Raymond-Hewitt v Northern Territory Coroner [2011] NTSC 94

PARTIES:	RAYMOND-HEWITT, GEOFFREY v NORTHERN TERRITORY CORONER
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE TERRITORY EXERCISING TERRITORY JURISDICTION
FILE NO:	53 OF 2011 (21114682)
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JUDGMENT OF:	KELLY J

CATCHWORDS:

Coroner – objection to autopsy – Coroner's duties, responsibilities, and powers – motor vehicle collision – reportable death – whether autopsy to be performed – considerations in favour of autopsy – cultural and spiritual considerations – statistics of motor vehicle accidents

Coroners Act, s 14(1), s 14(2), s 23(3), s 26(3), s 34(1)(a)(iii), s 34(1)(a)(v), s 34(2), s 35(1), s 35(2), s 35(3)
Motor Accidents (Compensation) Act

Green v Johnstone [1995] 2 VR 176; *Ex parte Minister of Justice; Re Malcolm* [1965] NSWR 1598 at 1604, applied

Re Unchango; Ex parte Unchango (1997) 95 A Crim R 65; *Wuridjal v The Northern Territory Coroner* (2001) 11 NTLR 202, followed

REPRESENTATION:

Counsel:

Plaintiff:	J Hunyor
Defendant:	S Brownhill

Solicitors:

Plaintiff:	North Australian Aboriginal Justice Agency
Defendant:	Solicitor for the NT

Judgment category classification:	B
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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

Raymond-Hewitt v Northern Territory Coroner [2011] NTSC 94
No. 53 of 2011 (21114682)

BETWEEN:

GEOFFREY RAYMOND-HEWITT
Plaintiff

AND:

NORTHERN TERRITORY CORONER
Defendant

CORAM: KELLY J

REASONS FOR DECISION

(Delivered 22 November 2011)

[1] On 7 May 2011 Geoffrey Hewitt ("the deceased") died on the side of the road, about 20 minutes after his Toyota 4 wheel drive vehicle collided with a Mack Truck on the Arnhem Highway.

[2] The coroner's office decided to order an autopsy to be performed to assist in determining the cause of death. The family of the deceased objected to an autopsy being performed on the deceased and made an urgent application to the Court for an order pursuant to s 23(3) of the *Coroners Act* ("the Act") for an order that an autopsy not be performed.

[3] The application was supported by affidavits from family members and from a senior ceremony man of the Marithiel people. The basis of the objection

was that the deceased was a senior Marithiel man and senior traditional owner in the Daly River Port Keats Aboriginal Land Trust and that cutting up a body was contrary to the traditional beliefs and practices of the Marithiel people. They believed it was important for the body not to be cut up or for anything to be taken out of the body because "keeping the body whole allows the spirit and soul to stay whole to send him up whole to our old people to our ancestors".

[4] The affidavits indicated that the time of death was a very hard time for the family and would become even harder and cause a lot of distress for the family and the community if the autopsy were to be performed.

[5] I heard the application as a matter of urgency on 13 May 2011 and made an order on that date pursuant to s 26(3) of the Act that an autopsy not be performed on the deceased. I indicated that I would publish my reasons at a later time. These are those reasons.

The collision

[6] The collision occurred on the Arnhem Highway. The deceased was driving his Toyota 4 wheel drive outbound towards Jabiru.

[7] Graeme Lacey was the driver of the truck. He made a statement to police that he was driving a Mack Truck Fleet Liner towing a low loader trailer in connection with roadwork along the Arnhem Highway. He left the job site at about 3:00 in the afternoon to drive to the Bark Hut inbound along the

Arnhem Highway towards Darwin. The truck handled normally and appeared to Mr Lacey to be in good condition.

[8] At around 3:15 p.m. Mr Lacey entered a long sweeping left hand turn travelling at approximately 95 to 100 km per hour, when he noticed a white Toyota Hilux coming in the opposite direction. As it approached him the Toyota began veering to the right and crossed onto the wrong side of the road in front of the on-coming Mack Truck. Mr Lacey pulled his truck to the left to try to avoid a collision but the Toyota side swiped his truck. The Toyota rolled and came to rest 110 metres from where the collision had occurred, about 12 metres from the side of the road. The driver was thrown from the vehicle into a table drain by the side of the road.

[9] Several other vehicles pulled up at the scene of the crash and a number of people tried to assist the driver. They helped him to roll onto his side. He asked them to rub his back and someone did so. About 5 minutes later he stopped talking. Those assisting him rolled him onto his back and started CPR. During this process he coughed, they rolled him onto his side and he spat out a lot of blood. After this the people helping went back to giving the driver CPR. Shortly thereafter a doctor arrived on the scene, examined the man and stated that he was dead. The driver was later identified as the deceased.

