Application relating to the death of Martin (Marjorie) Luke Harwood

REASONS FOR DECISION

11 April 2025

1. These are reasons for decision in an application by the mother of the deceased person for a coronial investigation and public inquest into the death.

2. The deceased was born Martin Luke Harwood on 8 December 1979 and died on 1 July 2018 at the Royal Hobart Hospital, aged 38 years. Although the deceased was born male, at all material times she was a transgender female known by the Christian name "Marjorie". Upon the evidence, she did not formally change her name. In this decision, I refer to the deceased as Ms Harwood. However, she was also referred to as 'Martin', 'he' or 'him' in many health and custodial records and therefore I replicate that terminology in that context.

3. On 2 July 2018, the day following the death of Ms Harwood, a "Medical Certificate of Cause of Death" (MCCD) was issued by a treating medical practitioner.

4. In the MCCD, the medical practitioner certified that death was due to natural causes, being end stage renal failure of 10 years duration. The medical practitioner specified personality disorder and polysubstance abuse of 15 years duration as being conditions contributing to death but not related to the disease or condition causing it.

5. Legal obligations are imposed upon a treating medical practitioner under the *Births, Deaths and Marriages Registration Act* 1999 to complete a MCCD in respect of a deceased person.[1] The MCCD must specify the cause of death and be conveyed to the Registrar under that *Act* for registration purposes.

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[1] **35. Notification of death by medical practitioner**

(1) A medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, must, within 48 hours after the death, notify the Registrar of the death and of the cause of death in a form approved by the Registrar.
Penalty: Fine not exceeding 10 penalty units.

(2) A medical practitioner need not give notice under this section if –
(a) another medical practitioner has given the required notice; or
(b) a coroner or a police officer is required to be notified of the death under the *Coroners Act* 1995 .

6. If, however, the death is one which is required to be reported under the *Coroners Act* 1995, there is no obligation to provide a MCCD to the Registrar, but there is an obligation under the *Coroners Act* 1995 to report the death to the Coroner.[2]

7. There are numerous categories of reportable deaths under the *Coroners Act* 1995[3] which invoke the coronial jurisdiction to investigate.[4]

8. Relevant to this matter, a death is reportable if the cause of death is unknown or if it appears to have been unexpected, unnatural, violent or to have resulted directly or indirectly from an accident or injury. Death by suicide is within the category of unnatural deaths which a Coroner has jurisdiction to investigate.

9. Therefore, it is the role of medical practitioners to issue MCCDs when a person dies of known natural causes such as conditions or diseases and which are not otherwise reportable to the Coroner. This system of death certification is not overseen by the

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[2] **19. Obligation to report death**
(1) A person who has reasonable grounds to believe that a reportable death, other than a reportable death referred to in subsection (4) , has not been reported must report it as soon as possible to a coroner or a police officer.
Penalty: Fine not exceeding 10 penalty units.

[3] ***reportable death*** means –
(a) a death where –
(i) the body of a deceased person is in Tasmania; or
(ii) the death occurred in Tasmania; or
(iii) the cause of the death occurred in Tasmania; or
(iiia) the death occurred while the person was travelling from or to Tasmania –
being a death –
(iv) that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury; or
(v) that occurs during a medical procedure, or after a medical procedure where the death may be causally related to that procedure, and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death; or
(vi) . . . . . .
(vii) the cause of which is unknown; or
(viii) of a child under the age of one year which was sudden and unexpected; or
(ix) of a person who immediately before death was a person held in care or a person held in custody; or
(x) of a person whose identity is unknown; or
(xi) that occurs at, or as a result of an accident or injury that occurs at, the deceased person's place of work, and does not appear to be due to natural causes; or
(b) the death of a person who ordinarily resided in Tasmania at the time of death that occurred at a place outside Tasmania where the cause of death is not certified by a person who, under a law in force in the place, is a medical practitioner; or
(c) the death of a person that occurred whilst that person was escaping or attempting to escape from prison, a detention centre, a secure mental health unit, police custody or the custody of a person who had custody under an order of a court for the purposes of taking that person to or from a court; or
(d) the death of a person that occurred whilst a police officer, correctional officer, mental health officer or a prescribed person within the meaning of section 31 of the *Criminal Justice (Mental Impairment) Act* 1999 was attempting to detain that person;

