Evans v Northern Territory Coroner [2011] NTSC 100

PARTIES:	EVANS, Shaun
	v
	NORTHERN TERRITORY CORONER
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE NORTHERN TERRITORY EXERCISING TERRITORY JURISDICTION
FILE NO:	149 OF 2011 (21140324)
DELIVERED:	6 DECEMBER 2011
HEARING DATES:	1 DECEMBER 2011
JUDGMENT OF:	RILEY CJ

CATCHWORDS:

CORONER – objection to autopsy – Coroner's duties, responsibilities and powers – unexplained death of an infant – Aboriginal culture and law – interests of the family to be weighed against the public interest.

Coroners Act s 12(1), s 14(1), s 14(2), s 34(1)(a)(iii), s 34(1)(a)(v), s 34(2) and s 35(3)

Re Unchango; Ex parte Unchango (1997) 95 A Crim R 65; *Krantz v Hand* [1999] NSWSC 432; *Horvath v State Coroner of Victoria* [2004] VSC 452; *Pope and Pope v State Coroner* [1998] SASC 6526; *Magdziarz v Heffey* [1995] VSC 201; *Ronan v State Coroner (WA)* [2000] WASC 260; *Price v Johnstone*, unreported, Supreme Court of Victoria, 17 June 1998; *Green v Johnstone* [1995] 2 VR 176, applied.
Wuridjal v The Northern Territory Coroner (2001) 11 NTR 202; *Geoffrey Raymond-Hewitt v Northern Territory Coroner* [2011] NTSC 94, followed.

REPRESENTATION:

Counsel:

Plaintiff:	A Wyvill QC
Defendant:	Dr I Freckelton SC and Dr P Dwyer

Solicitors:

Plaintiff:	North Australian Aboriginal Justice Agency
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

Evans v Northern Territory Coroner [2011] NTSC 100
No 149 of 2011 (21140324)

BETWEEN:

SHAUN EVANS
Plaintiff

AND:

NORTHERN TERRITORY CORONER
Defendant

CORAM: RILEY CJ

REASONS FOR JUDGMENT

(Delivered 6 December 2011)

[1] This application arose out of the sudden and tragic death of a young child at Borroloola. Following a preliminary investigation, and having taken expert advice, the Coroner determined that it was necessary for a direction to be given to a medical practitioner to perform an autopsy on the body of the deceased child.[1] The applicant is the father of the deceased child and he sought an order pursuant to s 23(3) of the *Coroners Act* that an autopsy not be performed. At the conclusion of the hearing I made an order in those terms. These are my reasons for so doing.

[1] Pursuant to s 20(1) of the *Coroners Act*.

The circumstances of the death

[2] The child was born on 3 October 2011 at 40 weeks gestation. He was delivered by emergency caesarean section. His birth weight was described as excellent as were his Apgar scores. Breastfeeding was successfully established and the child was discharged from hospital on 7 October 2011. A checkup by the Remote Area Nurse on 15 November 2011 revealed no medical problems.

[3] In a statement provided to Police the mother of the child advised that the deceased was the fifth child of herself and her husband. The other children were all healthy. On 22 November 2011 the husband was in Darwin on business. The mother stated that she and the children had slept together in the one room on mattresses on the floor. They had watched television for a while and the children gradually fell asleep. The child had consumed a bottle of milk and he then went to sleep. When all of the children were asleep the mother also went to sleep adjacent to the child.

[4] The mother advised that she slept through the night and woke about 7am. She said:

> I saw my baby and I tried to wake him but he was sleeping. Every morning I wake him up and he is happy and wants his titty bottle. This morning he didn't wake up.

Members of the family of the mother were immediately alerted and the child was rushed to the local clinic where he was seen by a doctor. After a period the doctor informed the mother that her child had passed away.

[5] The father of the child was notified and immediately returned to Borroloola. He spoke with the doctor and enquired whether there would be an autopsy. The doctor alerted him to the possibility that he may be able to stop any autopsy from taking place. The father subsequently obtained legal advice and brought these proceedings as a consequence.

