SUPREME COURT OF QUEENSLAND

CITATION:	*Yu v Attorney-General for the State of Queensland; Yu & Ors v Department of Justice and Attorney-General & Anor* [2010] QSC 195
PARTIES:	**HELENA YU** (Applicant) **v** **ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (Respondent) **CATHERINE YU, HELENA YU and ROSEMARY YU** (Applicants) **v** **DEPARTMENT OF JUSTICE AND ATTORNEY-GENERAL** (First Respondent) **STATE CORONER HIS HONOUR MICHAEL BARNES** (Second Respondent)
FILE NOS:	BS 8223 of 2009 BS 14082 of 2009
DIVISION:	Trial Division
PROCEEDINGS:	Application for Judicial Review Application for Injunction
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	4 June 2010
DELIVERED AT:	Brisbane
HEARING DATE:	30 April 2010
JUDGE:	White J
ORDERS:	**1. The applicants' application for a statutory order of review of the decision of the Attorney-General notified on 9 November 2009 made pursuant to s 47 of the *Coroners Act* 1958 be dismissed.** **2. The application for injunctive orders be dismissed.** **3. No order as to costs.**
CATCHWORDS:	ADMINISTRATIVE LAW - JUDICIAL REVIEW – GROUNDS OF REVIEW – REASONABLENESS – where children of deceased requested an inquest into their mother's death – where inquest held and State Coroner found that there

was no fault on the part of the hospital in relation to the death – where family requested re-opening of the inquest pursuant to s47(1) of the *Coroners Act* 1958 (Qld) – where Attorney-General declined the application to re-open the inquest – where children applied for statutory order of review of the decision - whether Attorney-General's decision so unreasonable that no reasonable decision-maker could properly have arrived at it

Burials Assistance Act 1965 (Qld), s 3(1)
Coroners Act 1958 (Qld), s 7(1)(d), s 24(1), s 31(1), s 34(1), s 35(1), s 40(1), s 47(1)

Annetts v McCann (1990) 170 CLR 596; [1990] HCA, cited
Buck v Bavone (1975-1976) 135 CLR 110, cited
Minister for Aboriginal Affairs v Peko-Wallsend Ltd (1985-1986) 162 CLR 24; [1986] HCA 40, cited
Minister for Immigration and Multi-Cultural Affairs v Eshetu (1999) 197 CLR 611; [1999] HCA 21, cited
National Companies and Securities Commission v News Corporation (1984) 156 CLR 296; [1984] HCA 29, cited
R v HM Coroner for West Yorkshire (Eastern District), ex parte Clements (1993) 158 JP 17, cited

COUNSEL: F Chai (solicitor) for the applicants
S Horneman-Wren SC, with S McLeod, for the Attorney-General and the Chief Executive
L Byrnes (solicitor) for the State Coroner

SOLICITORS: Chais Law Practice for the applicants
Crown Solicitor for the respondents

[1] The applicant seeks a statutory order of review of a decision made pursuant to s47(1) of the *Coroners Act* 1958[1] by the Attorney-General, declining to re-open a coronial inquest into the death of the applicant's mother, Mrs June Woo. Mrs Woo died on 15 November 2002. The applicant joined with her two sisters[2] in an originating application seeking an injunction restraining the chief executive of the Department of Justice and Attorney-General[3] from burying the body of their late mother.[4]

[2] By agreement between the parties the application for a statutory order of review and the injunction were heard together. It was accepted that the outcome of the review application would determine the injunction proceedings.

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1 The *Coroners Act* 1958 applies as the death of Mrs Woo was a "pre-commencement death" (prior to 1 December 2003) within the meaning of s 100 of the *Coroners Act* 2003.

2 The three sisters describe themselves as "the applicants" in their affidavit filed in support of the application for injunctive relief (BS14082 of 2009) as well as in the application for a statutory order for review (BS8223 of 2009). It is plain that they join in both applications and no point is made of this by the respondents.

3 The respondent "Department" should be the chief executive but no point is taken.

4 Acting on a recommendation of the State Coroner made in June 2009 and pursuant to s 3(1) of the *Burials Assistance Act* 1965.

[3] Mr Chai sought, and was granted without opposition, the joinder of the State Coroner[5] to the review proceedings at the commencement of the hearing. Mr Byrnes, solicitor of Crown Law, appeared for the State Coroner to abide the order of the court save as to any costs orders that might be made and to be excused from further participation in the proceedings. With the joinder of the State Coroner all necessary parties are present.

[4] It may be understood that the three sisters act in concert and it may be appropriate to refer to them as "the family" as occurs throughout the material, both in that of the respondents and of the applicants. The late Mrs Woo had other children but their names do not appear on any proceedings nor have they filed material. The applicants have been excused from paying court fees due to their meagre financial resources. They are each unemployed and in receipt of Centrelink payments. They came with their parents to Queensland from Hong Kong in 1988. Their late father died in February 2001. The ages of the applicants are not mentioned in the material but I understood them to be present in court and they appeared to be mature women.

