CITATION: *Inquest into the death of Mansur La ibu* [2004] NTMC 020

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0021/2003
DELIVERED ON:	19 March 2004
DELIVERED AT:	Darwin
HEARING DATE(s):	16, 17, 18, 19 & 20 February 2004
FINDING OF:	Mr Greg Cavanagh Territory Coroner
CATCHWORDS:	CORONERS: Inquest, Unexpected Death, Public Health & Safety of persons held in detention by Federal Agencies, Death in Custody.

REPRESENTATION:

Counsel:

Assisting:	Mr C. McDonald QC
Family:	Mr I. Read
Aust Fisheries Management Authority: (AFMA)	Ms D. Mortimer SC
Dept. of Immigration, Multicultural & Indigenous Affairs: (DIMIA)	Mr R. Bruxner

Judgment category classification:	A
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0021/2003

In the matter of an Inquest into the death of

MANSUR LA IBU
ON 26 FEBRUARY 2003
AT PONTOON AREA OF THE STOKES HILL WHARF, DARWIN HARBOUR

FINDINGS

(Delivered 19 March 2004)

1. Mansur La ibu ("the deceased") died sometime between 2:30 and 3:30am on a stormy night in Darwin Harbour on 26 February 2003; his death was unexpected. The death was reported to the Territory Coroner pursuant to Section 12(1) of the *Coroners Act* ("*the Act*") which defines a "reportable death" to mean a death that , inter alia:

> "appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury ".

2. For reasons that appear in the body of these Findings, the death fell within the ambit of that definition and a coronial investigation was mandatory. The holding of this Inquest additional to that investigation is a matter of my discretion. I have held the Inquest as, in my view, the circumstances concerning the death give rise to issues of public importance. Section 34(1) of *the Act* details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;

(ii) the time and place of death;

(iii) cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

(v) any relevant circumstances concerning the death.

3. Section 34(2) of *the Act* operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

4. The duties and discretions set out in subsection 34(1)and (2) are enlarged by section 35 of *the Act*, which provided as follows:

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner."

5. The public Inquest in this matter was heard at Darwin Magistrates Court between 16 and 20 February 2004. Counsel Assisting me was Mr Colin McDonald QC. Mr I Read sought leave to appear on behalf of the family of the deceased. I granted that leave pursuant to s.40(3) of *the Act*. Ms D Mortimer SC. representing the Australian Fisheries Management Authority (AFMA) and Mr R Bruxner representing the Department of Immigration, Multicultural & Indigenous Affairs (DIMIA) also sought leave to appear and I granted them leave.

FORMAL FINDINGS

6. In accordance with the statutory requirements under *the Act*, the following are my formal findings arising from this Inquest:

(a) The identity of the deceased was Mansur La ibu (also known as Mansyur La Ibu), a male Indonesian national apparently born and raised in South East Sulawesi, Indonesia; he was from a small village called Buton. I am unable to ascertain his exact date of birth however, I was told in evidence that he was a young adult male born in 1983.

(b) The place of death was at a place in Darwin Harbour adjacent to or on the pontoon area of the Stokes Hill Wharf and the time of death was between 2:30 and 3:30am on 26 February 2003.

(c) The cause of death is undetermined.

(d) The particulars required to register the death are:

1. The deceased was a male.

2. The deceased was an Indonesian national.

3. The death was reported to the Coroner.

4. A post mortem examination was carried out on 26 February 2003.

5. The pathologist viewed the body after death, and the pathologist was Dr Terence John Sinton of the Royal Darwin Hospital.

6. I was informed by counsel for the family, and accept that the father of the deceased was La Ibu and the mother was Wa Agu.

7. The deceased resided on board the fishing vessel "Yamdena" at the time of his death.

8. The deceased was employed as a fisherman at the time of his death.

RELEVANT CIRCUMSTANCES CONCERNING THE DEATH INCLUDING COMMENTS, REPORTS AND RECOMMENDATIONS

7. The evidence disclosed the following:

8. The deceased was one of six crew members who boarded the small wooden fishing vessel "Yamdena". The "Yamdena" was a type III Indonesian vessel which left a small village in South Eastern Indonesia on or about the 25th of January 2003 to fish in waters north of Australia. The vessel was about 13.5 metres long with a white and red hull, low green cabin and aft box. Other than having a small diesel engine it had no other mechanical devices or any modern day conveniences including toilet facilities. The deceased was a fisherman by occupation and a Muslim. The fishing vessel was apprehended by HMAS Fremantle on the 28th of January 2003 in the Arafura Sea. The vessel was approximately 52 nautical miles inside the Australian fishing zone.