[10] Police investigated the accident. The officer in charge of the investigation, Sergeant Mark Casey gave evidence that, in doing so, they had regard to three primary categories of possible factors which might have contributed.

(a) They assessed the scene for any apparent physical causative or contributory factors. This included matters such as lighting, road engineering, rainfall, animals and other obstructions.

(b) They took the vehicles away for inspection to see whether any apparent faults in the vehicles may have caused or contributed to the accident.

(c) They considered human factors that may have caused or contributed to the accident including the possibilities of speed choice, intoxication, medical conditions, fatigue, distraction or other human error.

[11] The police investigation found no physical factors within category (a) which may have caused or contributed to the accident.

[12] The investigation was not complete at the time of the hearing, but preliminary investigations indicated the accident was not likely to have been caused or contributed to by any apparent faults in the vehicles.

[13] Police provided an initial notification of death to the coroner which described the circumstances surrounding the death as follows:

> "Deceased was driving a dual cab Hilux outbound (towards Jabiru) on Arnhem Highway. Truck driving inbound. It appears the deceased's vehicle drifting onto the wrong side of the road and side swiped the truck. As a result the deceased lost control of his vehicle which rolled. Deceased ejected from vehicle – deceased at scene."

[14] The coroner's office decided to order an autopsy to be performed because otherwise the cause of death would have to be listed as "undetermined". The family of the deceased have objected for reasons I have outlined, and I accept the evidence of the various deponents that the performance of an autopsy on the deceased would cause real distress to members of his family and to other community members as well.

[15] The affidavit by the deputy coroner deposed (*inter alia*) as follows:

> "(d) the circumstances of the Deceased's death are such that he was killed as a result of a motor vehicle collision with a truck in circumstances where the vehicle he was driving was reported to have drifted into the lane of the oncoming truck. The circumstances of his death raise issues to be determined, if possible, as to:
>
> (i) whether the Deceased suffered a heart episode which resulted in his vehicle drifting into the oncoming lane; and
>
> (ii) whether the collision was caused or contributed to directly or indirectly by his pre-existing heart condition, or by some other factor or factors; and
>
> (iii) whether his death was caused or contributed to directly or indirectly by his pre-existing heart condition, or by some other factor or factors."

[16] Sergeant Casey gave evidence to the effect that his investigation needed to exclude crime or culpability on the part of the truck driver. However he said in cross examination that there was no evidence to suggest that the truck driver's version of events was untrue or inaccurate or anything to cast any doubt on it at all, and that there were no suspicious circumstances

surrounding the death. It was not suggested in any case that performing an autopsy on the deceased would assist Sergeant Casey in that aspect of his investigation.

[17] Evidence was also given by Dr Vuletic, the medical practitioner who, it was proposed, would perform the autopsy. In a report attached to her affidavit, Dr Vuletic commented that the deceased had a pre-existing heart condition and there is a possibility that that heart condition played a part in his death. He had a history of ischaemic heart disease which put him at risk of sudden cardiac death at any time from an acute myocardial infarction, moreover, he had suffered from an acute myocardial infarction in 2009, which left him vulnerable to cardiac rhythm disturbances. From Dr Vuletic's report the possibilities appear to be as follows.

(1) The deceased suffered an acute myocardial infarction or a rhythm disturbance which caused him to lose control of his vehicle and veer onto the wrong side of the road as a result of which he hit the truck. If so, he may have died:

(a) as a result of the acute myocardial infarction;

(b) as a result of physical injuries sustained in the crash; or

(c) as a result of a combination of the two.

(2) The deceased did not have an acute myocardial infarction or a rhythm disturbance before the accident, but veered onto the wrong side of the road for some other reason. If so, he may or may not have suffered an acute myocardial infarction after the crash as a result of the stresses involved. If he did suffer a post accident acute myocardial infarction, he may have died:

(a) as a result of the acute myocardial infarction;

(b) as a result of physical injuries sustained in the crash; or

(c) as a result of a combination of the two.

(3) If he did not have a post accident acute myocardial infarction, then presumably, he must have died as a result of physical injuries sustained in the crash. There is no suspicion of foul play or any other cause of death.

[18] Dr Vuletic gave evidence about what an autopsy might be expected to reveal. She said that, given the circumstances, and from her external examination of the deceased, she expects that physical injury probably at least contributed to the man's death. However, she could not tell whether that was the sole cause of death without an autopsy. The body showed skin and soft tissue damage which would not have been fatal alone, but which might or might not be indicative of more serious underlying injuries which could have been fatal. An autopsy would tell if the physical injuries alone were sufficient to cause death.