Background

[5] On 14 November 2002 Mrs June Woo, an 82 year old woman, was admitted to the Emergency Department of the Princess Alexandra Hospital ("the Hospital"). She had a history of pulmonary fibrosis, chronic respiratory failure and renal impairment with numerous past hospital admissions. She had been on oxygen support at home for the previous two and half years. On the evening of 15 November 2002 she stopped breathing. A "not for resuscitation" order was in place so resuscitation was not attempted. An attending doctor certified death as being caused principally by hyperkalaemia, that is, raised levels of potassium in the blood.

[6] The family, and in particular Mrs Woo's three daughters, were dissatisfied with the Hospital's treatment and care of their mother and, after representation, the Brisbane Coroner ordered a post-mortem examination of Mrs Woo's body. This was carried out by Dr Guy Lampe on 18 December 2002 at the (then named) John Tonge Centre. Dr Lampe, in a report dated 19 February 2003, confirmed Mrs Woo's cause of death as

> "1. (a) Hyperkalaemia due to, or as a consequence of:
> (b) Acute Renal Failure.
> Other significant conditions
> 2. End Stage Pulmonary Fibrosis."

His report was reviewed by an expert and the Brisbane Coroner concluded that an inquest was not necessary. On 17 June 2005 the file was closed.

[7] The family petitioned the then Minister for Health who awaited the outcome of an investigation of the family's complaint by the Health Quality and Complaints Commission. In August 2006, after extensive investigations, the Commission concluded that the complaints were without foundation. The family renewed the request for an order that an inquest be held to a new Minister for Health and on 12 July 2007 that Minister directed, pursuant to s 7(1)(d) of the *Coroners Act* 1958, that the State Coroner convene an inquest into Mrs Woo's death. The family's

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[5] The office of State Coroner was established by s 70 of the *Coroners Act* 2003. By s 100(3) the State Coroner has the functions and powers of a coroner under the *Coroners Act* 1958 in respect of a pre-commencement death.

principal complaints concerned the misuse of pharmacological treatment which they alleged caused or hastened her death; the failure to give Mrs Woo fluids/sustenance in a timely manner; the inappropriate use of an oxygen mask; and that the "not for resuscitation order" was given without their informed consent.

[8] The inquest was conducted by the State Coroner on 14 December 2007, 26 February 2008, 8, 9 and 10 July 2008 and 3 September 2008. On 1 June 2009 the State Coroner published his findings. After an extensive analysis of the evidence and the submissions made by or on behalf of the family, his Honour concluded: [6]

> "I find that Mrs June Woo died on 15 November 2002, at the Princess Alexandra Hospital in Brisbane as a result of hyperkalaemia due to or as a consequence of acute renal failure while suffering from end stage pulmonary fibrosis."

He further concluded, having regard to the information in the medical reports, the autopsy report and the reports and oral evidence of the independent experts, that:[7]

> "…there was no therapy or treatment available to the doctors at the Princess Alexandra Hospital that would have been likely to extend Mrs Woo's life or that should reasonably have been attempted."

His Honour made the following finding in respect of a "not for resuscitation" order, the basis for which had been strongly contested by the family:[8]

> "Having regard to Mrs Woo's family's tacit acceptance of the "*not for resuscitation*" order despite it being explained to them on numerous occasions, I consider the hospital staff was entitled to consider they were consenting to it.
>
> I consider the preconditions to such consent being validly acted on, namely that Mrs Woo had not previously expressed opposition to it; the withholding of CPR was in Mrs Woo's best interests; it was the least intrusive response; it best preserved her dignity; and it was consistent with good medical practice, were met. The order was entirely appropriate."

[9] His Honour made observations about the strong response of the family to their mother's death and their failure to arrange for the burial or cremation of her body some six and a half years after her death. His Honour concluded that it was inappropriate that this should continue and, pursuant to s 3(1) of the *Burials Assistance Act* 1965, recommended that:[9]

> "…unless within 28 days of these findings being delivered, the family of Mrs Woo has made arrangements for her burial, the chief executive of the Department of Justice take action pursuant to s3 of

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6 Affidavit of Catherine Elizabeth Scott, CES-2 at 21.
7 CES-2 at 22.
8 CES-2 at 26.
9 CES-2 at 28.

> the Burials Assistance Act 1965 to cause Mrs Woo's body to be buried."