9. A boarding party was dispatched from HMAS Fremantle and at about 0225 hours the boarding party boarded the vessel. Shortly thereafter, the Executive Officer from HMAS Fremantle conducted an interview with the master of the vessel, one Basri. The interview was by way of using Indonesian translation cards. Amongst other things Basri told the officer the vessel had sailed from Dobo. The purpose of the voyage was to catch fish and that the vessel had been in the area for about a day. Basri told the Executive Officer that he and the crew had caught approximately 2 kilograms of red fish. An Australian fishing licence was not produced nor was one located on the search of the vessel. No fish were found on the vessel although some scales from fish were found. Lieutenant James Ronald

Simpson questioned Basri, and elicited from Basri that he had been in the area for the one day 'with the intention of staying two days (Dua Hari)". He also explained the vessel has been seized and that it would be taken to Australia for further investigations into possible breaches of the *Fisheries Act*. Photographs were taken on the vessel and items found on the vessel. These photographs show the confined nature of the vessel and its small cabin area.

10. At 0632 hours on 28 January 2003 the vessel and its crew were apprehended by officers from HMAS Fremantle. The HMAS Fremantle placed a holding party on the vessel and proceeded east to look for other vessels. Later in the afternoon, it returned and escorted the "Yamdena" some 240 nautical miles to Darwin arriving on 30 January 2003. The return was obviously against the wishes of the captain and crew.

11. The deceased at the time of his death was in immigration detention and being held on board the vessel "Yamdena" at a mooring point just off Stokes Hill Wharf in Darwin. The "Yamdena" was one of a number of similar wooden vessels detained at the mooring site off Stokes Hill Wharf with their Indonesian crews kept on board. In response to questions asked by the Coroners Constable, AFMA advised that at the time the "Yamdena" was in port there were 13 boats and 14 crews also in Darwin Harbour. One of the boats sunk after apprehension. Crew from the sunken boat were accommodated on the other boats in port at the time. The captain and crew were detained on board the wooden vessels. Such detention on board the foreign fishing vessels appears to be standard practice. All members were under supervision of AFMA. A member of the crew of the fishing vessel which sunk was assigned to the "Yamdena" and, accordingly, seven Indonesian fishermen were sharing the cabin which was the only sleeping quarters and protection from the wet season storms.

12. The evidence of the police photographer (Senior Constable T. Sandry) is relevant in terms of the sleeping quarters on the "Yamdema" (Transcript P48):

> "How did you find getting down from the boat into the wheelhouse, easy?---No, difficult.
>
> Why?---It was confined spaces and I had the camera on me and I just had to – just sort of try and get down because there wasn't – the roof was very low so I had to - - -
>
> How would you describe the cabin area of the vessel that you were photographing?---It was small and confined in the wheelhouse area, yes.
>
> And in terms of sleeping six men? [*in fact seven men were sleeping there*]---I'd say that you'd have to be fairly close together if you were going to sleep six people in there.
>
> Would it be a fair description to describe the cabin as confined and narrow?---Yes, I could say that, yes. Narrow in height and width, yes."

And (P49):

> "THE CORONER: What were the – have you got – what were the dimensions of that wheelhouse that had seven men sleeping in it?---I couldn't tell you, Your Worship, I wasn't instructed to get the dimensions of the wheelhouse.
>
> But you were there?---Yes.
>
> Estimate it for me?---Its probably – height wise it would probably be about 3 foot in height, 3 and a bit feet in height. I had to duck walk through and approximately – wide – about 4 and 5 feet.
>
> Wide?---Yes.
>
> How long?---Length wise approximately about 5 or 6 feet length wise."

13. AFMA had in place a written contract with Kerrawang Pty Ltd trading as Barefoot Marine to look after the vessels and crew members until such time as they departed Darwin Harbour. Some of the terms of the written

agreement are of interest in the context of this Inquest. In the recitals section of the written agreement it is noted that:

a) AFMA requires the provision of caretaker services for foreign fishing vessels and crews apprehended in respect of suspected illegal fishing in the Australian Exclusive Economic Zone and the Torres Strait Protected Zone in waters of Northern Australia; and

b) Those services include ensuring the wellbeing of such crew *as detainees rather than as persons in custody...*

14. The owners of the "Yamdena" had in fact paid the valuation sum to the Australian Government and the vessel was waiting for suitable weather conditions before leaving Darwin Harbour. On 10 February, 2003 security of $3,460 was offered in relation to the boat.

15. On the night of 25 February 2003 and early hours of 26 February 2003 the weather conditions were characterised by storms, wind and intermittent and sometimes torrential rain. As to the state of the weather, Senior Constable Lade told me (Transcript P72):

> "MR READ: What time again was it that you got down to the pontoon area?---I was called out about – I was called out at quarter past 4 and it was within about half an hour to forty minutes. So about quarter to 5 o'clock.
>
> In the morning?---Yes.
>
> What were the weather conditions like, you said they were cyclonic and I think you also said it was inclement weather? Can you describe what it like?---Extremely heavy rain, extremely heavy wind to a point of I could hardly stand, I was being blown.
>
> Buffeted?---Yes.
>
> And down on the pontoon, what was it like down on the pontoon?---The same extremely heavy."