[6] In his affidavit filed in support of the application the father advised that he lives a traditional life with his wife and children. He said that he did not want the autopsy to take place as "it is against our way and culture". He explained the processes that would usually follow upon a death and went on to say:

> I do not want my son to undergo an autopsy because the Jungayi can refuse to look after him and prepare him for burial. This would be devastating to me and my family.
>
> If the autopsy takes place my son will not be able to enter the spiritual country and be with his ancestral family because his body would not be whole. He will be alone with nowhere to go and no one to look after him. This would be very distressing to me and my family if my son's spirit had to go on without his ancestors to look after him.

The father expressed concern that if the autopsy took place "bad things will happen to family members" and that his son would be "lost with nowhere to go because our law has been broken".

[7] The evidence of the father was supported by the affidavit of Samuel John Jamiga Evans who is the grandfather of the deceased child and who is also

"an elder of the Yanyula clan and a ceremony man on the Mara side of my family".

[8] There was no dispute that proceeding with the autopsy would cause the father, the mother, the family of the deceased child and others "great heartache and distress". The views expressed by the father on behalf of himself and his family were clearly, deeply and genuinely held.

The medical evidence

[9] The Coroner sought advice from Professor RW Byard, a Professor of Pathology at the Medical School North of the University of Adelaide. The Professor is an internationally recognised expert in sudden infant and child death. He was accepted as being an appropriate expert to provide advice in this matter. I was provided with the report of Professor Byard and he gave evidence before me.

[10] In the report the Professor advised that an autopsy was required in order to determine the exact reasons for the death of the child. He pointed out that it is well recognized that infants can have serious and potentially life-threatening illnesses and yet not appear unwell. Unless an autopsy is performed there will usually be no way that these conditions can be identified. He went on to say:

> While SIDS remains the most common cause of unexpected infant death in Western communities, it remains a diagnosis of exclusion, being defined as "the sudden unexpected death of an infant <1 year of age, with onset of the fatal episode apparently occurring during

> sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and clinical history". Thus, unless a full autopsy examination has been conducted according to established guidelines and protocols the term SIDS cannot be used.

[11] The Professor advised that in the present case the conclusion of SIDS in the notification of death to the Coroner could not be supported as there was insufficient information available. In the absence of an autopsy no cause of death would be determinable and the case would be relegated to the "undetermined" category of cases of this kind. He went on to observe that "the results of autopsies may help the community, both lay and professional, to gain an understanding of issues around such deaths that may be useful in formulating future preventative strategies". His evidence was supported by that of Dr AJ Wright who addressed the need for the gathering of as much information as possible in cases of this kind.

[12] The Professor concluded:

> It is recognised that even after autopsy no cause of death may be found in a certain percentage of infants. While some of these cases may be classified as SIDS deaths, others will remain "undetermined". The advantage of having performed a full autopsy in these cases, however, is to assure the family and community that as much as possible has been done to try to work out the terminal events. In addition, certain infectious diseases such as meningococcal disease, and particular types of inflicted injury such as blunt head trauma, will have been excluded. There is no doubt that the autopsy remains the definitive way of determining the cause of death in infants who have unexpectedly died.

[13] These views were also supported by Dr TJ Sinton who is a forensic pathologist at Royal Darwin Hospital.

The Legislative Scheme

[14] The *Coroners Act* invests the Coroner with jurisdiction to investigate a reportable death[2] and imposes an obligation to investigate a reportable death which is reported.[3] There is no dispute that the death of the child in this case was a reportable death.[4] The Act requires the Coroner, where possible, to find the cause of death[5] and any relevant circumstances concerning the death.[6] The Coroner may report on a matter, including public health or safety, connected with the death being investigated.[7] Where the Coroner believes that a crime may have been committed in connection with a death the Coroner must report to the Commissioner of Police and the Director of Public Prosecutions.[8] There was no suggestion in this case that a crime had been committed in connection with the death of the child. The police report concluded that "there are no apparent suspicious circumstances contributing to this death".