[10] On 23 June 2009 the family requested the Attorney-General to stay any proceedings in relation to the disposal of their mother's body and advised that they intended to request a re-opening of the inquest pursuant to s 47(1) of the *Coroners Act* 1958. On 31 July 2009 Ms Helena Yu filed an application for a statutory order of review of the State Coroner's decision of 1 June 2009 in which the Attorney-General is named as respondent.[10]

[11] On 1 October 2009 the family delivered to Crown Law a document dated 30 September 2009 seeking a re-opening of the inquest, together with a quantity of material. The daughters, who are the applicants for the injunction, sought the re-opening of the inquest as being in the interests of the general public of Queensland because the public is concerned with the treatment of patients in hospitals and with the public health system and because it was in the interest of the public to investigate "if some important people in our system are trying to cover up such problems as well as many cases of an unnatural death".

[12] Further material was provided by the applicants' solicitor, Mr Chai, in which submissions prepared by a Ms Felicity Maddison, a Carer Advocate, made to the State Coroner on behalf of the family (but withdrawn by the family) were drawn to the Attorney-General's attention, raising matters for his consideration. Mr Chai's covering letter raised the applicants' particular concerns that:

- only six out of 17 medical staff witnesses whose evidence was said to be crucial were called;
- the family was not provided with an interpreter during the coronial hearing to assist in following and participating fully in the inquest;
- there was no financial assistance for the family to obtain independent tests by their own expert witnesses on the toxicity of the drugs administered to their mother.

[13] By letter dated 9 November 2009 the Attorney-General declined the application to re-open the inquest into the death of Mrs Woo.

[14] By letter dated 18 November 2009 the Director-General of the Department of Justice and Attorney-General wrote to Ms Helena Yu, that in view of the Attorney-General's refusal to re-open the inquest into the death of Mrs Woo, arrangements be made to cremate or bury her body. If this did not occur within 14 days, the Director-General intimated, she would make the necessary arrangements. Thereafter, Catherine, Helena and Rosemary Yu sought an injunction restraining the Attorney-General from burying the body of their mother and an order that she be kept at the mortuary pending the hearing and determination of the proceedings.[11]

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[10] BS8223 of 2009.
[11] BS14082 of 2009.

[15] The parties have agreed that no steps will be taken by or on behalf of the Director-General in relation to the burying of Mrs Woo's body until the hearing and determination of these proceedings.

[16] The application to review the State Coroner's decision, although pre-dating the Attorney-General's decision notified by letter of 9 November 2009 not to re-open the inquest, has proceeded as an application to review the Attorney-General's decision.

Decision by Attorney-General declining to re-open inquest

[17] The *Coroners Act* 1958 provides that the Attorney-General may direct that an inquest be re-opened. To that end s 47(1) provides, relevantly:

> "Where any inquest has been concluded and it is shown to the satisfaction of the Minister that the inquest ought to be reopened, the Minister may direct that the inquest be reopened before the coroner who held the inquest or some other coroner."

[18] The approach to a review of a decision of that kind was discussed by Gibbs J in *Buck v Bavone:*[12]

> "It is not uncommon for statutes to provide that a board or other authority shall or may take certain action if it is satisfied of the existence of certain matters specified in the statute. Whether the decision of the authority under such a statute can be effectively reviewed by the courts will often largely depend on the nature of the matters of which the authority is required to be satisfied. In all such cases the authority must act in good faith; it cannot act merely arbitrarily or capriciously. Moreover, a person affected will obtain relief from the courts if he can show that the authority has misdirected itself in law or that it has failed to consider matters that it was required to consider or has taken irrelevant matters into account. Even if none of these things can be established, the courts will interfere if the decision reached by the authority appears so unreasonable that no reasonable authority could properly have arrived at it. However, where the matter of which the authority is required to be satisfied is a matter of opinion or policy or taste it may be very difficult to show that it has erred in one of these ways, or that its decision could not reasonably have been reached. In such cases the authority will be left with a very wide discretion which cannot be effectively reviewed by the courts."

That passage has been consistently applied. In *Minister for Immigration and Multicultural Affairs v Eshetu,*[13] Gummow J observed:[14]

> "… where the criterion of which the authority is required to be satisfied turns upon factual matters upon which reasonable minds could reasonably differ, it will be very difficult to show that no

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12 (1975-1976) 135 CLR 110 at 118-9.
13 (1999) 197 CLR 611; [1999] HCA 21.
14 Ibid at 654 [137].

> reasonable decision-maker could have arrived at the decision in question."

[19] The Attorney-General was provided with all the material which the applicants wished to have considered. The submissions by the applicants through Mr Chai to review that decision have not been directed to the central issue, namely whether the decision was, relevantly, unreasonable. Mr Chai grouped the concerns of the applicants under a number of the statutory grounds in s 20 of the *Judicial Review Act* 1991 and Mr Horneman-Wren SC, who appeared for the Attorney-General with Mr S McLeod, responded by joining issue on the identified broad subject matters of concern. If those concerns articulated as grounds of review, or some of them are made out, that may be sufficient to characterise the refusal to re-open the inquest as unreasonable.

