CITATION: *Inquest into the death of Kumanjayi Walker (Ruling No 7)* [2023] NTLC 11

TITLE OF COURT: Coroners Court

JURISDICTION: Alice Springs

FILE NO(s): A51 of 2019

DELIVERED ON: 27 April 2023

DELIVERED AT: Alice Springs

HEARING DATE(s): On the papers.

FINDING OF: Judge Elisabeth Armitage

CATCHWORDS: Coronial proceedings; inquests; death in custody; receipt of evidence under s 39 of the *Coroners Act 1993* (NT)

Coroners Act 1993 (NT), s 39.
Sullivan v Civil Aviation Safety Authority [2014] FCAFC 93.
Re Pochi and Minister for Immigration and Ethnic Affairs (1976) 36 FLR 482.
Walter Mining Pty Ltd v Hennessey [2010] 1 Qd R 593.
Priest v West (2012) 40 VR 521.
Doomadgee v Clements (2006) 2 Qd R 352.
HG v The Queen (1999) 197 CLR 414.
BrisConnections Finance Pty Limited (Receivers and Managers Appointed) v Arup Pty Limited [2017] FCA 1268.
Makita v Sprowles (2001) 52 NSWLR 705.
Ray Fitzpatrick Pty Ltd v Minister for Planning (2007) 157 LGERA 100.
Ruling on Application Regarding the Scope of the Inquest Tanya Day COR 2017-6424.
JD Heydon, *Cross on Evidence* (2021, 13th Ed), 1117 [29045].

APPEARANCES:

Counsel assisting:	Dr P Dwyer with Mr P Coleridge Instructed by Maria Walz Legal
For Zachary Rolfe:	Mr D Edwardson KC and Mr F Merenda Instructed by Tindall Gask Bentley Lawyers
For the Brown Family:	Mr G Mullins with Ms P Morreau Instructed by Streeton Lawyers
For the Walker, Lane and Robertson families:	Mr A Boe Instructed by Hearn Legal
For the Northern Territory Police Force:	Dr I Freckelton AO KC with Ms A Burnnard Instructed by PFES Legal
For the Department of Health:	Mr T Hutton Instructed by Hutton McCarthy
For NAAJA:	Mr P Boulten SC with Ms B Wild and Mr J Murphy Instructed by NAAJA
For the Parumpurru Committee:	Mr J McMahon SC Instructed by Doogue & George
For the Northern Territory Police Association:	Ms S Ozolins Instructed by Northern Territory Police Association

Judgment category classification:	A
Judgement ID number:	[2023] NTLC 11
Number of paragraphs:	15
Number of pages:	9

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A51 of 2019

In the matter of an inquest into the death of Kumanjayi Walker

Introduction

1. In this inquest NAAJA asks me to receive a report (and supplementary report) titled, *'In Normal Circumstances: Understanding the Structural Nature of Racial Violence in the Northern Territory'* (the **Report**, the **Supplementary Report** and, together, the **Reports**). The Northern Territory Department of Health (**NT Health**),[1] the Northern Territory Police Force (**NTPF**), the Northern Territory Police Association (**NTPA**) and Constable Rolfe (collectively, the **Objecting Parties**) object to the receipt of the Reports.[2]

2. The Objecting Parties submit that the Report is so plagued by deficiencies it should not be received. In particular they point to deficiencies concerning the expertise of the authors, the manner of its drafting, and its contents. As to that latter issue, the Objecting Parties emphasise that the Report does not properly disclose the process of reasoning by which its conclusions were reached, and that the conclusions are based on inaccurate assumptions or assertions. In light of the significant deficiencies, the Objecting Parties submit that the Report is not logically capable of assisting me in the discharge of my statutory functions. Alternatively, and to the extent that the Report is 'so capable', the Objecting Parties submit that it 'should not be received, because any assistance [it] might provide would be outweighed by the cost, delay, distress and other risks associated with [its] receipt.'[3]

---

1 In its original written submissions, NT Health emphasised that the Report was beyond the scope of an 'issues list' agreed between the Counsel Assisting and the interested parties in May 2022 (but later abandoned in September 2022). I did not understand this to be a submission that I could not receive the Report because I lacked power to investigate the nexus, if any, between any evidence of institutional racism within NT Health and the circumstances of Kumanjayi's death. Instead, I understood these submissions to make what I find to be a justifiable criticism of the circumstances in which NAAJA provided the Report.