[15] The Coroner is empowered to direct a medical practitioner to perform an autopsy on the body of a deceased person where the Coroner "reasonably believes that it is necessary for an investigation of a death".[9] In the present case the Coroner reached the conclusion that an autopsy was necessary and then informed the plaintiff as the senior next of kin of the decision.

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[2] *Coroners Act* s 14(1).
[3] *Coroners Act* s 14(2).
[4] *Coroners Act* s 12(1).
[5] *Coroners Act* s 34(1)(a)(iii).
[6] *Coroners Act* s 34(1)(a)(v).
[7] *Coroners Act* s 34(2).
[8] *Coroners Act* s 35(3).
[9] *Coroners Act* s 20(1).

The exercise of the discretion

[16] Section 23 of the Act provides for objections to an autopsy and it was pursuant to this provision that application was made by the plaintiff to the Supreme Court. The section 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.
>
> (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.

[17] In exercising the power under s 23(3) of the Act the Court is not to review the decision of the Coroner but rather must make a fresh decision whether to order that no autopsy be performed. In the present case the Court was required to balance the interests of the family of the deceased in following and maintaining their Aboriginal culture and law, against the interests of the

community that the cause of an otherwise unexplained death be ascertained if possible.[10]

[18] By reference to the legislative regime and authorities from various jurisdictions, the following observations may be relevant to the exercise by the Court of the discretion:

(a) the exercise of the discretion to make an order that no autopsy be performed is one that is unfettered;[11]

(b) each case should be decided individually on its own facts and circumstances;[12]

(c) the exercise is one of balancing competing interests;[13]

(d) it is appropriate to take into account the likelihood of, and the extent of, useful information being obtained from the autopsy for the purposes of the Coroner's investigation;[14]

(e) it is appropriate to take into account the genuinely held religious and cultural beliefs of the family of the deceased although those beliefs are not determinative;[15]

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[10] *Wuridjal v The Northern Territory Coroner* (2001) 11 NTR 202 at [5] and [10]-[14]; *Geoffrey Raymond-Hewitt v Northern Territory Coroner* [2011 NTSC 94 at [29]-[30].
[11] *Wuridjal v The Northern Territory Coroner* (2001) 11 NTR 202 at [5].
[12] Re Unchango; Ex parte Unchango (1997) 95 A Crim R 65 at 69.
[13] *Wuridjal v The Northern Territory Coroner* (2001) 11 NTR 202 at [13].
[14] *Raymond-Hewitt v Northern Territory Coroner* [2011] NTSC 94.
[15] *Krantz v Hand* [1999] NSWSC 432 at [41].

(f) in addition, in my opinion, the obligations imposed upon the Coroner under the relevant legislation[16] and the capacity of the Coroner to fulfil those obligations in the absence of an autopsy are to be taken into account although those matters are not determinative.

[19] A range of matters have been identified in various cases as favouring, but not requiring, that an autopsy be held. Those matters include:

(a) where there is evidence pointing to foul play, or suspicious circumstances surrounding the death, which would need to be investigated in order to ensure execution of the due process of the law;[17]

(b) circumstances where there may be a possibility of an outbreak of a serious infection which would need to be investigated in order to cater for public health interests;[18]

(c) cases where it may 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;[19]

[16] Eg s 34 of the Act.
[17] *Wuridjal v The Northern Territory Coroner* (2001) 11 NTR 202 at [18]; *Krantz v Hand* [1999] NSWSC 432; *Raymond-Hewitt v Northern Territory Coroner* [2011] NTSC 94 at [32].
[18] *Krantz v Hand* [1999] NSWSC 432 at [41].
[19] *Krantz v Hand* [1999] NSWSC 432 at [41].