(i) Breach of natural justice/procedural fairness

(a) Failure to call the applicants as witnesses

[20] The applicants complain that although they had provided written statements to the State Coroner, he had not called them to give oral evidence and in this way, denied them the opportunity to be heard.[15] They contend that s 35(1) of the *Coroners Act* 1958 required the State Coroner to call them.[16] It provides:

> "At every inquest the coroner shall, unless in the coroner's opinion the matter is already established, examine or have examined on oath (whether or not they have already given any evidence in the inquest) all persons who tender their evidence respecting any of the matters within the scope of the inquest and all other persons whom the coroner thinks it expedient to examine or have examined, but the admissibility of their evidence shall be subject to the provisions of section 34."

[21] So far as is relevant for the submissions on behalf of the applicants, s 35(1) requires that all persons who are to give oral evidence at an inquest shall be examined on oath. This does not mean that the State Coroner is compelled to call as a witness each of those persons who have given statements. It is for the State Coroner to decide within the exercise of his discretion which persons it is expedient to examine or have examined.

[22] A perusal of the transcript shows that Mr Chai appeared for "the next of kin" on the first day which was a directions hearing.[17] Counsel assisting the Coroner, Ms J Rosengren, in her opening said:[18]

> "… I'm not sure if her family would be prepared to do this, but there's currently no background information relevant to Mrs Woo and if a statement addressing that – her background and the family situation and just of that general information that would also be helpful as well."

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15 *Ridge v Baldwin* [1964] AC 40.
16 *Kioa v West* (1985) 159 CLR 550 at 614 per Brennan J.
17 CES-34 at 300.
18 CES-34 at 301.

A little later she said, when discussing potential witnesses, "a member of the family I'm sure will want to be – to be able to give evidence".[19] There was a discussion between his Honour and Mr Chai about the provision of some background information about Mrs Woo by the family.

[23] The hearing was adjourned until February to allow further witness statements to be obtained and for expert opinion to be received.

[24] On the resumption of the hearing on 26 February 2008, Mr Chai appeared for the family and tendered a signed background statement. The hearing proper commenced on 8 July 2008. Mr TM Carmody SC appeared for the next of kin. In her opening when discussing the question of an interpreter for the family, counsel assisting said, in the context of the interpreter being sworn or taking an affirmation:[20]

> "It has not been considered necessary that Ms Ing take an oath or an affirmation, given that, at this stage, it's not anticipated that any family member will give evidence. If that changes at any time, then we will revisit that issue, if your Honour is satisfied to approach it in that way."

[25] The inquest continued over four days, on 8, 9, and 10 July and 3 September 2008, hearing evidence from many witnesses who were cross-examined on behalf of the family by Mr Carmody. At the conclusion of the evidence of Dr Guy Lampe who had conducted the post-mortem, counsel assisting said:[21]

> "It's not proposed to cause any – call any further witnesses at the hearing unless there's any submission made by either of my learned friends? No further witnesses? No."

There was no application or intimation from Mr Carmody that any family member ought to be called to give oral evidence. The discussion with his Honour then turned to the question of submissions.

[26] His Honour was cognisant of the family members' account of events and their challenge to the evidence of the treating staff as he made ample reference to it in his findings. He was further exposed to their account of events in the Hospital and their disagreement with the treatment given to their mother and the conclusion of Dr Lampe by Mr Carmody's cross-examination of Hospital staff, Dr Lampe and the expert witnesses. Counsel assisting also put the concerns of the family to the expert witnesses.[22] It was a matter for the State Coroner as to which witnesses were called and, in the absence of any application to call family members as witnesses, there was no compelling reason to do so.[23] The family were given every opportunity to be heard and were "heard" in as much as their written concerns were taken into account by his Honour and their "case" was put to the witnesses by their counsel.

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19 CES-34 at 302.

20 CES-36 at 319.

21 CES-39 at 661.

22 See, for example, her questioning of Professor Drummer at CES-39 at 643.

23 *R v HM Coroner for West Yorkshire (Eastern District), ex parte Clements* (1993) 158 JP 17 at 22 where the court was considering a provision in the *Coroners Act* 1988 (Eng) which has parallels with s 35 of the *Coroners Act* 1958.

As Gibbs CJ observed in *National Companies and Securities Commission v News Corporation:*[24]

> "The authorities show that natural justice does not require the inflexible application of a fixed body of rules; it requires fairness in all the circumstances, which include the nature of the jurisdiction or power exercised and the statutory provisions governing its exercise."

The State Coroner did not fail to accord the applicants natural justice or procedural fairness when he did not have them called to give oral testimony. They were treated fairly in all the circumstances. The Attorney-General, accordingly, was correct to be satisfied, so far as these matters were concerned, that there should be no re-opening of the inquest.