And (P73):

> "Now when you went back up onto the main wharf, could you see where the fishing boats were moored?---Could you see the other boats?---No.
>
> Was that because of dark or because of the storm or combination?---Both.
>
> Certainly there was no moon that night or if it was it was covered?---Yes.
>
> Yes, and did you say you were buffed by the wind, there was quite a lot of noise as well?---Yes.
>
> Wind blowing between the pylons and whatever?---Yes."

16. Employees of Barefoot Marine maintained contact with the vessels by means of having a mother ship in the quarantine area and two small dinghies for getting to and from the small fishing vessels. Barefoot Marine employees delivered food and water to each detained vessel regularly. The employees worked in shifts and would do a head count of detained members twice each day at 6.30am and 7.00pm. On the evening of Tuesday 25 February, 2003 employees of Barefoot Marine undertook the 7.00pm headcount and did not observe anything unusual. There were about 13 vessels in the quarantine area at the time. They did not receive at that time any complaint from the captain or crew.

17. The deceased was discovered to be seriously unwell by crew members during the night. Observations were made of the deceased losing his breathe and shaking. The deceased did not have anything to say. The Captain of the vessel, one named Basri, cradled the deceased until he finished shaking. Basri gave a statement to investigating Coroners Constables and I quote (Transcript P17):

> "Mansur woke up earlier this morning shaking and he lost his breath, we're all sleeping together when he had a fit. Mansur sleeping closest to the steering wheel of the boat, he was towards the front of the boat. After Mansur was shaking it was about two minutes before his breath was gone.

> Mansur didn't say anything, Mansur hadn't been sick, he was all right, the last time we ate was at lunchtime yesterday, we had some rice, chicken, vegetables and orange. We all ate some food including Mansur. Mansur didn't have any medications. None of the crew feels sick, everyone is well. There is no tinned food on the boat, all the food we get is fresh food.
>
> There are a lot of mosquitos on the boat and mostly during the night. There is no dried meat on the boat, this is the first time that I saw Mansur shaking. I haven't seen him do that before. When Mansur finished shaking I cradled him in my arms and wake up the rest of the crew.
>
> The sing out for the Barefoot Marine for help the security contractors. Two men from Barefoot Marine come and we put Mansur on the boat and take him to the wharf. One man from Barefoot Marine tried to help Mansur back to life, by blowing air into Mansur's mouth, this happened on the wharf. Out of the crew I am the closest to Mansur, I consider myself as family. My father and Mansur's father are cousins. I don't know why Mansur died, we were really surprised when he died."

And another crew member (P18):

> "Mansur has never talked to me about being sick, yesterday morning we all had breakfast on the boat, we had chicken and rice, after breakfast we all just sat on the boat, we didn't have any lunch or tea because we ate all our rice for breakfast, there was no other food on the boat that we could eat."

18. The Indonesian crew urgently tried to attract attention and did so by starting their engine and breaking the mooring line. Employees of Barefoot Marine had their attention drawn to the emergency by seeing the "Yamdena" break its mooring. They went to investigate. Barefoot Marine employees together with the crew carried the deceased from the confined cabin of the Yamdena and placed him into a dinghy. The deceased was then conveyed to the nearby pontoon area of Stokes Hill Wharf. Resuscitation attempts and the provision of first aid was not practicable on board the "Yamdena" or on board the dinghy because of the confined space and the prevailing weather conditions at the time.

19. Two Barefoot Marine employees reached the vessel at around 3.20am according to records kept by them. They boarded, opened the cabin hatch and found the deceased unconscious and being held up by crew members. They proceeded to check for vital signs. One of the employees held a current first aid certificate, and he found apparent pulse and breathing. So he telephoned the managing director of Barefoot Marine, Jennifer Scullion to obtain instructions. He was instructed to take the deceased immediately to Stokes Hill Wharf. In the meantime Jennifer Scullion telephone 000 and requested St Johns Ambulance for assistance. St John Ambulance records disclose that Ms Scullion contacted the organisation at 0328 hours and an ambulance was dispatched to Stokes Hill Wharf at the same time.

20. The St John Ambulance unit dispatched to Stokes Hill Wharf arrived at 0342 hours. The ambulance members in the unit were Matthew Davis and Antoni Kwiatowski. On arrival they saw the deceased lying on a boat landing with resuscitation (EAR) being performed on him.

21. Ms Scullion reported events to AFMA acting officer in charge, Mick Munn by telephone at 0345 hours.

22. The ambulance officers immediately sought to treat the deceased with oxygen and cardiac compressions. The officers noticed his eyes were fixed and dilated and there was no pulse. There was no response to the cardiac and other treatment. Treatment continued until about 4.00am with no response. Officers pronounced life extinct and ceased treatment.