(d) cases where there is a real issue as to an entitlement to benefits of infant beneficiaries[20] unable to assent to the bringing of an application and it is necessary to resolve the issue for an autopsy to be performed;[21] and

(e) cases where a congenital problem may be disclosed which may be of benefit in preventing other deaths.[22]

[20] Counsel for the Coroner pointed to differences between s 23(3) of the *Coroners Act* and the equivalent provisions in the relevant Victorian and New Zealand legislation. It was noted that, by way of contrast to those provisions, the Northern Territory Act does not include an explicit recognition of the cultural interests of persons related to the deceased. It was argued that whilst cultural and religious interests may be taken into account in the Northern Territory, they are to be treated as secondary to the purposes of the Act and, in particular, the findings to be made pursuant to s 34 of the Act. It was also submitted that the Court in making a determination is obliged to stand in the shoes of the Coroner and to reach a decision having regard to the functions and investigative and fact-finding duties imposed upon the Coroner. I do not accept those submissions. As has been noted above the discretion provided in the Act is unfettered. In my opinion there is nothing in the Act that would require such a qualification to be placed upon the unfettered discretion vested in the Court. It is necessary

[20] Eg under the *Motor Accidents (Compensation) Act.*
[21] *Raymond-Hewitt v Northern Territory Coroner* [2011] NTSC 94 at [36].
[22] *Horvath v State Coroner of Victoria* [2004] VSC 452 at [15].

for the Court to consider and weigh all relevant considerations in the circumstances of the particular case. The weight to be accorded a particular matter is to be assessed in light of all the circumstances not by reference to any preconceived notion that it is more or less important than other considerations.

[21] In matters such as the present case it is incumbent upon the Court 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. In some cases it has been held that ascertaining the precise cause of death is less important than the spiritual and cultural beliefs of the family in the particular circumstances.[23] In *Wuridjal v The Northern Territory Coroner*[24] I adopted the observations of Beach J in *Green v Johnstone*[25] where his Honour made observations that have been repeated with approval in a number of cases. His Honour said:

> 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 interests of

[23] *Ronan v State Coroner (WA)* [2000] WASC 260 at [7]; *Price v Johnstone*, unreported, Supreme Court of Victoria, 17 June 1998.
[24] (2001) 11 NTLR 202 at [10]-[14].
[25] [1995] 2 VR 176 at 178 and 179.

> society that the cause of her death be ascertained outweigh the interests of her parents in preserving her body unmutilated 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.

The present case

[22] In the present case there were grounds upon which the Coroner was justified in requiring a post-mortem examination including an autopsy. The Coroner reasonably believed that it was necessary for an autopsy to be performed. Without an autopsy the cause of death could not, finally, be determined. There is a public interest in knowing the exact cause of death.

[23] On the other hand the public interest in knowing the cause of this death must be weighed against the public interest in giving deeply held spiritual and cultural beliefs proper recognition and respect.[26] In this case I was satisfied that the spiritual beliefs of the family of the child were genuinely held. To perform an autopsy would compound the great grief and distress already being suffered by the family.

[24] The available evidence strongly pointed to the likelihood of the cause of death being accidental asphyxia or SIDS. The deceased child was sleeping with his mother who is a smoker and those two matters are recognised as significant SIDS risk factors. The evidence of Professor Byard disclosed

[26] *Ronan v The State Coroner (WA)* [2000] WASC 260 at [4].

that following an autopsy usually all that can be stated is that no other causes of death were identified and so suffocation from co-sleeping would remain a possibility. In this case there was no evidence pointing to the child having suffered any relevant injury, sickness, genetic or other pre-existing health problem which would need to be ruled out. The child was observed to be a healthy child who was well cared for. There was no indication that there were suspicious circumstances surrounding the death.

[25] In all the circumstances the likelihood was that the performance of an autopsy would not provide any additional information as to what actually caused the death of the child, although it may have done so. If there was any additional information to be obtained from the autopsy it was likely to be quite limited. The findings resulting from an autopsy were unlikely to contribute in any meaningful way to a better understanding of the death of this child or to contribute in any meaningful way to efforts being made to improve health outcomes for other infants.

[26] In all the circumstances I considered that, in this case, the interests of the family outweighed the public interest in determining the precise cause of death and I ordered that no autopsy be performed.
