

Wuridjal v The NT Coroner [2001] NTSC 99

PARTIES: REGGIE WURIDJAL

v

THE NORTHERN TERRITORY
CORONER

TITLE OF COURT: SUPREME COURT OF THE
NORTHERN TERRITORY

JURISDICTION: SUPREME COURT OF THE
NORTHERN TERRITORY exercising
Territory Jurisdiction

FILE NO: 187 of 2001

DELIVERED: 9 November 2001

HEARING DATES: 2 November 2001

JUDGMENT OF: RILEY J

REPRESENTATION:

Counsel:

Plaintiff: A Hanley
Defendant: C McDonald QC

Solicitors:

Plaintiff: NAALAS
Defendant: Solicitor for the Northern Territory

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

Wuridajl v NT Coroner [2001] NTSC 99
No. 187 of 2001

BETWEEN:

REGGIE WURIDJAL
Plaintiff

AND:

**THE NORTHERN TERRITORY
CORONER**
Defendant

CORAM: RILEY J

REASONS FOR JUDGMENT

(Delivered 9 November 2001)

- [1] This matter arises out of the tragic death of a young Aboriginal girl in Darwin. Her body was found in circumstances suggestive of suicide by hanging.
- [2] Following his preliminary investigation into the death the Coroner decided that it was necessary for a direction to be given to a medical practitioner to perform an autopsy on the body of the deceased. That decision was conveyed to members of the family of the deceased and the plaintiff, who is the senior next of kin of the deceased person, objected to the performance of the autopsy. When agreement could not be reached with the Coroner the

plaintiff made application to this Court pursuant to the provisions of s 23(3) of the Coroners Act seeking an order that the autopsy not be performed. The application came before me on 2 November 2001 and, on that day, I declined to grant the relief sought. I published short reasons for my decision.

During the course of the hearing Mr McDonald QC, who appeared on behalf of the Coroner, noted that this was the first occasion on which s 23 of the Coroners Act had been considered by this Court and he invited me to provide detailed reasons for my decision in due course. I now do so.

The Legislative Scheme

- [3] The functions of the Territory Coroner include an obligation to ensure that all reportable deaths reported to the Coroner are investigated and, further, to ensure that an inquest into a death is held where there is a duty to do so under the Act or where it is desirable that an inquest be held. A “reportable death” is defined to include a death “that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury”. The Coroner is, inter alia, charged with finding the cause of death and any relevant circumstances concerning the death.
- [4] By virtue of s 20 of the Act, if a Coroner reasonably believes that it is necessary for an investigation of a death, he or she may direct a medical practitioner to perform an autopsy on the body of the deceased person. Where the Coroner directs a medical practitioner to perform such an autopsy, the Coroner is required to take reasonable steps to advise the senior

next of kin of the deceased person of the direction. Section 23 of the Coroners Act then provides:

“(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 shall immediately give notice in writing of the decision to the senior next of kin.

(2) Unless the coroner believes that an autopsy needs to be performed immediately, where a request has been made under subsection (1), an autopsy shall 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.”

[5] Sub-section 23(3) permits the Court to order that no autopsy be performed and it does so in terms that provide the Court with an unfettered discretion in that regard. The application that is made to the Court under that subsection is not in the form of a review of the decision of the Coroner but rather it involves a fresh decision whether to direct that an autopsy be performed.

[6] An issue raised in the course of submissions in this matter was as to the appropriate role of the Coroner in proceedings such as this. Reference was made to the judgment of the High Court in *The Queen v Australian Broadcasting Tribunal and Others; Ex parte Hardiman and Others* (1980) 144 CLR 13 where (at 35) the Court commented upon the “unusual course” taken by the Tribunal in that matter in contesting the claim for relief. The

Court observed that the “course which was adopted by the Tribunal in this Court is not one which we would wish to encourage” and noted the concern that if a Tribunal becomes a protagonist before a court “there is the risk that by so doing it endangers the impartiality which it is expected to maintain in subsequent proceedings which take place if and when relief is granted.”

[7] However an application under s 23(3) of the Coroners Act is in a different position from that discussed by the High Court. In *The Queen v Australian Broadcasting Tribunal and Others; Ex parte Hardiman and Others* (supra) the procedures adopted by the Tribunal in undertaking its functions were in question. The matter came before the Court by way of an application for mandamus and prohibition. In the present case the matter before the Court was not a review of the decision of the Coroner but rather an application in which the Supreme Court undertakes a fresh exercise of the discretion. Here there had been no inter parties proceedings before the Coroner. He was fulfilling an investigative role. Issues regarding the impartiality of the Coroner did not arise.

