CITATION: *Inquest into the death of Leo Kauka Simukka* [2011] NTMC 023

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0127/2009
DELIVERED ON:	24 June 2011
DELIVERED AT:	Darwin
HEARING DATE(s):	16 June 2011
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Unexpected death, subdural haemorrhage**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman

Judgment category classification:	B
Judgement ID number:	[2011] NTMC 023
Number of paragraphs:	40
Number of pages:	14

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0127/2009

In the matter of an Inquest into the death of

LEO KAUKA SIMUKKA
ON 23 JULY 2009
AT ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

INTRODUCTION

1. Leo Kauka Simukka ("the deceased") was a 48-year-old Caucasian man who was born on 5 December 1960 in Ingham in the State of Queensland. Mr Simukka died at approximately 8.07pm on 23 July 2009 at the Royal Darwin Hospital ("RDH") when his ventilator was turned off. At the time of his death the deceased was unemployed and living at 21 Glebe Crescent, Wulagi in the Northern Territory of Australia.

2. For reasons which will appear below, this death was reportable to me pursuant to s.12 of the *Coroners Act* ("the Act") because it was unexpected and unnatural and appeared to have resulted from an accident or injury. During the course of investigations undertaken by police, allegations were received of the deceased having complained of being mistreated by certain person/s before his death. As a result, I determined to exercise my discretion to conduct an inquest into this death pursuant to s.15(2) of the Act.

3. Pursuant to section 34 of the Act I am required to find if possible:

> "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. The cause of death;

iv. The particulars needed to registered the death under the Births, Deaths and Marriages Registration Act;

v. Any relevant circumstances concerning the death"

4. This inquest was held on 16 June 2011. Ms Jodi Truman appeared as Counsel assisting. There were no other formal appearances; although I note that notice of the inquest was placed in the NT News and sent to the deceased's next of kin.

5. Three (3) witnesses were called to give evidence at this inquest, namely:

a. The Officer In Charge of the coronial investigation, namely Detective Senior Constable Wayne Newell;

b. Michael Renwick; and

c. Dr Terence Sinton, Director of the Forensic Pathology Unit at RDH.

6. A brief of evidence containing various statements, together with numerous other reports, photographs and police documentation was tendered at the inquest (exhibit 1). The deceased's medical file was also tendered in evidence (exhibit 2). Public confidence in Coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I thank Detective Acting Sergeant Newell for his investigation.

Formal Findings

7. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings in relation to the death of Mr Leo Kauka Simukka, as required by the Act:

    i. The identity of the deceased was Leo Kauka Simukka who was born on 5 December 1960 in Ingham in the State of Queensland.

    ii. The time and place of death was at approximately 8.07pm on Thursday 23 July 2009 at the Royal Darwin Hospital.

    iii. The cause of death was subdural haemorrhage.

    iv. Particulars required to register the death:

        a. The deceased was male.

        b. The deceased's name was Leo Kauka Simukka.

        c. The deceased was of Caucasian descent.

        d. The cause of death was reported to the Coroner.

        e. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton.

        f. The deceased's mother was Helvi Marajatta Simukka and his father was Leo Aramus Simukka.

        g. The deceased lived at 21 Glebe Crescent, Wulagi in the Northern Territory of Australia;

        h. The deceased was unemployed.

Circumstances surrounding the death

<u>Background</u>

8. Leo Kauka Simukka was born in Ingham, Queensland to Helvi Marajatta Simukka and Leo Aramus Simukka. He had 5 siblings, namely Paivi, Rita, Helga, Kym and Kauka. He moved to Mount Isa with his family at a young

age and attended the Central State School. There he befriended Michael Renwick, attending Grade 1 together, and they remained lifelong friends. According to Mr Renwick, both he and the deceased called one another "brother" due to the closeness of their relationship.

9. In about 1977 both the deceased and Mr Renwick were sent to the Westbrook Boys Home near Toowoomba, Queensland. They later moved to Brisbane and there they joined a small street gang known as the "Valley Boys" in Fortitude Valley, Queensland.

10. In about 1979 the deceased travelled to Alice Springs for a period of time and then returned to Brisbane. The deceased, sometimes together with Mr Renwick, then travelled back and forth between Queensland and the Northern Territory. The deceased is first recorded as getting into trouble with the police in the Northern Territory in or about 1983. He is then recorded as appearing in court every year thereafter until 1991. The deceased then appears to have left the Northern Territory before finally settling in Darwin on a permanent basis in about 1995.