    One of the ambulance officers opined as follows in evidence (Transcript P40):

> "Now its your understanding that – it was your understanding from what you were told that this person had lost his breath and had lost consciousness on board a fishing vessel somewhere out in the harbour?---That's correct.

How difficult is it to treat an unconscious non-ambulant patient?---In a confined space it is very difficult.

Do you need any equipment to be able to treat a person who has collapsed in a confined space?---Well, the more equipment you have got, the better chance you have got of doing that treatment successfully.

How difficult is to treat a non-ambulant patient who comes from a boat to the land in your experience?---Its quite difficult.

What are the difficulties in public health terms?---In conveying a patient from one vessel to another is a risk to the officers – to the rescuers of falling because of the instability of the platform that you are on. Particularly at night there are the hazards of tripping and falling and injuring yourself and injuring the patient in manual handling risks associated with it.

How many persons would be needed to extricate a person from a boat to another boat to be conveyed to land?---It would depend but we would normally want at least four able bodied people for the lifting alone."

23. At about 4.00am Ms Scullion again telephoned Mr Munn informing him that Mansur was unable to be resuscitated. Ms Scullion asked Mr Munn if it was Barefoot Marine's duty to inform DIMIA. Mr Munn told her that he would do this at 8.00am. Ms Scullion asked for an interpreter to explain to the crew what had happened. Mr Munn replied that he would bring an interpreter down at 8.30am that day.

24. The ambulance officers questioned the other Indonesian crewman present via an interpreter concerning the deceased's history and were advised by those members that there was no recent illness or injury. No cause for the state of collapse was given to the ambulance officers. The St Johns Ambulance notes state "Patient under the jurisdiction of the Australian Fisheries Management Authority." The deceased was not known to be on any medications or susceptible to any allergies.

25. At 3.52am on the 26th of February 2003 Northern Territory Police were notified of the death by an unknown person. C.I.B officers Wayne

Brayshaw and Greg Lade were called on duty. These members together with Coroners Constable Anne Lade attended the pontoon area at Stokes Hill Wharf together with forensic member Kim Chilton. Life had been pronounced extinct before members arrived. An examination of the deceased's body did not reveal any obvious signs of injury or trauma.

26. The members resolved to contact the Coroner's office to ascertain if the matter was to be investigated as a death in custody. Police also concluded that they would need an interpreter in order to interview the Indonesian crew members as none of them spoke English. Subsequently, members did not investigate this unexpected death in the manner they would have if it was a death in custody in a Northern Territory institution. There appears to be a lacuna in the NT Coroner's Act in this regard.

27. The deceased's body was conveyed by Darwin Funeral Services to the Royal Darwin Hospital ('RDH'). Hospital records indicate that the deceased was dead on arrival at 6:15am. Doctor Vandelt certified the death at RDH at that time. He gave a provisional diagnosis as to the cause of death as "unknown cause". He noted it was a Coroner's case with the reason for notification to the Coroner as being "unknown cause of death".

28. An autopsy was performed on the 26th of February 2003 by Doctor Terence Sinton. A cause of death was not given at that time pending the return of toxicology results.

29. A decision was made, it seems by police and Barefoot Marine management to explain to the Indonesian fisherman on the boats at the mooring area what had happened regarding the deceased's death and to explain in general terms that it was now a legal case and the cause of death would be decided by the Coroner.

30. Police made inquiries to locate the deceased's next of kin with the Indonesian Consulate, but early inquiries did not produce the necessary

information. Inquiries were made by Consular officers at the Coroners Office concerning the cause of death. They were advised that the post mortem report could not be finished until toxicology results from Adelaide were complete.

31. A toxicology report dated the 19th of March 2003 from the Forensic Science Centre in Adelaide was sent to the pathology section of RDH. A handwritten note would seem to indicate that as being received on the 24th of March 2003. No common drugs were detected in the deceased's blood.

32. On the 4th of June 2003 Doctor Terence Sinton signed and dated his autopsy report regarding Mansur. He stated the cause of death as: "epileptic seizure". In the comments section of his written report, comments 1 and 6 were as follows:

> "1. The deceased was a fisherman living on board a foreign fishing vessel moored in Darwin Harbour. He reportedly suffered an unexpected epileptic type fit, and died shortly after …
>
> 6. Given the history and autopsy findings, it was *likely* that this man died as a result of an unexpected epileptic fit, the origin or cause of which could not be determined at the time of this report."

33. Doctor Sinton said that the only information that he had was from the police to the effect that Mansur had had a fit.