[4] **21. Jurisdiction of coroners to investigate a death**
(1) A coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be a reportable death.
(2) Unless the Attorney-General directs otherwise, a coroner need not investigate a death if an investigation or inquest is held in another State or in a Territory.

coronial system at all. MCCDs are independently issued by medical practitioners in the vast majority of deaths without being brought to the attention of a Coroner.[5]

10. However, on occasions, a death previously the subject of a MCCD is brought to the attention of the Coroner because it is thought that it appears to be a reportable death and not one appropriate for the issuing of the certificate. In such a case, the Coroner may assess that the death is reportable and may commence investigation, even though a lengthy period of time may have passed between the issuing of the MCCD and the reporting of the death to the Coroner.

11. In the present case, the Coroner's Office first became aware of Ms Harwood's death over two months after her death had occurred. On 12 September 2018, correspondence was received at the Coroner's Office from Brooke Winter Solicitors who acted for Ms Harwood's mother, Rosemary Harwood ("Mrs Harwood').

12. In the correspondence, the solicitor requested the Coroner to accept jurisdiction to investigate Ms Harwood's death on the basis that it was a reportable death occurring as an indirect result of injury or by suicide.

13. The solicitor asserted that in 2017 Ms Harwood was seriously assaulted and raped whilst serving a sentence at Risdon Prison and spent two months at the Royal Hobart Hospital as a result of her severe injuries.

14. It was further asserted that, either in April or June 2018, Ms Harwood was served with a summons which caused her to be fearful of returning to prison where she might again be assaulted, raped, and possibly killed. It was submitted that she was in such fear that she refused to continue her dialysis in which she had been participating constantly.

15. As such, the solicitor submitted that *"this death is rightfully categorised a suicide. The suicide is from her refusal to receive treatment because of her genuine and reasonable fears that she would be returned to the place where the assault and rape occurred".*[6]

16. At my direction, on 25 September 2018, the Manager of the Coronial Division replied to the correspondence from Brooke Winter Solicitors, indicating that the assertion that Ms Harwood intended to end her life by declining medical treatment was not supported by any evidence. The Manager further stated in the letter:

[5] The number of deaths in Tasmania from the year 2023 (January to December) was 5,073. Of this total, 1077 were reported to the Coroner's Office. Therefore, approximately 3996 deaths were certified with a MCCD by a medical practitioner as being from natural causes.

[6] Page 3 of Brooke Winter Solicitors Application to the Coroner to Investigate Death in 2018

> *"The coroner requests more information and evidence to satisfy herself that Marjory's(sic) death was a "reportable death" warranting a coronial investigation, according to the definition in the Coroners Act 1995, s3. The evidence may include, but is not limited to, any reports to Police or Corrective Services regarding the allegations of rape and assault that occurred in Risdon Prison, and medical records and reports from medical specialists that were treating Marjory(sic) at the time of her death.*
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> *The coroner has advised the coroner's associates of this application. Please contact the coroner's associates should you obtain any more evidence that may satisfy the coroner that a coronial investigation is warranted regarding the death of Marjory(sic)."*[7]

17. Nothing more was heard from Mrs Harwood or her legal representatives for a period of almost five years, during which time Ms Harwood's death remained certified and registered as being due to natural causes in accordance with the MCCD.

18. On 24 October 2023, correspondence addressed to me in my capacity as Chief Coroner was received from two solicitors (jointly) at Hobart Community Legal Service, requesting an investigation and inquest into the death of Ms Harwood. The same submission was made in this correspondence as was made by Brooke Winter Solicitors five years earlier; that is, that Ms Harwood refused medical treatment because of an imminent fear of prison, particularly of being housed in the male section of the prison. Therefore, it was submitted that the death should be categorised as suicide. It was also submitted that the death was reportable on the basis that it was an "*indirect result of injury*".[8] It was somewhat unclear whether this was submitted as an alternative avenue of reportability or whether it was part of the submission relating to suicide.