(b) Failure to provide proper interpreting assistance

[27] The applicants contend that they were disadvantaged throughout the proceedings as they were unfamiliar with the procedure of the inquest and were "relegated to the back of the court". They further contend that although an interpreter sat with them, the interpreter did not adequately assist them to follow the proceedings. Being unable to afford legal representation for the preparation of final submissions to the State Coroner they make something of the fact that they were reliant on the assistance of a lay advocate to do so. This may be seen as an allegation that they were denied natural justice because they were unable, appropriately, to participate in the proceedings.

[28] At the second directions hearing on 26 February 2008, Mr Chai told his Honour:[25]

> "In relation to the children of the deceased, I'm having a bit of difficulty trying to explain everything to them. I'm wondering whether the Court will be mindful in assisting by providing an interpreter for some time where I could go to some of the people with them [sic]. They have got no electronic communication facility, I am unable to copy or e-mail documents to them. I've got to print them out and go through with them and I'm having a lot of difficulties in getting the right translation through.
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> I think it might assist this inquiry if I'm been able to be provided with someone to at least go through some of the essential statements, in particular the events leading from the 14th of November to the 15th of November, just exactly what happened so that I can get a full statement from the facts in the paperwork that's been five years now down the track and I'm trying to establish the chain of event."

His Honour established that Mr Chai was not proficient in the language of his clients which was Cantonese. His Honour responded that his office would look into the provision of an appropriate interpreter.

[29] At the commencement of the hearing proper on 8 July 2008, counsel assisting said:[26]

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24 (1984) 156 CLR 296 at 312.

25 CES-35 at 315.

> "Your Honour will be aware that an interpreter has been arranged by the office to provide assistance to the family during the course of this hearing. The interpreter is in the back of the Court and her name is Ms Ing, and I have had a conversation with her. I have also had a conversation with my learned friend, Mr Carmody, and subject to your Honour's view, it is thought that the best approach here would be to enable Ms Ing to sit in the rear of the Court with the family and to interpret simultaneously with the proceedings that are going on here.
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> It has not been considered necessary that Ms Ing take an oath or an affirmation, given that, at this stage, it's not anticipated that any family member will give evidence. If that changes at any time, then we would revisit that issue, if your Honour is satisfied to approach it in that way."

His Honour assented to that course and added:

> "Mr Carmody, if your clients become concerned about their ability to follow the proceedings at any stage, please let me know and we'll review those arrangements."

The transcript does not reveal that any concerns were raised with his Honour in the course of the inquest hearing. In his findings his Honour referred to the evidence of the interpreter provided to the family by the Hospital in which she said "[t]he daughters can speak English themselves".[27] His Honour noted:[28]

> "This is consistent with what I observed in court. The interpreter who had been retained by the Court to translate the proceedings to Mrs Woo's daughters was only required to explain a small part of what transpired. For the majority of the time, it was obvious the daughters were following what was being said unaided. This was confirmed by the lawyers then acting for her."

[30] The applicants now complain that the interpreter provided was not proficient in medical terminology. That is a concern which they could have ventilated with their counsel at the time but did not. The State Coroner through his office and in his conduct of the hearing afforded the family all that was appropriate for their participation in the proceedings and the Attorney-General was correct to be satisfied, so far as that matter was concerned, not to direct a re-opening of the inquest.

(c) Expert witnesses not independent

[31] The applicants contend that two expert witnesses, Dr Paul Kubler and Professor Jeffrey Lipman, were not independent because they were employed by Queensland Health. This is said to be an aspect of want of procedural fairness by Mr Chai. In their affidavit filed 1 April 2010 the applicants assert that expert

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26 CES-36 at 319.
27 CES-9 at.107.
28 CES-9 at.107.

witnesses should have been called from outside Queensland because Queensland Health was the service provider at the Hospital. Dr Kubler was, at the time he gave his evidence, Clinical Pharmacologist in the Department of Clinical Pharmacology at the Royal Brisbane and Women's Hospital. Professor Lipman was the Head of Anaesthesiology and Critical Care at the University of Queensland and Director of the Department of Intensive Care Medicine at the Royal Brisbane Hospital. Dr Lampe in his autopsy report had written that:[29]

> "… when using narcotics in patients with respiratory failure, it is difficult to predict the drug's action with respect to dose; it would be useful to have an expert opinion from a clinical pharmacologist on this matter."

It was to explore those matters that this body of expert evidence was called.