34. Brain autopsy slides and general organ autopsy slides were later sent to Doctor A.E.G. Tannenberg, a consultant neuropathologist at the John Tonge Institute of Forensic Pathology in Brisbane. By way of a written report dated the 10th of October 2003, Doctor Tannenberg concluded that "the cause of death is undetermined". The usual accompaniments of a cerebral epilepsy-related seizure and death are not seen and the autopsy does not readily show a cause of death". Dr Tannenberg told me in evidence (Transcript P80):

"My full name is Anthony Edward Garnet Tannenberg, I am a consultant pathologist at Queensland Medical Laboratories in West End, Brisbane.

And are you also the associate professor in the Department of Pathology at the University of Queensland?---Yes, my other appointments are as a visiting Neuro-Pathologist to the Queensland Health Services and the Forensic Services and I'm also an associate professor Pathology Department University of Queensland.

And you're also a consultant Neuro-Pathologist at the John Tonge – T-O-N-G-E Institute of Forensic Pathology down there in Brisbane?---Yes."

And:

"Before asking some questions in relation to that report, can I ask you what it was that you were asked to do by the Northern Territory Coroner's office?---Yes, I was asked two things. I was asked to look at the brain slides and the autopsy report on Mansur and also provide an opinion as to the likelihood of epilepsy producing death and other conditions which may mimic epilepsy producing sudden death."

And (Transcript Page 81):

"THE CORONER: Is that whether it was epilepsy related or not, you just couldn't tell?---That's correct, yes. Epilepsy when it gives rise to sudden death usually does so in a background of someone who's got a history of many epileptic seizures. This, as I understood, this man did not have such a history and nor did his brain show any evidence of having had either previous epileptic seizures or of any pre-existent damage which could relate to epilepsy. So I was really unable to document epilepsy in this man. That is not to say that he couldn't have it, it's just that I couldn't document it."

And:

"MR McDONALD: Doctor in your second paragraph you say that congestion and focal haemorrhages in lung and the thymus would tend to suggest an agonal hypoxic mode of death which is non-specific?---Yes.

What do you mean by an agonal hypoxic mode of death?---As I said it's totally non-specific. If you heart beat was beating and one gets a lack of oxygen and the blood vessels become fragile in certain areas and red blood cells escape, so really it is – it's not specific, it

just means that basically you're perhaps still trying to breath but there's no oxygen getting there and the blood – you know the red blood cells are just escaping. It really has no significance. It doesn't indicate a cause of death. Just a mode – a very common mode of death.

In your experience, doctor, is it unusual for a pathologist upon autopsy not to be able to ascertain from autopsy the cause of death?---No, it's not unusual.

In what percentage of cases would that be, in your experience, does this occur?---Okay, it depends upon the practice in hospital based practice, it would be unusual. In general community practice where people who had a sudden death and gone to the Coroner's Court it would I imagine of the order of a few percent. It's not unusual."

And (P82):

"When you have a normal thymus and a normal adrenal it's indicative – it's a sudden death that they've been perfectly well, up until the time that they have died and they haven't had what we call an inter-current severe illness.

In a death such as this where you could find nothing in the autopsy slides or in the examination undertaken by Doctor Sinton and such that there is an agonal hypoxic mode of death are you able to say anything about the speed at which death occurs un such cases as this?---This has to be fairly fast and I think you – you'd indicate that if there'd be a witness to it, as there was, in this case as I understand that that would correlate as a very rapid mode of death.

And are we talking more in minutes rather than hours, half hour?---Yes, we're definitely talking more in minutes rather than hours."

And:

"And you deal with epilepsy in the main body of the paragraph there, would it be a fair reading of that paragraph on page 1 that you're inclined to rule out epilepsy as a contributing factor on the balance of probabilities?---Yes, on the balance of probabilities I consider that it would be highly unlikely, however it can never be totally excluded. But if you ask me in a proportion less than 5% possibility of epilepsy."

And especially (P83):

> "THE CORONER: Yes, but it's not only – I think Mr Read was putting to that – and he finished a summary of what he thought you were saying by saying, is that all you can say. Well, you can say more, what you're telling me is it's undetermined but you're ruling out – you're excluding some things, aren't you, like a pre-existing illness or a stressful several hours of slow decline, you're ruling those things out?---Yes.

35. Doctor Tannenberg's written report was shown to Doctor Sinton and the doctor said in evidence that he agreed with Doctor Tannenberg's opinions. He modified his comment number 6 from "likely" to "possibly" the deceased died as a result of an unexpected epileptic fit. So the evidence is likely to indicate that the cause of death fits in that unusual category of cause where the autopsy is unable to determine the cause of death. However, the medical evidence does not indicate anything suspicious about the death, no sign of injury, no sign of pre-existing disease, no sign of hunger nor indeed malnutrition. That is to say there was nothing remarkable found at the autopsy examination and the body appeared to be normal. Dr Sinton also said in evidence (Transcript P138):

> "MR McDONALD: Now you sent away for and received a toxicology report?--- Yes.
>
> And what did that inform you?---In summary it said, 'No common drugs were detected in the blood'.
>
> Now the cause of death being, 'Undetermined cause', does that – have you – do you come across that from time to time as a pathologist?---I have to say unfortunately, yes.