2 Report, 1.

3 Submissions of NT Health dated 3 February 2023, [6].

Legal principles

3. Section 39 of the *Coroners Act* governs the 'receipt' of evidence by a Coroner during an inquest. It provides as follows:

> **39 Rules of evidence not binding**
>
> A coroner holding an inquest is not bound by the rules of evidence and may be informed, and conduct the inquest, in a manner the coroner reasonably thinks fit.

4. The following basic principles appear not to be in dispute:

   (a) Whether a coroner may inform herself from 'evidence' depends on whether she subjectively 'thinks fit' to do so, but her subjective state of satisfaction must be 'reasonable'.

   (b) Section 39 disapplies the rules of evidence that might otherwise govern the 'admission' of evidence in an inquest.

   (c) That s 39 of the *Coroners Act* disapplies the rules of evidence does not absolve a coroner of the 'obligation to make findings of fact based upon material which is logically probative'.[4] Hence, the logical capacity of evidence to assist a coroner to fulfil her statutory functions, by illuminating one or more of the subject matters of the coronial inquiry,[5] provides an 'objective outer limit' to a coroner's power to inform herself.[6] Whether evidence has this capacity was identified by the parties as the 'threshold question'.[7]

   (d) Given the nature of a coroner's statutory functions, and in light of the 'broad and indefinite' subject matters of the coronial inquiry, it is appropriate that a coroner take an expansive or inclusive approach to the evidence and issues that may, ultimately, assist the coroner to discharge her statutory functions.[8]

---

4 *Sullivan v Civil Aviation Safety Authority* [2014] FCAFC 93, [97] (Flick and Perry JJ); see also, *Re Pochi and Minister for Immigration and Ethnic Affairs* (1976) 36 FLR 482, 492 (Brennan J).

5 See, *Coroners Act*, ss 26, 34 and 35.

6 Submissions of NAAJA dated 8 October 2022, [18].

7 Submissions of NAAJA dated 8 October 2022, [11]; Submissions of NT Health dated 3 February 2023, [9].

8 Submissions of NT Health dated 3 October 2022, [35].

(e) Ultimately, and in light of each of the above principles, s 39 may permit the receipt of opinion evidence which does not engage any recognised form of specialised knowledge and would not be admissible in a court, provided that the evidence could, at the conclusion of the inquest, be logically probative of one or more of the subject matters of the coronial inquiry, and, in that sense, is *capable* of assisting the coroner in the discharge of her statutory functions.[9]

5. I do not, however, accept NAAJA's submission that once the threshold question is satisfied, a coroner *must* receive the relevant material unless it would be legally unreasonable to do so. The authorities considering provisions like s 39 hold that such provisions do 'not suggest that the coroner can, or should, conduct an investigation without paying proper regard to questions of cost, delay and feasibility'[10] or the *'likelihood'* that a particular item of evidence will 'influence the outcome of the hearing' (as opposed to its bare *capacity* to do so).[11]

<u>Analysis</u>

Findings as to deficiencies in the Report

6. I accept the submissions of the Objecting Parties that the Report is deficient as an item of expert evidence. In summary, I find that:

(a) Although I do not doubt that the authors of the Report possess relevant 'expertise', it is difficult to discern how the Report's conclusions are the product of it. Some of the 'opinions' – for example, opinions that conduct did or did not occur, or that it was or was not motivated by racial bias – appear to be lay inferences from the primary evidence.[12] Other opinions – such as those criticising clinical decisions as 'unreasonable' – would seemingly require expertise that most of the authors do not have.[13] Finally, each of the authors is said to possess very *different*, or 'unique',[14] expertise. Assuming that the opinions *are* based in relevant expertise, this begs the question: how am I to assess

---

9 Submissions of NT Health dated 3 October 2022, [35], citing *Walter Mining Pty Ltd v Hennessey* [2010] 1 Qd R 593, [37].