19. Further, it was submitted that, for various reasons, it would be desirable for the Coroner to hold a public inquest.[9] Essentially, it was submitted that the Tasmanian Prison Service failed to protect Ms Harwood, with particular reference to her increased vulnerability to physical and sexual assault arising from her sexuality and gender identity.

20. A Coroner may only hold an inquest if the death is reportable in the first instance.

21. A large folder of documents accompanied the submission, comprising mostly hospital, prison, and correctional health records. An electronic copy of the 75 documents (called

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[7] Response from Coroner's Office to letter from Brooke Winter Solicitors.
[8] Page 2.
[9] Section 24(2)- A coroner may hold an inquest into a death which the coroner has jurisdiction to investigate if the coroner considers it desirable to do so.

"Annexures") attached to the correspondence were submitted via USB to the Coroner's Office. On 7 May 2024, an additional 11 Annexures were filed by Hobart Community Legal Service, which included general guidelines and documentation relating to transgender prisoners.

22. The annexures provided to support the application were not presented in an ordered, logical, or chronological manner. Many documents were of such poor quality that they could not be read. A significant number of records were obviously incomplete (by reference to page numbers). Many were out of sequence with other related records. No explanation was provided as to why the records were presented in this unacceptable form.

23. I requested that the Coronial Nurse assist with a chronology of the records. This was a most time-consuming task, given the state of the documents, but it has considerably helped me in navigating the Annexures. Attached to this decision is a chronology of relevant dates and entries, largely based on the efforts of the Coronial Nurse, extracted from the evidence provided. The chronology is not and does not purport to reproduce the Annexures in their totality. However, it provides important general information regarding Ms Harwood's medical and life circumstances pertaining to this application over the period of nine years from 2009 until her death.

24. The applicant's submission that Ms Harwood's death is reportable is predicated upon the occurrence and consequences of a rape in prison in July 2017, in which she was the victim.

25. Therefore, I highlight particularly the following entries contained in the records provided, being the only ones that mention Ms Harwood[10] in the context of being the victim of any physical assault and/or sexual assault.[11]

> **1 February 2009** – Prison Patient Consultation Summary List
> Registered Nurse recorded that Martin said he had been sexually assaulted in prison in Western Australia in 2008 and has issues surrounding this incident.
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> **8 February 2009** – Prison Patient Consultation Summary List
> Noted by Psychiatric Nurse that Martin said he had returned from Western Australia in November 2008, had gone for work, but lost job due to alcohol and

[10] Described as Martin.
[11] These are also summarised in the attached chronology.

ended up in jail. He was traumatised there by a sexual assault. On return to Tasmania, he described fractious family relationships so went to live on Bruny Island. He said he drank large quantities of alcohol and was raped by a 'bikie'.

26 February 2009 – Prison Patient Consultation Summary List
Martin told Dr Julian that he was a homosexual rape victim whilst in Prison in WA the previous year.

5-25 November 2009 – Prison Case Notes
Martin described verbal attacks and targeting by another inmate and feeling unsafe. He was upset after verbal attacks and that he is "*sick of these attacks"*. He had a note passed to him of a sexual nature. He also made several complaints about the unacceptable food.

6 December 2009 – Prison Patient Consultation Summary List
Martin had a custodial admission to Inpatients after making an allegation of sexual assault to Therapeutic Services. He said this happened one week ago.[12]

12 January 2010 – Prison Case Notes
Staff escorted Martin to the Department of Emergency Medicine at the Royal Hobart Hospital (RHH). During discussions with staff, Martin implied that all the problems he was experiencing at that time, loss of weight, etc, were due to an alleged sexual assault which took place in prison late November 2009. He said nothing was done about the alleged assault.