And:

> "MR McDONALD: Does – if death is – I withdraw that last question. In relation to this particular death, are you able to say whether this particular man died quickly and if so are you able to give it a range in time?---In my opinion he died very quickly and I – very quickly referring to perhaps a few minutes or even less. Maybe a sudden death, effectively an instantaneous death. Instantaneous death is possible."

And (Transcript P139):

> "Is there anything, having read that file, that's significant in terms of the a – this is another Indonesian fisherman?---Without going through the file, I'm not sure if I'm right in saying this, but I believe there was another incidence of someone fitting who subsequently survived. And my understanding is and correct me if I'm wrong that a diagnosis – a potential diagnosis or provisional diagnosis of some sort of meningoencephalitis or virile infection of the brain was proposed.
>
> THE CORONER: But we know from Doctor Tannenberg that there is no such evidence of that kind of virus in the slides that he looked at of the deceased?"

And

> "In relation to Mansur, were there any clinical signs of malnutrition that you were able to detect on examination?---I saw none.
>
> And in a case were a person is malnourished over a period of time, you would expect to see such clinical signs at an autopsy?---Very much, yes."

And (P140):

> "MR READ: Whatever the reason a person's heart stopping or breathing stopping, is obvious to say that a person's chances of survival are greater than sooner they get professional CPR type treatment, even from a paramedic doctor or someone suitably qualified, is that right?---Short answer is, yes, yes."

36. On 6 March 2003, after weather conditions had improved, the "Yamdena" left Darwin Harbour with captain Basri and the four remaining crew members on board. At no stage were any of the crew members including the deceased charged with any offence contrary to Australian laws.

37. The deceased's body lay in the morgue for about four months. This length of time was contrary to the normal burial practices of Muslims. After much anxiety expressed in the Darwin Indonesian Community the Indonesian Consulate and the Northern Territory Government paid for the deceased to be buried. He was buried in the Muslim Section at Thorak Cemetery,

Darwin on 16 June 2003. His family could not afford to pay for the return of his body. Whilst living seamen are repatriated by DIMIA, DIMIA did not take responsibility for the body or the repatriation or burial of the deceased.

38. A question of jurisdiction arose in the hearing as to whether I have jurisdiction to inquire into, comment upon and make recommendations concerning the deceased's burial.

39. Counsel Assisting, Mr McDonald QC. submits that I do have jurisdiction to inquire into and, comment upon the deceased's burial. Ms Mortimer QC, senior counsel for AFMA agrees with Mr McDonald's submissions that I do have jurisdiction in this respect. Mr Bruxner counsel for DIMIA submits I do not have jurisdiction. I gave him leave on 20 February 2004 to supplement his oral submissions concerning jurisdiction with written submissions. These written submissions were provided to my office by close of business on 23 February 2004. I have read and considered these submissions.

40. The issue of the deceased's burial is an important issue for Mansur's family and, I infer, for the local Indonesian community. There was understandable concern that the holding of Mansur's body in the morgue and the delay in burial was such as to offend Muslim sensitivities. Further, DIMIA's main witness, Mr Tony Tucker the regional manager of DIMIA had a close involvement with the local Indonesian community and was open and frank enough to concede the obvious, namely, that Mansur's burial could have been handled better by his office. He told me (Transcript P222):

> "All right. Now, that e-mail appears to indicate a willingness on the part of DIMIA to make some contribution to funding the cost of a funeral. To your knowledge, has DIMIA previously contributed funding in comparable circumstances?---If a person dies whilst in Immigration detention, and they are indigent, I think is the word, on a case by case basis, we will look at and, yes, we have on previous occasions if there has been no other source of funding, provided some or all funding for a funeral.

All right and do you - - - ?---Sorry, for a burial.

And do you provide that funding because of some sort of acknowledge to legal obligation at DIMIA?---No we do not.

All right. Now, in this particular case, was that willingness to contribute – a willingness of DIMIA to contribute to the funding of the funeral for Mansur, even in fact communicated to the consulate?---No it was not.

And do you regard that as a shortcoming as to the manner in which your office managed that question?---Yes, I think that whole issue could have been handled a lot better."

And (P226):

"MR McDONALD: Yes. I mean, it – can you envisage the reasonable prospect of there being a protocol to deal with this type of – what was a unique occurrence in this particular situation, for the future?---Yes, I think that could be quite reasonable approached.

Now in terms of, if there were to be another death say on the harbour of an Indonesian fisherman in the future, what would you see as the best way to approach it from your department's point of view in the future?---Well, I think we need to do some more work on developing the protocols between AFMA and us. A death in Australia and I take the point about people not wanting to be here in the first place, is normally a consular problem and that's the way that I approached it last – on this occasion. I think we have some work to do to sort out what we can do in the future."