10 *Priest v West* (2012) 40 VR 521, [7].

11 *Doomadgee v Clements* (2006) 2 Qd R 352, [52].

12 As to which, see *HG v The Queen* (1999) 197 CLR 414, [44] (Gleeson CJ).

13 As to which, see Submissions of NT Health dated 3 October 2022, [61].

14 Report, 8.

whether this is the expertise of one, some or all of the authors?[15] If it is not based in the expertise of all of them, how am I to assess *which* opinions are based in *what* expertise?

(b) While joint opinions are not inherently problematic,[16] difficulties arise when it is not possible to say whether a jointly authored report contains genuine consensus between two experts each having relevant expertise or 'compromised opinions'. In this context, 'compromised opinions' have been described as 'opinions reached as a result of decision [by one author] to "adopt" an opinion' by another, where the 'opinion is not the result of an application of the specialised knowledge of [the first author]'.[17] The number of authors and the differences between their areas of expertise, raises this as a genuine issue. On the face of the Report, it is not possible to resolve it.

(c) It is not clear what materials the authors have reviewed. The authors state that they were provided with the brief of evidence and that they 'undertook a *collaborative* analysis' of it.[18] This suggests that different authors may have been responsible for reviewing different materials and that each author may have had an incomplete understanding of the evidence. That possibility is seemingly consistent with the attempt, in the Supplementary Report, to explain various factual inaccuracies in the Report on the basis that the brief of evidence was 'voluminous' and 'difficult to navigate'.[19] Further, although the authors criticise NTPF and NT Health, they make no reference to any consideration of the written evidence of a number of significant institutional witnesses. Finally, the extent to which each of the authors kept abreast of the *oral* evidence (if at all) is unclear.

(d) On some significant matters, the Report fails to expose the process of reasoning by which, and the assumptions upon which, its conclusions are based. For example, the Report cites the 'concerningly high' number of use of force incidents (46) in which Constable Rolfe was involved as evidence of the NTPF's failures to appropriately supervise and/or discipline Constable Rolfe. The conclusion that 46 Use of Force incidents is

---

15 It is no answer to this question that the Report states that each author 'agreed' with each of the Report's conclusions: a layperson might agree with, or accept, the opinion of an expert, but that does not mean that the agreement is the product of the *layperson's* 'expertise'.

16 *BrisConnections Finance Pty Limited (Receivers and Managers Appointed) v Arup Pty Limited* [2017] FCA 1268, [48].

17 *BrisConnections Finance Pty Limited (Receivers and Managers Appointed) v Arup Pty Limited* [2017] FCA 1268, [48].

18 Report, 8.

19 Supplementary Report, 4.

'concerningly high' may be true, or it may not, but the authors do not explain by what metric or comparison their conclusion has been reached, and they point to no evidence that would allow for such a conclusion.

