, in its context, the statement at [541] is a preliminary causative conclusion on the evidence which forms part of the continuum of analysis which underpins the ultimate finding at [524]. Therefore, it was not an appealable finding for the purpose of the Coroners Act.<sup>28</sup>

This conclusion was fortified by the following factors: <sup>29</sup>

- The statement at [541] immediately follows the finding at [540] and precedes the finding at [542]. It refers to subject matter in both of those findings and presents a summary of the evidence and previous findings in the Report which leads to the ultimate statutory finding at [542].
- The statement at [541] does not contain the expression 'I find'.
- The statement at [541] was not included in Appendix B which is the section of the Coroner's Report which 'all' the Coroner's findings appear.

Moreover, Quigley J notes that even if [541] was to be characterised as a finding, it is not one which is 'against the evidence and the weight of the evidence to such an extent that no reasonable coroner could have made it' nor lacks an evident and intelligible justification.<sup>30</sup>

<sup>&</sup>lt;sup>28</sup> [323] <sup>29</sup> [324]

<sup>&</sup>lt;sup>30</sup> [325]