[8] In my view it was necessary for the Coroner to take an active part in the proceedings before the Supreme Court. The Coroner is the defendant to the matter and is likely to be the only party with access to the whole of the information upon which the decision to undertake an autopsy was made. As was observed by McDonald J in *Magdziarz v Heffey* (Supreme Court of Victoria, unreported, 3 October 1995), it would be “unhelpful” if the Coroner failed to put before the Court necessary material and, further, to

make submissions which would assist the Court in the exercise of its discretion. If that does not occur the Court will not have the advantage of full adversarial argument on the facts and issues necessary to be addressed. That would be an undesirable situation.

- [9] In the present case the Coroner appeared by counsel instructed by the Solicitor for the Northern Territory. Evidence was presented in affidavit form setting out the surrounding circumstances of the matter and identifying the concerns that led to a decision that a medical practitioner be directed to perform an autopsy. Counsel made submissions as to why it was appropriate in all the circumstances for an autopsy to be performed. This occurred without objection from the plaintiff. It was a necessary process to enable all relevant material to be placed before the Court. In my opinion this was an appropriate way for the Coroner to proceed in this matter. It permitted the identification and ventilation of the relevant issues and provided the Court with the benefit of adversarial argument.

The exercise of the discretion

- [10] The exercise of the discretion to make an order that no autopsy be performed is one that is not fettered in any way. It is a task that has been the subject of comment in other jurisdictions in relation to similar legislative schemes. Most cases have involved the Court having to resolve a conflict between the decision of the Coroner that an autopsy is necessary and the competing wishes of family, relatives or friends of the deceased person generally based

upon cultural or religious beliefs that are genuinely and strongly held. The present matter is just such a case. *Green v Johnstone* [1995] 2 VR 176 was also such a case. In that case Beach J observed (at 178):

“It is clear from the wording of the subsection that this court has an unfettered discretion in the matter. In determining how that discretion is to be exercised, one must balance the interests of the parents of the child on the one hand that they be permitted to follow and maintain 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] Beach J went on to make further observations that have been repeated with approval in a number of cases. He said (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.

If there were any suspicious circumstances surrounding the death of Leslie Green, I may well have taken the view that the interest of society that the cause of her death be ascertained outweigh the interests of her parents in preserving her body un mutilated by any autopsy. But that is not the situation. All available evidence is to the effect that the infant died from natural causes, probably from the syndrome described as Sudden Infant Death Syndrome. In such a situation it is my opinion that the rights of the parents to be spared further grief as a consequence of their daughter’s death outweigh the interests of the community that the actual cause of death be ascertained.”

[12] In *Krantz v Hand* (1999) NSWSC 432 Wood CJ at CL recorded his “entire agreement” with the appropriateness of taking into account the religious beliefs of the family of the deceased where they can be demonstrated to be

genuinely held and to accord with the faith of those concerned. He went on to say (par 41):

“That is a matter to be taken into account although it will not necessarily be determinative in any given case. In some circumstances, it may be that there is evidence pointing to foul play, which would need to be investigated, in order to ensure execution of the due process of the law. In other circumstances there may be evidence of a possibility of an outbreak of a serious infection which would need to be investigated in order to cater for public health interests. Additionally there may be cases where it could be in the interests of the immediate family of the deceased to determine whether there is some genetic predisposition to serious disease, that might possibly be treated or detected in its early stages if the possibility of its onset is known.”

[13] What is required is a balancing exercise. The weighing up of the competing interests may require an assessment of the strength of the available evidence and of the advantage to be obtained from adopting one course or another. For example, if an autopsy would provide only marginal assistance to the Coroner in the discharge of the Coroner’s functions the fact that a post mortem would cause deep distress to family members may be sufficient to warrant the exercise of a discretion against allowing an autopsy: *Abernethy v Deitz* (1996) 39 NSWLR 701 at 708.

[14] Each case must be determined in light of its own facts and circumstances. The exercise is one of balancing the identified competing interests. That exercise involves a careful and sensitive consideration of all of the relevant circumstances of a particular matter. Each case must be dealt with individually: *Re Death of Simon Unchango (Jnr); Ex parte Simon Unchango (Snr)* (1997) 95 A Crim R 65.

The Present Case

[15] On 24 October 2001 the Coroner's Office was alerted to the death of the deceased. She was reported to have been found sitting on a bed with a curtain tie knotted around her neck. The death was clearly a "reportable death" for the purposes of the Coroners Act. The Coroner therefore commenced an investigation into the death. As a result of those preliminary investigations the Coroner formed a view that it was necessary for the investigation that he direct a medical practitioner to perform an autopsy on the body of the deceased person. The reasons for his decision are set out in the affidavit material filed on behalf of the defendant. Those concerns centre upon establishing the cause of death and ruling out the prospect of foul play and/or the intervention of others in the death. A summary of the reasons is contained in the report of the forensic pathologist, Dr CH Lawrence. He reviewed the available information and conducted an external examination of the deceased. He then reported as follows:

"In my opinion a complete three cavity postmortem is essential to establish the cause of death for the following reasons:

1. In some cases of hanging where the suspension point is low and part of the body is supported it can be very difficult to distinguish hanging from ligature strangulation. (The deceased) was reported to have been sitting on the bed with a curtain (curtain tie) knotted around her neck. The ligature mark is very difficult to see and consists of a horizontal compression mark (which would be caused in the post mortem period) and a slight abrasion on the left side of the neck.