22 January 2010 – Prison Case Notes
Martin said that when he was in the shower and was annoyed by another inmate, this prompted a flashback of assault in Mersey[13] which contributed to a fainting spell.

3 October 2013 – Prison Review Record
Martin stated in writing that he would like to stay in Mersey for his safety and welfare, stating that he was worried about showering with a group and persons taking advantage of him by doing "*sexual things*" as happened to him previously.

3 December 2014 – Prison Patient Consultation Summary List

[12] There is no contemporaneous reference, record or details relating to this alleged occurrence.
[13] "Mersey" is a unit at Risdon Prison Complex (RPC) – Needs Assessment Unit

Dr David, Prison Medical Officer, recorded that Martin detected a large left gluteal abscess which he thought was due to "*frequent spanking from inmates*".

28 May 2015 – Prison Complex Case Notes, Patient Consultation Summary
The Clinic Nurse recorded a late entry for the previous day upon assessing Martin. There was a left eye laceration and pain in ribs from being assaulted in Mersey yard by repeated punches. 1cm laceration to left eyebrow. Not deep, not requiring suturing.

29 May 2015 – Prison Patient Consultation Summary List
Martin told the psychiatric nurse that he knew his attacker on the unit from the community but did not provide details regarding any trigger for the previous days' assault. He was told that the inmate responsible had been removed from Mersey and would not return. He said he wanted to return to prison as there was nothing for him in the community. It was recorded that, despite the assault, he was in good spirits.

13 July 2017 – Medical Progress Notes from RHH (only one page)
Appear to relate to treatment for rectal bleeding. It was noted that Martin declined to eat and as he stated he felt he was getting "fat". He spoke to nursing staff about sexual abuse as a child.

16 October 2017 – Tasmanian Ambulance Service Case History Presentation
Ambulance Tasmania recorded a call-out to Ms Harwood who was presenting with a ruptured colostomy bag. The notes record that she was heavily intoxicated and was a very poor historian. The notes stated, *"patient has had recent rectal trauma ? being raped in prison"*. Ms Harwood told the attending paramedics that she had been in hospital approximately two months previously due to pre-existing renal problems and bowel problems but self-discharged against advice. The paramedics were unable to ascertain specific medical history from her, noting *"obviously intoxicated/?psychiatric issues"*.

26. Upon review of the records provided, it may well be that Ms Harwood was victim of a sexual assault/rape in a West Australian prison in 2008. However, official or institutional reports and accounts were not provided within the documents for consideration. As such, the references relating to the incident appear to be provided directly from Ms Harwood to Risdon Prison staff and I could not make a finding on this basis that such an incident did occur.

27. It also appears from the injuries and the Prison Clinical Notes that Ms Harwood was the victim of a physical assault on 28 May 2015.

28. In any event, Mrs Harwood's current application depends upon the occurrence of an incident in Risdon Prison in July 2017 which was said to be the trigger for Ms Harwood to later refuse dialysis. The only *possible* reference to anything approaching such an incident is contained in the Ambulance Tasmania notes of 16 October 2017 (summarised above). The reference to rectal trauma being caused by a recent sexual assault/rape in prison was accompanied by a question mark and was clearly speculation or emanated from information given by Ms Harwood whilst heavily intoxicated and unable to provide an accurate medical history. I also note that no date was mentioned regarding such an incident. It is inconceivable that the details of such an incident, if it occurred, would not be the subject of incident reports and notifications to treating medical and health practitioners. It is also inconceivable that Ms Harwood would not have referred to it or reported it.

29. It was submitted by Brooke Winter Solicitors, Mrs Harwood's previous solicitors, that, *"As a consequence of physical injuries inflicted during the rape, Marjory (sic) required a colostomy bag to be fitted".*

30. The prison and hospital records for 26 July 2017 unequivocally record that Ms Harwood was physically unwell with weight loss, cold extremities and vomiting and diarrhoea. She also fainted and hit her nose, a fact directly reported by Ms Harwood to Dr Frances. In the prison notes, Dr Frances recorded *"no option but to send him via nonurgent ambulance to the RHH".*

31. Once being treated in hospital, the notes of 27 July 2017 make no mention of recent trauma whatsoever. They are summarised as best they can be in the annexed chronology.