11. Upon settling in Darwin, the deceased was thereafter joined by Mr Renwick. They lived together in various locations around Darwin until the deceased finally moved in to the residence occupied by Mr Renwick at Glebe Crescent, Wulagi in or about 2006. He remained there until the date of his death. Another occupant of that address was Mr Nygel Reeves who had lived on and off at the residence since about 2008. I note that I received evidence that Mr Reeves recalls first meeting the deceased in 2006 and referred to the deceased as "Uncle Leo", such was the nature of their relationship.

12. According to the evidence received at this inquest, the deceased was a diabetic and was prescribed Diamicron MR 120 mg and Metformin 850 mg for this condition. It appears he had been receiving this medication for

some time prior to his death. In addition he was also prescribed MS Contin, a time released formulation of morphine, for an injury to his back.

13. I received evidence that the deceased was a very heavy drinker of alcohol who would drink each and every day and would often drink to the point of extreme intoxication. This also caused him health difficulties and he was diagnosed as suffering from pancreatitis. Mr Renwick himself, the deceased's lifelong friend, described the deceased as an alcoholic.

14. It is clear that the deceased also had a history of illicit drug taking and I received evidence that previously he would "shoot up" morphine and also "speed". He was known to police as an illicit drug user and dealer. In terms of his general health, it is clear from the findings made at autopsy that the deceased was suffering from chronic coronary artery, liver and pancreatic disease and, as Dr Sinton described it, his general health was "poor at best".

Events prior to hospitalisation

15. I received evidence from Mr Renwick that on Monday 20 July 2009, Mr Renwick asked Mr Reeves if he could go and collect his car from Jabiru and take it to a mechanic. Mr Reeves agreed and the deceased said he would go with him. The two men left some time that morning, although it is unclear as to precisely when.

16. Mr Renwick gave evidence that when the deceased and Mr Reeves returned home that afternoon, he was in his bedroom. Mr Reeves came and told him that they had placed the car with the mechanic. Mr Renwick thanked him and then returned to watching television in his bedroom. Mr Renwick stated that he did not see the deceased at that time.

17. Mr Reeves set out in his statement to police that on the way back to Darwin, he and the deceased shared the driving. Mr Reeves stated that he recalled the deceased "driving erratically and swaying all over the road to the left mostly". When they got back into Darwin they drove to the Karama Shops

for the deceased to get some tally-ho's, but the deceased also purchased some alcohol, which Mr Reeves recalled was a 750ml bottle of port. Mr Reeves stated that the deceased asked him to drop him off at Casuarina, but he dropped him off "on the corner near the church in Wulagi". I note that there was other evidence before me that suggested Mr Reeves had previously described the alcohol as being VB, but I do not consider this makes a significant difference as to the maters that I must determine and consider it explicable simply because of the effluxion of time.

18. Mr Reeves noted that the deceased was:

> "sculling the port and he had nearly finished it before I dropped him off".

Mr Reeves noted that the deceased appeared drunk and he simply thought the deceased was:

> "going to sit in the long grass and get drunk. He used to do that; binge drink and never see him for days".

Mr Reeves stated that after he left the deceased he:

> "was fine other than being drunk".

19. About half an hour after Mr Reeves had returned home, Mr Renwick left his room to go to the bathroom. When he came out of his door he bumped into the deceased and thanked him for taking care of his car. Mr Renwick states that at this time the deceased was saying, "*What car? What car?*" and that he was "*really slurring*". Mr Renwick stated that he thought the deceased was simply drunk and so he returned to his bedroom to let the deceased use the bathroom. Mr Reeves also recalled the deceased arriving half an hour after he got back, and that when the deceased got home:

> "he just looked his normal drunken self. He appeared just as drunk as when I dropped him off".

20. Approximately 10 minutes later, Mr Renwick stated that he decided to go out and speak to the deceased about his drinking. Mr Renwick stated that when he came out of his bedroom he could see the deceased sitting in a chair in the lounge room and appeared to be asleep. Mr Renwick stated that the deceased was snoring loudly and as a result he thought the deceased was "pretending".