[19] However, an autopsy would not distinguish between any of the other alternative possibilities. All that an autopsy would show would be the extent of the underlying heart disease and whether he had had an acute myocardial infarction which had been present for 8 hours or more before his death. It is not possible to identify an acute myocardial infarction unless it has been present for 8 hours or more as there are no visible microscopic changes until then.

[20] Any conclusions drawn from the autopsy are likely to come by a process of elimination. If the physical injuries alone were not sufficient to account for his death, then the doctor performing the autopsy would explore other causes, such as stroke or heart disease. If no visible signs of an acute myocardial infarction were present, and there was no other discernable cause of death, given the deceased's medical history she would assume that death was caused or contributed to by an acute myocardial infarction which had been present for less than 8 hours.

[21] An autopsy would not reveal whether the deceased had suffered either cardiac rhythm disturbance or acute myocardial infarction shortly before or shortly after the accident. The autopsy, therefore, would reveal nothing meaningful about the causes of the accident – for example whether the deceased had suffered a heart problem which caused him to veer onto the wrong side of the road, or whether he had veered onto the wrong side of the road for some other reason and had suffered an acute myocardial infarction after the collision. In these circumstances it is difficult to see what value there would be in deeply distressing the family and the community by performing an autopsy which contravenes their cultural practices and beliefs.

Coroner's powers and duties in respect of the death

[22] Counsel for the defendant, Ms Sonia Brownhill, conveniently summarised the coroner's duties, responsibilities and powers, so far as relevant to this proceeding in her written submissions.

[23] As it appears that the deceased died directly or indirectly as the result of an accident, his death is a reportable death under s 12 of the Act.

[24] A coroner has jurisdiction to investigate a reportable death,[1] and a duty to investigate a reportable death which is reported,[2] as was the case with the deceased. A coroner investigating a death is required to find, if possible, *inter alia*, the cause of death[3] and any relevant circumstances concerning the death.[4]

[25] In finding the cause of death, the coroner must find not only the "terminal" or "medical" cause of death, but also the "real" cause of death which may be identified as a definable event from which the terminal cause directly and consequentially followed.[5]

[26] A coroner investigating a death may comment on a matter, including public health or safety or the administration of justice, connected with the death,[6] and may report to the Attorney-General on a death and make recommendations to the Attorney-General on a matter, including public

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1 s 14(1)

2 s 14(2)

3 34(1)(a)(iii)

4 s 34(1)(a)(v)

5 *Ex parte Minister of Justice; Re Malcolm* [1965] NSWR 1598 at 1604 per McClemens J. In that case, the terminal cause of death was pneumonia, but the real cause of death was found to be poisoning.

6 s 34(2)

health or safety or the administration of justice connected with a death.[7] In this case it has not been suggested that there are or may be any issues relating to public health or safety or the administration of justice on which the coroner may wish to comment which would be materially assisted by the performance of an autopsy.

[27] A coroner is required to report to the Commissioner of Police and the Director of Public Prosecutions if the coroner believes that a crime may have been committed in connection with a death.[8] In this case, the police investigating officer gave evidence that there were no suspicious circumstances connected with the death, and that there was no reason to doubt the statement made by the driver of the truck. In any event, an autopsy would not assist that aspect of the police investigation.

The jurisdiction under s 23(3)

[28] The plaintiff has made application under s 23(3) of the Act. Section 23 is in the following terms.

> "**Objections to autopsy**
>
> (1) Where the senior next of kin of the deceased person asks a coroner not to direct that an autopsy be performed but the coroner decides that an autopsy is necessary, the coroner must immediately give notice in writing of the decision to the senior next of kin.

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7 s 35(1), (2)

8 s 35(3)

(2) Unless the coroner believes that an autopsy needs to be performed immediately, where a request has been made under subsection (1), an autopsy must not be performed until 48 hours after the senior next of kin of the deceased person has been given notice of the coroner's decision under that subsection.

(3) Within 48 hours after receiving notice of the coroner's decision under subsection (1), the senior next of kin of the deceased person may apply to the Supreme Court for an order that an autopsy not be performed and the Court, in its discretion, may make an order that no autopsy be performed."

[29] When exercising the power given to it under s 23(3), the Court is not to review the decision of the Deputy Coroner made on 9 May 2011 under s 23(1) that an autopsy be performed; rather the Court must make a fresh decision whether to order that no autopsy be performed.[9]

[30] The exercise of the discretion of the Court under s 23(3) is not fettered in any way.[10] In determining how that discretion is to be exercised, the Court must balance the interests of the family of the deceased in following and maintaining their Aboriginal culture and law, against the interests of the community on the other that the cause of an otherwise unexplained death be ascertained if possible.[11]

[31] Beach J observed in *Green v Johnstone*[12]:

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9 *Wuridjal v The Northern Territory Coroner* (2001) 11 NTLR 202 at [5] per Riley J; *Re Unchango; Ex parte Unchango* (1997) 95 A Crim R 65 at 70 per Walsh J.