32. Relevantly, the notes describe Ms Harwood's chronic bowel issues, including investigation in 2016 because of melaena (blood in stools). They also describe persistent diarrhoea since the previous hospital admission three weeks ago with rectal bleeding in the past week. Under the category of "social history", it is recorded that Ms Harwood was a "*man who has sex with men"* but makes no mention of any sexual assault. The records of this comprehensive examination would have mentioned that Ms Harwood sustained or may have sustained traumatic injuries if that indeed had occurred. As they stand, the records do not even suggest consideration of trauma.

Suicide

33. Suicide is a voluntary act intended to effect the destruction of one's own life, whereby the person performing the act understands the nature of the act, and where the act does in fact cause the death of the person performing the act.[14]

34. Suicide is a different concept than voluntarily declining medical care. It is well-established by authority and in legislation that an adult with decision-making capacity is entitled to make decisions regarding their medical care. This stems from the fundamental right to the integrity of the person and the principal that every person's body is inviolate.[15]

35. In the case of Ms Harwood, the evidence supplied to me discloses that she had a long history of renal failure and had entered the final stage – Stage 5, requiring dialysis. Ms Harwood was in Stage 5 on 26 March 2018 when she was reviewed by the Department of Nephrology. At that review, Dr Stephen Yew, nephrologist, reported that Ms Harwood's kidney disease was long-standing and probably not reversible. Dr Yew recorded that Ms Harwood expressed that she was keen to get back to work in hospitality or hairdressing as well as horse riding. However, when the prospect of dialysis was discussed, Dr Yew noted that Ms Harwood had not turned up for most clinic appointments and recorded the following in his notes:

> *"Martin has on occasion acknowledge that he would have difficulty in keeping on a strict regimen required of dialysis.*
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> *On other occasions, Martin would say he would say(sic) he wants to give dialysis a go. I would have significant reservations re-: Martin's to engage with regular dialysis. I have spoken to Rosemary (Martin's mother) re: Martin - while he is slightly better (now staying with a friend, not gone missing for protracted periods), she does not believe he has changed significantly to be able to engage with a strict regimen such as dialysis – etoh[alcohol]/marijuana still problems."*[16]

36. Dr Yew noted that Ms Harwood's other conditions included an eating disorder, alcohol excess, marijuana use, a colostomy due to prolapse repair and hepatitis C.

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[14] *R v Cardiff City Coroner; ex parte Thomas* (1970) 134 JP 673

[15] *Collins v. Wilcock* (126) (1984) 1 WLR 1172, at p 1177; *Department of Health & Community Services v JWB & SMB ("Marion's Case")* [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992)

[16] Renal Correspondence, Department of Nephrology 26 March 2018.

37. Thus, Ms Harwood appeared equivocal regarding committing to dialysis, with her mother indicating she would likely be unable to commit to the strict regimen. There is no evidence that she started dialysis or had any intention to do so. Her mother's assertion that she later refused dialysis because of a fear of prison is not plausible at all in this context.

38. It is asserted by Mrs Harwood's lawyers that in April 2018 Ms Harwood received a summons, and this event triggered her to "*refuse medical treatment*" in order to effect suicide. The fact of service of the summons is unsupported by the evidence as is the assertion that she refused medical treatment in order to die because of the fearful prospect of returning to prison. If this account emanates from Ms Harwood's mother, there is no sworn document or credible statement made by her to this effect. There is also nothing in the records indicating that Mrs Harwood made any contemporaneous assertions or representations to medical or custodial staff that Ms Harwood was refusing treatment solely to end her life due to the prospect of returning to prison. There is also no contemporaneous complaint or account of the event from Ms Harwood herself.