21. Mr Renwick told the deceased to get up, but the deceased did not move. As a result, Mr Renwick went and poured some water into a cup and tipped it on the deceased's head, but again the deceased did not move. Mr Reeves recalled that Mr Renwick came out of the house and told him that he could not wake the deceased. As a result they both went back into the lounge room. Mr Reeves then poured water into the deceased's ear, but the deceased would still not wake up. After this occurred, the men called an ambulance. Mr Renwick stated that at this time he was worried about what was happening with the deceased. I received evidence that this call was made at about 7.11pm and the ambulance arrived at the residence at about 7.20pm.

22. The records of St John Ambulance show that the deceased was unconscious and nonreactive to stimuli after multiple attempts. His pupils were also "very slow" to react and had minimal constriction to light, with the described as "unreactive". The notes also record there being "signs of facial trauma" with the "right eye area" and "bloodied nose". The deceased however was not in any breathing difficulty. The deceased was then taken by ambulance to Royal Darwin Hospital ("RDH") and is recorded as arriving there at 7.53pm.

Attendance at Hospital

23. At the hospital the deceased was examined by Dr McCaffrey who found no exterior signs of significant head trauma but did note bleeding from the left nostril. A later scan revealed a subdural haemorrhage on the left side of the

deceased's head. As a result the deceased underwent a craniotomy at about 10.18pm in an attempt to relieve pressure on his brain due to the bleeding. Despite this intervention, the deceased's condition worsened and his prognosis in the RDH records was described as poor.

24. I received evidence that after the ambulance left, Mr Renwick made contact with the deceased's sister, namely Paivi Simukka. Ms Simukka confirmed via her statement to the police that she was contacted by Mr Renwick and also "someone" at the RDH who advised that the deceased had been admitted, had bleeding on his brain and that he was on life support. Ms Simukka was advised to come to the hospital if she was able. Ms Simukka arrived in Darwin at about 2.30pm on Thursday 23 July 2009. Upon her arrival she was met by the pastor of the Lutheran Church who drove her to the RDH.

25. At the RDH she met Mr Renwick and was introduced for the first time to Mr Reeves. All three (3) persons went with the pastor whilst he gave the deceased his last rites in the Intensive Care Unit ("ICU"). The deceased's ventilator was turned off when it was realised that he had no reasonable prospect of living unassisted and at 8.07pm he passed away.

Issues raised for consideration at this inquest

26. At the commencement of this inquest, Counsel assisting submitted that although the cause of death of subdural haemorrhage was clear on the evidence, a significant issue for my consideration was ***how*** the deceased developed that subdural haemorrhage to the left side of his head. This issue exercised upon my mind throughout the evidence.

27. In this regard I note that the evidence of Mr Renwick was that he had very little contact with the deceased on the day of his hospitalisation. It appears that the deceased spent the majority of that day in the company of Mr Reeves. It is clear that initially Mr Reeves did not wish to assist the police in their investigation and refused to provide them with a statement. Police

records show that at the relevant time, Mr Reeves in fact had an outstanding warrant for his arrest and I accept therefore that he would have been reluctant to spend much time with the police, particularly as it could result in his subsequent incarceration.

28. Since that time however, Mr Reeves has in fact been arrested and as at the date of this inquest was incarcerated and serving a sentence at the Berrimah Correctional Centre. After contact was made with Mr Reeves by Counsel assisting, Mr Reeves agreed to provide a statement to police as to his involvement with the deceased on the day of his death and his recollection of events. That statement was tendered into evidence as exhibit 4.

29. In that statement Mr Reeves sets out his reasons for not providing a statement earlier, which includes the fact that he "didn't want to go to the police station and end up getting locked up". Mr Reeves' version of events has been detailed already in these reasons and is fairly consistent with the version of events that Ms Paivi Simukka says she was told by him at the RDH on 23 July 2009.

30. Ms Simukka also set out in her statement however that after her return to Queensland on 6 August 2009 (following the deceased's funeral) she received some text messages from her nephew, namely Leo Esko Simukka (born 14 March 1984) and his partner, namely Debbie Csoma. Ms Simukka stated that those text messages alleged that the deceased had been:

> "mistreated a couple of times in Darwin"

and that:

> "both of them said that Michael had given my brother Leo a beating a few times if he had too many beers and that Michael had left him out in the bush a couple of time and made him walk home"

The reference to "Michael", I take to be a reference to Mr Renwick.