[32] In her opening statement, counsel assisting raised with his Honour the family's desire for the engagement of a pharmacologist and Dr Kubler's name was mentioned. Dr Kubler gave evidence on 10 July 2008. Mr Carmody raised with Dr Kubler that he practised in the field of public medicine rather than in the private sphere[30] and questioned him about his training as a pharmacologist. At the conclusion of a very lengthy cross-examination about Mrs Woo's drug treatment his Honour reminded Mr Carmody that if he intended subsequently to make submissions that Dr Kubler's employment or career aspirations would have bearing on the weight that should be given to his evidence it needed to be put to him. Mr Carmody responded that he was not then in a position to do so. In light of that response, counsel assisting did not deal with that matter in re-examination. When his Honour said that he wished to raise the possibility of bias because Dr Kubler worked for Queensland Health, both counsel assisting and Mr Carmody said Dr Kubler's independence was not an issue. Dr Kubler had concluded that the drugs administered to Mrs Woo in the Hospital were unlikely, alone or in combination, to be a contributing factor to her death.

[33] Professor Jeffrey Lipman, after extensive questioning in evidence-in-chief and cross-examination, expressed his satisfaction that none of the drugs administered to Mrs Woo caused or contributed to her death. Mr Carmody did not challenge Professor Lipman's independence.

[34] Professor Olaf Drummer, Head of Scientific Services in the Department of Forensic Medicine at Monash University and the Victorian Institute of Forensic Medicine in Melbourne with a Doctorate of Philosophy in the field of pharmacology, gave evidence in the inquest. Professor Drummer was cross-examined by Mr Carmody without challenge to his expertise. In his opinion it was unlikely that the combination of the drugs and their use in the treatment of Mrs Woo had any significant impact on her death. Professor Drummer further concluded that since drugs about which he was questioned (morphine and Midazolam) had been administered some three and a half hours prior to death, they were less likely to have had any role to play in that death than if Mrs Woo had been injected shortly before death. The applicants complain that although independent of Queensland Health, Professor Drummer was not a *clinical* pharmacologist. Professor Drummer

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29 CES-17 at 256.

30 CES-38 at 515.

made clear that he was not a clinician but, from a pharmacological perspective, the identity and combination of the drugs administered to Mrs Woo did not raise "any alarm bells".[31] His opinion and that of Dr Kubler, who was a clinical pharmacologist, were very similar. His Honour accepted Professor Drummer's evidence, noting his reservations that he was not a clinician.

[35] Dr Guy Lampe, who undertook the post-mortem, was employed by Queensland Health as a pathologist. Although some reference was made in the course of evidence-in-chief to concerns by the family about his independence, this was not taken up in cross-examination.

[36] It is clear from his Honour's questions that he was conscious that if there was a challenge to independence, it would go to the weight to be accorded to the opinion evidence of the experts employed by Queensland Health. The challenge, if any, was muted. The plainly independent Professor Drummer supported the evidence of Professor Lipman and Dr Kubler. There was no error by his Honour in accepting the evidence of those experts. The Attorney-General was entitled to be satisfied that he could decline to direct a re-opening of the inquest on the basis that these witnesses were either not independent or not relevantly qualified to offer an opinion.

(ii) Failure to call relevant witnesses apart from family

[37] The applicants contend that there were 11 further witnesses who ought to have been called to give evidence at the inquest. The failure to do so is said to be a failure to take into account relevant considerations but also involved a denial of procedural fairness.

[38] The scope of an inquest on death is determined by s 24 of the *Coroners Act* 1958. It provides, relevantly:

> "(1) Where an inquest into a death is held under this Act it shall be for the purpose of establishing so far as practicable –
>
> (a) the fact that a person has died;
>
> (b) the identity of the deceased person;
>
> (c) when, where and how the death occurred;
>
> (d) …"

In their joint affidavit filed 1 April 2010 the applicants state that:[32]

> "Doctors Massarotto (registrar on respiratory team) and Armstrong were important witness [sic] as were Nurses Smith and Colless. These witnesses who were not called could have and would have provided new relevant considerations or new and fresh evidence who could and would lead to a clearer and truer picture of the events preceding the death of our mother."

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31 CES-39 at 645.

32 At [14].

That paragraph cross-references to para 18 of the joint affidavit of the applicants filed on 14 December 2009 where all 17 medical staff from the Hospital who attended Mrs Woo are identified.

[39] As the applicants recognised in para 18, locating the relevant witnesses was an issue. The inquest took place five years after the death of Mrs Woo and not all witnesses were able to be located. The complaint is that not enough effort was taken to locate those particular 11 witnesses. This difficulty was adverted to by counsel assisting at the first directions hearing on 14 December 2007.[33] The transcript indicates the considerable effort to which the Health Service District went to find the treating witnesses. There was no application from Mr Carmody for other witnesses to be called. It is within the discretion of the State Coroner as to which witnesses he reasonably regarded as necessary to investigate the death.[34] The applicants have not shown that his Honour failed to take into account material evidence which he was bound to consider by virtue of not calling all or any of the 11 witnesses.[35]

(iii) Insufficient weight given to the applicants' submissions by the State Coroner

[40] The applicants contend that insufficient weight was given to their submissions. In a sense this is an aspect of their contention that his Honour demonstrated bias against them but I will deal with it separately as it has been raised as a failure to take into account a relevant consideration. It is clear from his Honour's findings that he did take into account and considered important the submissions made by and on behalf of the family.