39. The evidence discloses that Ms Harwood was a very mentally and physically unwell person over many years and had multiple presentations and admissions to hospital. Towards the end of her life, her medical condition was worsening significantly. In addition to her other multiple medical and psychiatric illnesses, she experienced consequences of surgery for her loop colostomy closure procedure made necessary by her rectal prolapse.

40. Ms Harwood's kidney disease had worsened towards the end of her life and on 23 June 2018 when she presented to hospital, she had a worsening cough with brown discharge and shortness of breath. She said she had been unable to leave the house for a week. She also reported upper right sided abdominal pain radiating across her abdomen with abdominal distension.[17]

41. She was admitted to the RHH under General Medicine and assessed as having acute pulmonary oedema, likely community-acquired pneumonia, and normocytic anaemia in the setting of stage 5 chronic kidney disease. Ms Harwood was aggressive at times and difficult to engage during the admission. During her admission, dialysis was discussed by the doctors who conveyed to her that without it, death would result.

[17] Annexures 9 (one page provided of four) and 38 (two pages provided of seven) provided relating to admission of 23 June 2018 were incomplete

42. Despite the advice given, Ms Harwood did not accept dialysis. She said that she knew she was dying and wished to be left alone. Arrangements were put in place for palliative care at home, but she passed away in hospital on 1 July 2018.

43. Ms Harwood correctly understood that her kidney disease and other conditions would imminently result in her death. She was given the option of treatment which she was entitled to decline, as previously indicated.

44. Her renal failure was a long-standing natural condition and was clearly the cause of her death. Declining to accept treatment for a terminal natural disease is not suicide.

45. Upon the evidence provided to me, I am only able to conclude that Ms Harwood could not and would not commit to the onerous process of dialysis. It is impossible to determine her exact thought processes for not accepting dialysis. The most likely scenario is that she understood the terminal nature of her condition and her inability to commit to dialysis. There is evidence of such reasoning process in the records.

46. There is, however, no evidence at all that an alleged fear of returning to prison was a factor in her decision.

47. Refusal of treatment may be made by patients for many different reasons. Even if part of Ms Harwood's reasoning for refusing treatment was related to fear of possible return to prison for any reason, her death nevertheless remains due to natural causes. Her decision to refuse treatment for a terminal condition, being a longstanding and worsening natural disease, was not the operative cause of her death. Her death was directly caused by the terminal natural condition.

48. It appears that Mrs Harwood's solicitors make an alternative submission of reportability: that injuries (whether physical or psychological) from the alleged rape *indirectly* caused Ms Harwood's death because she subsequently refused life-saving treatment. The submission fails for the same reasons as articulated above. Upon the material presented to me, Ms Harwood was not a rape victim at the time alleged, did not suffer injuries from a rape and did not consequently refuse dialysis because of those injuries.

49. Further, common sense notions of causation in coronial law must be applied. It is doubtful that any death occurring from a natural progressive disease, can be said to result indirectly from physical or psychiatric injury in the manner submitted. Certainly in this case, there is no causal connection at all.

50. In reaching this decision, I am conscious that, for a death to be reportable, such as to invoke coronial jurisdiction, the threshold test is low. I must be satisfied[18] that it *appears* that the death *may* be a reportable death. In turn, a reportable death is one that *appears* to have been unnatural or to have resulted directly or indirectly from an accident or injury.[19]

51. For the reasons stated, the evidence provided cannot satisfy the test. Therefore, the death of Ms Harwood is not reportable under the *Coroners Act* 1995.

52. For the avoidance of doubt, I have concluded by this decision, with reasons, that I have no jurisdiction under the *Coroners Act* 1995 in respect of the death of Ms Harwood. It is a well-established principle that a court is permitted to decide whether or not a claim made in the court is within its jurisdiction. [20]

Olivia McTaggart

Coroner

Notation: The medical summary annexed to the original finding has not been published at the Coroner's direction due to the sensitive nature of content.

[18] On the balance of probabilities.
[19] s3 and s21 and the *Coroners Act* 1995
[20] *State of New South Wales v Kable* (2013) 252 CLR 118, 133 [30] - [31]