The horizontal positioning of the ligature is difficult to distinguish from a ligature strangulation, and the petechiae on the conjunctiva and the congestion of the face are features which while they can occur in hanging are more common in ligature strangulation.

Dissection of the neck will identify of (sic) bruising in the strap muscles and fracturing of the hyoid bone and thyroid cartilage. These features would push me towards a ligature strangulation rather than a hanging.

On external examination alone I cannot tell if these marks indicate hanging or ligature strangulation.

2. There is no suicide note, history of depression or obvious precipitant for suicide. The issue of pregnancy has been raised in the initial report of death to the Coroner. Early pregnancy may not be obvious on xray, but should be identifiable on histological examination of the endometrium. Likewise, physical assault or sexual assault, because of the relative difficulty in identifying external bruising, cannot be adequately excluded by external examination.

3. It has been suggested that (the deceased) had asthma and that she in fact died of asthma. Macroscopic and microscopic examination of the lungs should establish whether she is in 'status asthmaticus' – severe asthma capable of producing death.

4. In this case there have been rumours of possibly (sic) causes of the suicide. In my experience of 13 years a thorough and complete autopsy is the only effective way to accurately document internal injuries, medical conditions such as asthma or pregnancy and to collect a complete range of samples for toxicology. Documentation of these findings is the most effective way of stopping speculation.”

[16] The grounds of the application made pursuant to s 23(3) of the Coroners Act were set out in two affidavits. In the affidavit of Gordon Machbirrbirr, Mr Machbirrbirr identified himself as a senior lawman for the community of Maningrida. He identified himself as a Yolngu man and noted that the deceased and her family lived by traditional Yolngu beliefs. He was an appropriate person to speak for the community in this matter. He went on to say:

“5. My opinion, based on my knowledge of Yolngu Aboriginal customary law in my community, is that to carry out an autopsy on the deceased would be against our traditional Yolngu law and custom.

6. Even though the death was unexpected, the custom of our community is that we are more worried about spiritual matters than about learning exactly what caused the death of the one who died.
7. According to traditional Yolngu law and custom:
 - (a) The body of the one who died must be returned to the family's traditional country at Saint Theresa Mission in Alice Springs straight away for funeral ceremonies. The family cannot wait any longer to start the funeral ceremonies, or else the family might suffer bad luck;
 - (b) If the body is not returned to our country the spirit of the one who died may never be at rest and may haunt the family;
 - (c) If the body is cut, this will harm the spirit of the one who died and the spiritual life of the family of the one who died and the whole community will suffer;
 - (d) According to Yolngu law and traditions the one who dies will be reincarnated to be with out spiritual ancestors and will need to be recognised by those ancestors and become a part of our knowledge and a part of our spiritual blessing. The body has to be whole and not mutilated for the spiritual ancestors to recognise the spirit of the one who died.
8. Cutting the body of a person who has died is very bad in Yolngu traditions and customary law.”

Those statements and sentiments were confirmed in the affidavit of the senior next of kin, the plaintiff in these proceedings.

[17] There is no dispute that the views expressed in support of the application are deeply and genuinely held by those concerned. The strength of those feelings and the level of concern engendered by the proposed autopsy was reflected in the evidence I received from Dr Arnold of the Maningrida Health Centre as to the distressed reaction of the mother of the deceased when the prospect of an autopsy was mentioned to her.

[18] However a weighing up of the competing interests in this matter led me to the conclusion that it was appropriate that an autopsy be performed. The matters raised by the Coroner were significant and of weight. Those matters give rise to genuine concerns that have to be addressed. The most significant concern was the need to determine whether the marks on the neck of the deceased indicated a hanging or ligature strangulation. There were in the circumstances of this matter suspicious circumstances surrounding the death. In my view the level of suspicion arising was such that the interests of the community that the cause of death be ascertained outweighed the interests of the family and the senior next of kin in preserving the body of the deceased unaffected by any autopsy.

[19] Clearly the decision I made was such as to cause significant distress to those people represented by the plaintiff and added to the pain of this already painful tragedy. Notwithstanding those matters this is a case in which it is appropriate that an autopsy be performed.

[20] In all the circumstances I declined to grant the relief sought.