31. In this regard I note that Detective Newell gave evidence that as a result of this information he made contact with both Leo Esko Simukka and Debbie Csoma by telephone and that they agreed to provide a statement to him as to their knowledge of events. Detective Newell stated however that when Queensland Police attempted to contact the pair and take their statements, they had left Mount Isa and were unable to be located for a considerable period of time. Contact however was finally made 29 May 2011 at which time both persons advised that they "did not wish to provide a statement in relation to a coronial matter involving Leo Simukka in the Northern Territory". I note that they each signed a police notebook to that effect and this was tendered into evidence before me as exhibit 3.

32. As a result there is only the third hand hearsay allegation of the deceased's sister as to what she says she was told by such persons. Whilst I acknowledge that pursuant to s.39 of the Act, I am not bound by the rules of evidence and may be informed in such manner as I think fit, given the refusal of Leo Esko Simukka and Debbie Csoma to give any evidence or assistance to this inquiry, or to corroborate those allegations by swearing as to the information contained in their text messages, I am not prepared to accept there is any truth in these allegations.

33. I also note that both Mr Renwick and Mr Reeves have denied outright that they were involved in any assault upon the deceased on the day of his hospitalisation, namely 20 July 2009. I place weight on these denials, particularly from Mr Renwick given that he was frank enough with police, and also in his evidence before me, to admit that he and the deceased would sometimes fight with one another, but that it was not serious and was "just a drunken fight".

34. In terms of this evidence, I had the opportunity of seeing Mr Renwick in the witness box. Having seen and heard him give his evidence, I found him to be an impressive witness who obviously cared a lot about the deceased. I

note that he continued to describe the deceased as his "brother" and despite the considerable period that has passed since his death, Mr Renwick was reduced to tears during the course of his evidence. I therefore dismiss the allegations contained in the text messages to Paivi Simukka that suggested Mr Renwick was in any way involved in bringing about the death of the deceased.

35. In addition, although there is a notation in the St John Ambulance records of there being "signs of facial trauma" to the "right eye area" and a "bloodied nose", I also note that it was only the bleeding from the left nostril that was seen by Dr McCaffrey when he conducted his physical examination of the deceased at the RDH. I therefore find that the trauma noted to the right eye area was not significant. In terms of the bleeding from the nose, I note that Dr Sinton gave evidence that during the course of the autopsy he carefully examined the body of the deceased to see if there were any external physical signs to indicate the deceased had suffered trauma prior to his death. I note that Dr Sinton stated that there were no external signs of any physical trauma having been suffered by the deceased and that although his autopsy occurred on 29 July 2009, he stated that had such signs existed he would have expected they would have been seen by him.

36. In terms of how the deceased suffered a subdural haemorrhage, I note that Mr Renwick gave evidence that he was aware that the deceased had "got into some fight in the long grass" a "couple of weeks before he was taken to hospital" and that the deceased had suffered "a black eye", but he could not remember which side. I also pause to note that this "black eye" could have been what was noted by St John Ambulance as the "facial trauma" to the "right eye area". In terms of this event being the possible cause for the subdural haemorrhage, I note that Dr Sinton stated that he considered this "unlikely" given the time frame and that he would have expected there to have been signs of the haemorrhage having developed and of it affecting the deceased.

37. Mr Renwick also stated that the deceased would fall over sometimes "when he was blind drunk", which appears was fairly regular on the evidence, but that he did not see the deceased fall over on the day that he went to hospital. In terms of this possible cause, I note that Dr Sinton gave evidence that it was his opinion that subdural haemorrhages were "overwhelmingly" caused by trauma and therefore some type of blow to the head. Dr Sinton was quick to point out however that "any" blow to the head "can" lead to a subdural haemorrhage and that it did not need to be significant, with a "relatively minor trauma" able to result in a subdural haemorrhage.

Findings and Recommendations

38. It is in light of all of this evidence that although I am able to find that a subdural haemorrhage caused the deceased's death in circumstances in which a trauma to the head must have occurred, I am unable to make a finding as to the circumstances in which such trauma occurred. Those circumstances are unknown and therefore I cannot entirely rule out some foul play. However, that remote possibility aside, I consider that the more likely view is that the trauma occurred accidentally.

39. I certainly consider that, based on the evidence before me, it is entirely speculative to suggest foul play and in such circumstances I find that there is insufficient evidence of a crime having been committed in connection with this death. Accordingly I make no report to the Commissioner of Police or the Director of Public Prosecutions pursuant to s.35(3) of the *Coroners Act*.

40. I have no recommendations to make arising from this Inquest.

Dated this 24th day of June 2011

_____

GREG CAVANAGH
TERRITORY CORONER