(e) The Report contains significant factual inaccuracies which have formed the basis, or part of the basis, for its conclusions. For example, the Report concludes that the portrayal by NTPF and NT Health of the community of Yuendumu as 'presenting a continuing physical threat to staff' was unreasonable and, ultimately, reflected a racial bias.[20] The stated foundation for that conclusion – that 'there was no evidence in the health personnel statements of actual threats of physical violence'[21] – is objectively false.[22] Likewise, the Report offers numerous opinions about the conduct of Constable Rolfe and the NTPF that are based on objectively false assumptions. For example, the Report concludes that the NTPF 'comprehensively failed to hold Rolfe to account for at least 12 known and 64 further instances of alleged misconduct'.[23] In the Supplementary Report the authors clarify that the figure '64' was a 'typographical error' and should have been '46'. Even so, on no reasonable view could that figure be said to record 'instances of alleged misconduct'. Similarly, the authors assert that Constable Rolfe has a 'violent criminal history', including a 'criminal conviction for grievous bodily harm,'[24] which exaggerates or misconstrues his criminal history of a fine for 'public nuisance.'[25] These inaccuracies are not insignificant and they undermine my confidence in the Reports' conclusions.

(f) Finally, I accept that there is evidence of prejudgment by some of the Report's authors.[26] I express no view as to whether the conclusions expressed in the Reports actually were prejudged.

Without more, report not logically capable of assisting in discharge of my functions

7. NAAJA's 'ultimate submission' was that the alleged deficiencies in the Report, including 'any substantiated assertions of factual inaccuracies' could '*only* go to the *weight* the Coroner might give it, not to the threshold question of whether to be

[20] Report, 64.

[21] Report, 64.

[22] See eg, Recorded Statement of Lorraine Walcott dated 10 November 2019 (9-14), 32-34.

[23] Report, 10.

[24] Report, 28-30.

[25] Email from Terry Poole dated 9 June 2020 (3-57), 9.

[26] See, Submissions of NT Health dated 3 October 2022, [80].

informed by it at all.'[27] Similar submissions were made by the WLR families,[28] the Brown family[29] and the Parumpurru Committee.[30] I am not persuaded by these submissions.

8. The common law developed strict exclusionary rules to govern the admissibility of expert evidence. Among them were requirements that:

   (a) There be a field of specialised knowledge;

   (b) By reason of their training, study or experience, the witness has become an expert in an aspect of that field;

   (c) The opinion be wholly or substantially based on the witnesses' expert knowledge;

   (d) The witness identify the assumptions of primary fact on which the opinion is based;

   (e) The evidence proves the assumptions of primary fact on which the opinion is based;

   (f) The proven and assumed facts logically support the opinion; and,

   (g) The process of inference from the assumptions to the witnesses' conclusions, be exposed, so that an examination of the 'scientific or other intellectual basis of the conclusions' can occur.[31]

9. Insofar as the common law requirements operate as strict exclusionary rules, s 39 disapplies them. But they remain relevant to the 'threshold question', which is whether the evidence is, or may ultimately be, logically capable of assisting me to make findings, comments and recommendations at the conclusion of the inquest. That is because the purpose of the common law requirements was to 'assist both cross-examiners and triers of fact to *assess* and test [expert opinion] evidence',[32] or, as Heydon JA noted in *Makita v Sprowles*, to 'furnish the trier of fact with

---

[27] NAAJA's Supplementary Submissions dated 3 February 2023, [8].

[28] Submissions of the WLR families dated 8 October 2022, [7].

[29] Submissions of the Brown family dated 8 October 2022, [5].

[30] Submissions of the Parumpurru Committee dated 8 October 2022, [9].

[31] JD Heydon, *Cross on Evidence* (2021, 13th Ed), 1117 [29045].

[32] JD Heydon, *Cross on Evidence* (2021, 13th Ed), 1118 [29045].

criteria *enabling* evaluation of the validity of the expert's conclusions', where otherwise such evaluation might not be possible.[33]

10. The common law requirements provide simple, and logical, criteria that enable a decision maker to assess not just the *extent* to which opinion evidence has probative value or 'weight', but *whether* it has probative value at all. In *Ray Fitzpatrick Pty Ltd v Minister for Planning*,[34] Jagot J made this point in a case that concerned the receipt of expert evidence by a court that, like this court, was not bound by the laws of evidence.[35] Her Honour noted that '[t]o *be* logically probative of issues whether the rules of evidence apply or not, expert opinions must be *capable of being assessed* by the trier of fact.'[36] As Heydon JA noted in *Makita,* such an assessment 'cannot be [undertaken] unless the intellectual basis of the opinion is laid out'.[37]