10 Ibid at [10], citing *Green v Johnstone* [1995] 2 VR 176 at 178 per Beech J.

11 Ibid

12 at 179

> "In a multicultural society such as we have in this country, it is my opinion that great weight should be given to the cultural and spiritual laws and practices of the various cultural groups forming our society, and that great care should be taken to ensure that their laws and practices, assuming they are otherwise lawful, are not disregarded or abused."

[32] Of course if there are any suspicious circumstances surrounding the death, or there are other compelling reasons why it is in the public interest that an autopsy be performed, those cultural and spiritual considerations must take second place to the public interest.

[33] Ms Brownhill for the plaintiff submitted that there were a number of considerations in this case favouring the performance of an autopsy. First, she pointed out that Dr Vutelic is unable to determine the cause of the death without an autopsy. With an autopsy, she will be able to say whether the deceased died from the injuries he received in the motor vehicle accident. As appears from the analysis of Dr Vutelic's evidence, that is in all probability the only thing which an autopsy will determine. It is highly unlikely to be of any assistance in determining the cause of the collision.

[34] Ms Brownhill submitted that recording the consequences of motor vehicle accidents (eg death versus minor injuries) is an important tool in addressing the Territory's road toll, and that understanding the causes of motor vehicle accidents is critical to that process. That is of course true, but the evidence of Dr Vutelic is that an autopsy is unlikely to shed any light on the cause of this accident. Even if the autopsy were to show that the deceased did not

die as a result of the injuries received in the collision, and therefore, it is likely that he suffered an acute myocardial infarction, that will not determine whether that episode occurred before or after the collision.

[35] It was suggested that, if the cause of this death was natural disease, knowing and recording the cause is of assistance in addressing medical treatment and health outcomes for Aboriginal people in the Northern Territory. However, it is well known that Aboriginal people in the Territory suffer disproportionately high levels of heart disease – and efforts are being made by appropriate professionals to address the problem. Further, it was known that this man had a serious heart condition. Having it recorded that he died from heart disease is not going to contribute in any meaningful way to the efforts being made to address medical treatment and health outcomes for Aboriginal people in the Northern Territory.

[36] It was further submitted that knowing that the cause of this death was the deceased's heart condition, rather than the presence of alcohol or drugs in his system, may ensure that the deceased's dependents obtain the full benefits available to them under the *Motor Accidents (Compensation) Act*. I was informed that toxicology results were pending, meaning that information about whether the deceased had alcohol or other drugs in his system at the time of death will become available as a result of blood samples and that it is not necessary to perform an autopsy to achieve this result. In any case, this application was brought by members of the family and I was informed by counsel that it was made on behalf of all family

members. (If there had been evidence that there was a real issue as to the entitlement to benefits of infant beneficiaries unable to assent to the bringing of this application, and that it was necessary to resolve that issue for an autopsy to be performed, that would have been a different matter altogether.)

[37] It was further submitted on behalf of the coroner that understanding the cause of this death may give rise to consideration and discussion of the entitlement to drive of persons with serious heart conditions, the capacity and obligation of treating medical personnel to report such conditions to the licensing authorities, and the power and duty of those authorities to consider and determine a driver's entitlement. There is a real possibility that this man's death was caused or contributed to by heart disease, and an autopsy will do nothing to establish the cause of the collision. In those circumstances, it seems to me that the coroner has all the information he is ever going to get, autopsy or no autopsy, on which to base any such comments or recommendations.

[38] Sergeant Casey also gave evidence that it was important to identify the cause of death for the purpose of records kept by the Territory in relation to the statistics of motor vehicle accidents. He said there were approximately 50 fatalities a year on Territory years and in one or two cases a year the cause of death was "undetermined". One purpose to be served by an autopsy was to attempt to identify the cause of death for the purpose of those statistical records. In oral submissions, counsel for the coroner emphasised

the importance for public health and safety in keeping accurate statistics into causes of death and causes of motor vehicle accidents. I do not wish to be perceived as being dismissive of the importance of such matters. They are a vital tool for research and for determining relevant government policies. If applications of this nature became sufficiently frequent as to jeopardise the process of gathering such statistics, that would weigh (perhaps heavily) in the balance against granting such applications. However, that is not yet the case. I was referred to very few such applications over the past 10 years.

[39] In the circumstances, given the very limited amount of additional information which would be made available from an autopsy, and the real distress which will be caused to the family of the deceased and other community members if an autopsy is performed, I consider that, in this case, the interest of the family outweighs the public interest in determining the precise cause of death.