41. The issue of jurisdiction essentially comes down to whether, on a proper reading of section 34(2) of the Coroner's Act ('the Act') when read in context, the burial is connected with the deceased's death.

42. I accept that in construing the meaning of section 34(2) in context I am bound to adopt a purposive approach to statutory interpretation. This is required by section 62A of the *Interpretation Act (NT)* and appears also now to be the common law position.

Section 34(2) of the Act provides:-

> "A coroner may comment on a matter, including public health or safety on the administration of justice, connected with the death or disaster being investigated"

43. It seems to me that the meaning of the phrase "connected with the death" is critical to the disputed issue of jurisdiction.

44. Section 34(2) of the Act appears in Part 6 of the Act. The subsection's specific context is in section 34 of the Act and section 35 of the Act. The purpose of section 34 of the Act is, amongst other things, to provide a mandatory obligation to make certain findings including any relevant circumstances concerning the death and a non mandatory power to comment on a broad range of matters, including public health and safety or the administration of justice provided such comment is "connected with the death". The comment power has a public interest element to it which can be important in alerting Government and relevant persons to matters that the Coroner considers, after considering all the evidence, they should be alerted to by way of comment. The limit imposed by the Legislature in respect of such comment is that the matter the subject of any comment must be "connected with the death".

45. I was not referred to any authority where this precise phrase has been the subject of judicial consideration. However, I was referred to Federal Court authorities, in a different statutory context, where Justice Wilcox interpreted the phrase "in connection with". The two relevant Federal court cases were *Our Town FM PTY LTD v Australian Broadcasting Tribunal* (1987) 16 FCR 465 at 479–480 and *Claremont Petroleum NL v Cummings and Another* (1991) 11 ALR 239 at 280. In the latter case Justice Wilcox in reference to the phrase "in connection with" said this:

> "The phrase "in connection with" is one of wide import, as I had occasion to observe in a different context in Our Town FM Pty Ltd v Australian Broadcasting Tribunal (1987) 16 FCR 465 at 479-80; 77 ALR 577 at 591-2: "The words 'in connection with' . . . do not

> necessarily require a causal relationship between the two things: see Commissioner for Superannuation v Miller (1985) 8 FCR 153 at 154, 160, 163; 63 ALR 237 at 238, 244, 247. They may be used to describe a relationship with a contemplated future event: see Koppen v Commissioner for Community Relation (1986) 11 FCR 360 at 364; 67 ALR 215; Johnson v Johnson [1952] P 47 at 50-1. In the latter case the United Kingdom Court of Appeal applied a decision of the British Columbia Court of Appeal, Re Nanaimo Community Hotel Ltd [1945] 3 DLR 225, in which the question was whether a particular court, which was given 'jurisdiction to hear and determine all questions that may arise in connection with any assessment made under this Act', had jurisdiction to deal with a matter which preceded the issue of an assessment. The trial judge held that it did, that the phrase 'in connection with' covered matters leading up to, or which might lead up to an assessment. He said . . . :'One of the very generally accepted meanings of "connection" is "relation between things one of which is bound up with or involved in another"; or, again "having to do with". The words include matters occurring prior to as well as subsequent to or consequent upon so long as they are related to the principal thing. The phrase "having to do with" perhaps gives as good a suggestion of the meaning as could be had.' This statement was upheld on appeal."

46. I find this analysis helpful in seeking to give a purposive construction to the phrase "connected with the death" in section 34(2) of the Act.

47. In my opinion the phrase "connected with the death" in section 34(2) of the Act is also a phrase of wide import, especially bearing in mind the public interest component to be discerned from the section, and from section 35 of the Act. Similarly, I do not consider that the phrase is restricted to a causal connection. If I were to adopt such an interpretation I could be unnecessarily restricting the Legislature's intent that the power to comment related to only matters before the death. If I were to adopt a restrictive approach something happening at an autopsy after the death which deserved comment as a matter of public health and safety or in the public interest would be precluded.

48. I do not consider the Legislature intended the phrase "connected with the death" to have such a restrictive meaning. On the contrary, I consider the

phrase includes matters occurring subsequent to or consequent upon the death so long as they are related to the death.

49. The burial of the deceased was subsequent and consequent upon his death, albeit the burial was delayed for an unacceptable period of time. The burial clearly related to the death and was bound up with the death.

50. I bear in mind the warning of Davies J in *Hatfield v Health Insurance Commission* (1987) 15 FCR 487, 491 where his Honour said:

> "Expressions such as 'relating to', 'in relation to', 'in connection with' and 'in respect of' are commonly found in legislation but invariably raise problems of statutory interpretation. They are terms which fluctuate in operation from statute to statute . . . . The terms may have a very wide operation but they do not usually carry the widest possible ambit, for they are subject to the context in which they are used, to the words with which they are associated, and to the object or purpose of the statutory provision in which they appear."