11. In this case, the deficiencies at [6] mean that the bases for the opinions expressed in the Reports have not been disclosed and it is not possible to logically assess the probative value of those opinions. I do not accept the analogies drawn by NAAJA and the Brown family[38] between the Reports, and other 'opinions' received during the inquest. Those 'opinions' did not suffer from issues of the nature and degree that I have found to affect the Reports. Most were given by a single witness, during oral evidence, whose expertise was apparent, whose process of reasoning was exposed, and whose conclusions could readily be assessed.

The cost and delay of reopening proceedings

12. As the Brown family's submissions contemplate, the only way to undertake the necessary assessment of probative value would be to call the Report's authors, and

---

33 *Makita v Sprowles* (2001) 52 NSWLR 705, [59].

34 (2007) 157 LGERA 100, [23].

35 Section 38 of the *Land and Environment Court Act 1979* (NSW) provided that the NSW Land and Environment Court was 'not bound by the rules of evidence but may inform itself on any matter in such manner as it thinks appropriate and as the proper consideration of the matters before the Court permits.'

36 (2007) 157 LGERA 100, [23].

37 *Makita* (2001) 52 NSWLR 705, [82].

38 Submissions of the Brown family dated 8 October 2022, [1.4]

in that way to allow 'matters that might detract from their ultimate opinions [to] be interrogated in cross-examination by the interested parties.'[39]

13. I cannot ignore the 'practical difficulties' associated with that proposal. In this case if I were to inquire into the probative value of the Report and hear from the authors, I would need to convene a special sitting of the inquest. A conservative estimate is that the process would take a full week of court time (four days of evidence and one day of submissions) and, in light of listing pressures, would delay the conclusion of the inquest until well into 2024. In light of the identified deficiencies in the Report, I do not have sufficient confidence in its value, or the evidence that might be given by its authors, to justify the expense and delay that would be associated with such an inquiry.

Conclusion

14. Pursuant to s 39 of the *Coroners Act 1993* (NT) I do not think fit to inform myself from those parts of the Report that contain conclusions or opinions, namely, Parts 1, 2, 4, 5, 6 and 7. Those Parts are not received into evidence.

15. As to Part 3, I note that during the inquest a number of Objecting Parties, including the NTPF and Constable Rolfe, have expressly accepted 'that the Coroner has an interest in, and may receive evidence in relation to, matters such as racist expressions or views held by members of [their organisations], and whether systemic racism or unconscious bias operated within [those organisations]', provided there is an arguable nexus between that racism or bias and the circumstances of Kumanjayi's death.[40] NAAJA submitted that concepts of institutional or systemic racism may provide a 'lens' through which to view the relevant conduct and decisions of the NTPF, NT Health and their agents, and assist to 'determine whether systemic racism is in fact present in this case'.[41] Accordingly, I *will* receive Part 3 of the Report, which provides a general explanation of 'key

---

[39] Submissions of the Brown family dated 8 October 2022, [1.2]; see also, [8], [15].

[40] Submissions of NTPF dated 7 October 2022, [4]. See also, Transcript of Proceedings of 9 November 2022 (Mr Edwardson KC), 308: 'One can well understand how issues of racial basis or motivations in a broader sense might be of concern to this inquest'.

[41] Submissions of NAAJA dated 8 October 2022, [41], citing *Ruling on Application Regarding the Scope of the Inquest Tanya Day* COR 2017-6424, [74].

concepts' such as institutional and systemic racism, and the 'racial distribution of threat, risk, care and safety', which may inform the parties' submissions.

Dated this 27th day of April 2023.

____

ELISABETH ARMITAGE
TERRITORY CORONER