[41] Just before the hearing of the inquest proper, the family terminated Mr Chai's retainer and his Honour determined that the inquest would commence on 8 July 2008 to allow time for the new legal representatives to read the material. On 28 October 2008 his Honour recorded that the family advised that they had terminated the retainer of the new lawyers who had represented them at the inquest. On 30 October 2008 a list of issues for submissions were sent to the parties for response and a finalised list was distributed on 17 November 2008. Counsel assisting's final submissions were circulated to the parties on 19 December 2008 seeking responses by 30 January 2009. On 28 January 2009 his Honour received an application from the family for a four week extension, which was granted.

[42] His Honour recorded that submissions on behalf of the family drafted by Ms Felicity Maddison, a carer advocate from Carers Queensland, were received on 27 February 2009. His Honour recorded that the family attended at the State Coroner's office the following week to advise that "they were unhappy with the submissions provided and would like to provide their own submissions". That request was granted and they were given a further week to provide their submissions.

[43] Another person contacted the State Coroner's office to advise that she was now assisting the family and needed additional time to provide the submissions. An

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33 CES-34 at 301.

34 See *Coroners Act* 1958, ss 34(1) and 35.

35 *Minister for Aboriginal Affairs & Anor v Peko-Wallsend Limited & Ors* (1985-1986) 162 CLR 24 at 39-40 per Mason J.

extension was granted. Ultimately extensions were granted until 30 March 2009. The State Coroner's office received a second set of submissions on behalf of the family drafted on 31 March 2009. His Honour noted that in the intervening period, submissions were also received from another lay advocate on behalf of the family. Since the receipt of those last submissions, he noted that the family had continued to write to the State Coroner's office raising new issues and reiterating the matters contained in previous correspondence. His Honour concluded:[36]

> "In view of the amount of material submitted on behalf of the family of Mrs Woo, it is impossible for me to be sure I have dealt in these findings with all of the allegations and arguments. However, I believe I have responded to the main issues. I have consciously striven to ensure the frustration generated by the way the family have complicated these proceedings has not influenced my assessment of the evidence."

The applicants are critical of that observation, contending that it demonstrates a failure to give their submissions proper attention. In light of the history relating to the submissions, that was a cautious and not inappropriate comment.

[44] His Honour devoted considerable analysis to the family's submissions. The applicants complain about his observation that:[37]

> "Strictly speaking, I do not need to have regard to submissions from the family unless I am considering making findings critical of them."

His Honour referred to *Annetts v McCann.*[38] As was observed in that decision, it is the statute to which resort must be had. By s 31(1) of the *Coroners Act* 1958:

> "At any inquest any person who, in the opinion of the coroner, has a sufficient interest in the subject or result of the inquest may attend personally or by counsel or solicitor and may examine and cross-examine witnesses."

As to addresses, s 40(1) provides that no person shall be permitted to address the coroner upon the facts but may address the coroner upon points of law applicable to the case. *Annetts v McCann* held that the parents of a boy who perished in the desert had a common law right to be heard by the coroner in opposition to any potential adverse finding about them or their deceased son, but they had no right to make submissions on the general subject matter of the inquest.

[45] His Honour, nontheless, had regard to the impact of the inquest upon Mrs Woo's family and endeavoured to respond to the submissions made on their behalf. It is unnecessary in these reasons to canvass his Honour's analysis of those submissions, save to comment that he gave close and earnest attention to the concerns raised in the several submissions made on their behalf. The real complaint seems to be that the State Coroner was unpersuaded by the family's submissions.

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36 CES-9 at 100.
37 CES-9 at 16.
38 (1990) 170 CLR 596; [1990] HCA 57.

(iv) Bias

[46] The applicants maintain that certain "disparaging statements"[39] by his Honour demonstrate overt bias towards the lay advocates who had assisted the applicants and towards the applicants themselves. The applicants assert that his Honour should have been more sympathetic to the concerns raised by them and ought not to have made comments about the way they had behaved vis-à-vis the burial of their mother or in the final part of his report headed "Pathological Grief". His Honour had firmly dismissed their allegations, particularly that the Hospital staff were lying. His Honour, after quoting from experts in the field of grief and loss, said:[40]

> "Mrs Woo's family have failed to arrange for the burial or cremation of her body six and a half years after her death; they continue to harbour anger towards those they wrongly hold responsible for the death in the face of all available evidence to the contrary; and they appear unwilling to accept the findings of a number of independent investigations into the death. This is suggestive of a complex grief response which remains unresolved. They have my sincere sympathy and I regret being unable to assist them. They have rejected numerous offers from expert grief counsellors who may have assisted with their acceptance of their loss."