51. Nonetheless, in the context of the Act and Part 6 of the Act in particular, I find the analysis undertaken by Justice Wilcox in the *Claremont Petroleum NL* quoted above in respect of the phrase "in connection with" helpful. I propose to adopt a similar interpretation in relation to the phrase "connected with the death" in section 34(2) of the Act.

52. Therefore, I reject Mr Bruxner's submission that I do not have jurisdiction to inquire into and comment on the burial.

53. I note this interpretation is consistent with the broad interpretation adopted by my brothers Mr Donald SM and Mr Lowndes SM in the Inquests into the deaths of Danny Tjakarti (Case No. 9421880) on 1st November 1993, and Robert James Jones (Case No. 9514981) on 22 August 1997.

54. Therefore, I hold I have jurisdiction to inquire into and make comment upon the burial of the deceased in this case and proceed on this basis.

55. In my view the evidence disclosed nothing to criticize in relation to the performance by ambulance officers, employees of Barefoot Marine, and others connected with AFMA or DIMIA that had some responsibility for the deceased up to and prior to his death. Indeed, the evidence given by Jennifer Scullion was impressive in its detail and content and this was expressly conceded by counsel for the family of the deceased.

56. The deceased died extremely quickly and I find that despite some apparent difficulty in emergency communication and medical treatment, such difficulties were not causative or did not contribute to death. Furthermore, I find that despite complaints of hunger from some of the detained fishermen, if the deceased was indeed hungry prior to his death, such hunger was not causative nor did it contribute to death.

RECOMMENDATIONS

57. The *Coroners Act* be amended by Legislative change providing for the definition of a "death in custody" to further include a death in Immigration detention or any form of detention in the Northern Territory brought about by the operation of Commonwealth Laws. In my view, there is no reason in logic or law why this should not be so, and, no doubt this is why in some other Australian Jurisdictions it is the case. If this death had been a "death in custody" as defined in the NT *Coroners Act*, there would have been greater powers of investigation, recommendation and comment available to me. Furthermore, there would have been mandated a greater investigatory effort by police than was the case. The Royal Commission into Aboriginal Deaths In Custody effectively recommended many years ago (and such recommendations were accepted by Parliament) that deaths of persons held against their will by executive Government agencies are deserving of special attention. I note, and in my view it is creditworthy, that both AFMA and DIMIA through their counsel, do not oppose this recommendation.

58. In my view, consideration of the issues that flow from exposing the conditions under which the deceased was kept in the period immediately prior to his death are not helped by the use of euphemisms. On the one hand there is a seemingly careful choice of words such as "caretakers", "detainees" and "immigration detention", on the other hand one might go to the other extreme and use words such as "gaolers", "prisoners", and "custody". Futhermore, one hardly needs to point out that the fishermen are not immigrants, intended migrants or asylum seekers. The reality of the position that the deceased (and others like him) found himself in was somewhere between being "cared for" and being "imprisoned". I am told many of the fishermen prefer to remain with their boats and crew pending the "bonding" back of the boat to Indonesian owners. Indeed, many are compliant and complaints are not numerous. The whole issue is very complex.

59. However, matters of high principle are involved for the deceased was held by Federal Government agencies for some weeks against his will, as a virtual prisoner without charges being preferred against him, without trial and without access to judicial review. In my view, such a state of affairs is to be deprecated. Furthermore, the standard of such detention in the case of the deceased is also to be deprecated; to keep seven men on a vessel such as the "Yamdena" for some weeks where their only shelter (and sleeping accommodation) is a small box the size referred to in the evidence of Senior Constable Sandry is unacceptable. In my view, this situation is not made acceptable by the fact (as Mr Munn opined) that the fishermen do not seem to mind such conditions. Accordingly, I recommend that where detained crew members of vessels are not charged with any offence, they be repatriated home as soon as reasonably practicable, this repatriation should be to their home region or port of origin. Such repatriation in my view should not depend on consent or otherwise.

60. I was going to forward all of the transcript and evidence in this Inquest to the Ombudsman for review, however, Counsel for AFMA advise that such is not necessary as they intend to conduct a full and complete review themselves of all the issues involved, and I recommend that they do so.

61. I recommend, that the vessels and crews detained in the detention area, be provided with a horn, sounding or other signalling device to be used in case of emergency.

62. I recommend, that AFMA and DIMIA devise a protocol to deal with the Indonesian Consulate and each other in respect of the issues of the burial and/or repatriation of bodies of any Indonesian fisherman who dies in Immigration detention or detention under Commonwealth Fisheries legislation and take responsibility for repatriation or burial.

Dated this 19th day of March 2004.

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GREG CAVANAGH
TERRITORY CORONER