[47] His Honour also observed that while the children's loss was great, Mrs Woo's death impacted on other people. He said:[41]

> "The doctors and nurses of the PAH who treated and cared for her have been unfairly maligned. Dr Lampe and other independent experts have been accused of being biased and unprofessional. I hope these findings vindicate them. They do not deserve to be so harshly and unfairly criticised."

These were observations which, against the background of the actions and allegations of the applicants, the State Coroner was entitled to make. Those observations did not demonstrate bias. The Attorney-General was correct to be satisfied that there was no basis for directing a re-opening of the inquest having regard to that allegation.

Other issues

[48] Mr Chai sought to raise other issues on the review application. They were, in effect, the submissions made before the State Coroner about such matters as discrepancies in, or an incomplete, toxicology; that Mrs Woo was not given adequate and proper care in the form of fluid and sustenance; the "not for resuscitation" order; and the management of Mrs Woo's oxygen intake. These are all matters either considered above or are merits review issues. However, one of those issues may be elaborated upon. It was the applicants' contention that their mother did not and would not have agreed to "euthanasia" and that they did not give their consent to a "not for resuscitation" order. The family had the benefit of a Cantonese speaking interpreter

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39 Applicants' affidavit in support of judicial review filed 1 April 2010 at [36].
40 CES-9 at 121.
41 CES-9 at 121.

from time to time. The interpreter had interpreted for the family on a number of previous occasions but in their submissions the applicants argued that there had been a failure to communicate adequately with them or Mrs Woo. The interpreter gave evidence at the inquest, as did Registered Nurse Oakland who was present during the conversation with the applicants when the issue of resuscitation was raised with them by the treating doctor. His Honour gave careful consideration not just to the evidence in relation to Mrs Woo, but generally with respect to the policy about "not for resuscitation orders" at the Hospital. He concluded that the family tacitly accepted that order which was explained to them on numerous occasions and that the Hospital staff were entitled to consider that they were consenting to it and that it was an entirely appropriate order in the circumstances. Nothing has been submitted which demonstrates that his Honour erred in reaching that conclusion.

Conclusion on application for a statutory order of review

[49] The Attorney-General in response to the application to re-open the inquest stated that he had considered the application and the material provided by the applicants' lawyers and was not persuaded that there was any cogent ground or reasoned argument as would warrant or necessitate the re-opening of the inquest into Mrs Woo's death. There is no basis for concluding that the Attorney-General ought not to have been satisfied of those matters when he declined to re-open the inquest.

The injunction

[50] The applicants sought to have the body of Mrs Woo retained for further toxicological analysis. It was accepted by Mr Chai on behalf of the applicants that if they failed on the statutory order of review, then the injunction would not lie. Associate Professor Naylor, a specialist pathologist with expertise in taking samples for toxicological analysis and interpretation, was asked his opinion as to the current state of Mrs Woo's body and the likely value of toxicological analysis of further samples taken from the body. On 20 April 2010 he made an external examination of the body of Mrs Woo. He noted that while her body appeared fairly well preserved externally, given the period of just over seven years in cold storage, the external appearance was unlikely to provide a reliable guide to the state of the internal tissues or their suitability for toxicological analysis. Professor Naylor noted that human tissue progressively deteriorates and although those changes are retarded by refrigeration, they are not prevented. He also noted that well preserved samples taken from a deceased body deteriorate even while deep frozen and that while some drugs are relatively stable, others break down. He noted that there were seven samples of blood of which small amounts remain. The tube labelled urine, he noted, was empty. The reduction in volume of the samples was attributable to usage during analysis. Professor Naylor deposed that due to the elapse of seven years since her death:[42]

> "… submitting further samples from the body of Mrs June Woo for toxicological analysis for therapeutic drugs is likely to be of very limited value. On the other hand, the seven samples of blood mentioned are likely to be better preserved than the tissues in the body and could be used for further toxicological analysis if required."

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[42] Affidavit of Associate Professor Charles Paul Etchell Naylor filed 28 April 2010 at [11].

There would be no utility in continuing to preserve the body of the late Mrs Woo in a mortuary for further toxicological analysis.

[51] The respondents do not seek any costs order against the applicants if the applications are dismissed.

Orders

1. The applicants' application for a statutory order of review of the decision of the Attorney-General notified on 9 November 2009 made pursuant to s 47 of the *Coroners Act* 1958 should be dismissed.
2. The application for injunctive orders be dismissed.
3. No order as to costs.