CITATION: *Inquest into the death of Daryl Jabangardi Riley* [2019] NTLC 030

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0055/2018
DELIVERED ON:	27 September 2019
DELIVERED AT:	Alice Springs
HEARING DATE(s):	12 September 2019
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in custody, prisoner in correctional facility, natural causes**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Central Australian Health Service	Klarin Sivyer

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

No. A0055/2018

In the matter of an Inquest into the death of

DARYL JABANGARDI RILEY

ON 18 AUGUST 2018
AT ALICE SPRINGS CORRECTIONAL FACILITY

FINDINGS

Judge Greg Cavanagh

Introduction

1. Daryl Jabangardi Riley (the deceased) was born 17 May 1976 in Alice Springs Hospital to Ivy Nabarula Limbiari and John Jabananga Riley. He had two siblings, Alvin and Connie.

2. He met Leonie Hunt in Ernabella, South Australia in 1997. They had two children, Linda (1998) and Christopher (2005). The relationship with Leonie was a volatile one and he was in and out of prison for various periods generally to do with assaulting Leonie or the Police. Those period however were generally relatively short, being at most a matter of days or months. The longest period was 4 months and 30 days in 2005.

3. However, on 12 December 2009 he was alleged to have had sexual intercourse with Leonie without consent. He was found guilty of the offence and on 24 February 2011 he was sentenced in the Supreme Court at Alice Springs to 10 years and 3 months imprisonment with a non-parole period of 7 years and 3 months. The sentence was backdated to 5 June 2010. He lodged an appeal. However on 20 July 2011 withdrew the appeal.

4. The earliest date for release was 5 June 2017. Without parole he was due for release on 4 June 2020. He was known as a prisoner who displayed appropriate behaviour and complied with routines.[1] He was transferred to Darwin Correctional Facility at his request on 17 April 2013.

5. He was noted to be fluent in Warlpiri and English. He was polite and generally interacted well with both prisoners and staff. He was noted to be a good worker needing little supervision.

6. He was transferred to Darwin Correctional Facility at his request on 17 April 2013. He stayed there until November 2017.

7. The Parole Board met on 18 April 2017. For reasons that are not altogether clear, the deceased said he did not wish to be released on parole. He had sent a letter to the Parole Board declining parole.

8. Later that year he asked to be transferred back to Alice Springs Correctional Facility to be closer to his family. He was transferred on 2 November 2017.

9. During his time in prison he was considered to be a healthy man. He said he did at least 30 minutes a day of exercise. That appears to have been in the form of either football or basketball. There were a number of times he went to the Health Clinic with injuries incurred while playing sports.

10. In 2015 he had surgery to repair an umbilical hernia. In preparation for that operation he attended the surgical clinic. An ECG was completed and his cardiovascular score was calculated. It was low risk at seven percent.

11. He was medically cleared for work on 19 July 2015 and worked in the prison at the Health Clinic and in the laundry. The only consistent medical complaint was that he had trouble sleeping. He was provided medication to assist his sleep.

[1] Statement of William Yan dated 28 August 2019

12. On 15 February 2017 he complained that he felt pain when he pushed on his chest. He said he had been doing a lot of push ups lately and it was thought it may have been muscle related. He had a full adult health check later that month on 28 February 2017. His BMI was 23.54. His blood pressure was 134/34. His blood tests were within normal limits. He appeared healthy.

13. On his transfer back to Alice Springs on 2 November 2017 he had a return to prison health check. He appeared healthy.

14. On 8 May 2018 he had the flu vaccination and had the skin test for tuberculosis. On 9 July 2018 he saw the dentist because of a loose wire on his dental plate.

15. At the time of his death he was classified as Low 1 Security and was housed in Tango Block within the Management Zone Sector. He was employed in the laundry.

16. On Saturday 18 August 2018 the deceased did some push ups before being let into the exercise area with other prisoners from his block to play basketball. After their game they returned to the recreation room to play some pool. There is a CCTV camera in that area. The recording from that camera was obtained by the police investigators. That along with the statements from the other prisoners in the recreation room indicates that while playing pool he said he had some chest pain. He handed the cue to another prisoner and walked outside and spoke through the mesh fence to another prisoner's family. He then returned to playing pool.

17. At 10.37am the deceased clutched his chest and put a hand on the pool table as if to steady himself. He then collapsed to the floor. The other prisoners pushed the intercom button and ran to the yard yelling "code blue". Correctional Services Officers were on the scene quickly. They found that his breathing was shallow and he was making gurgling sounds when breathing. An oxygen mask was placed on his face.

18. The medical officers arrived at 10.41am and commenced full resuscitation. They continued until 11.08am when the St John paramedics arrived and took over. However, he could not be revived and was pronounced deceased at 11.28pm.

19. An autopsy was conducted by the Forensic Pathologist, Dr John Rutherford. He found the deceased had left ventricular hypertrophy, severe calcific coronary artery atherosclerosis, moderate pulmonary congestion and severe pulmonary oedema. He was of the opinion that the deceased died from ischaemic heart disease due to the narrowed coronary arteries being unable to supply an adequate flow of blood to the enlarged left ventricle.

20. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

    (i) The identity of the deceased is Daryl Jabangardi Riley, born on 17 May 1976 in Alice Springs, Northern Territory.

    (ii) The time of death was 11.28pm on 18 August 2018. The place of death was Tango Block, Alice Springs Correctional Facility in the Northern Territory.

    (iii) The cause of death was ischaemic heart disease due to coronary artery atherosclerosis and left ventricular hypertrophy.

    (iv) The particulars required to register the death:

        1. The deceased was Daryl Jabangardi Riley.
        2. The deceased was of Aboriginal descent.
        3. The deceased was a prisoner.
        4. The death was reported to the Coroner by Alice Springs Correctional Centre.
        5. The cause of death was confirmed by Forensic Pathologist, Doctor John Rutherford.
        6. The deceased's mother was Ivy Nabarula Limbiari and his father, John Jabananga Riley.

21. Pursuant to section 26 (1) Coroners Act I must investigate and report on the care, supervision and treatment of a person that is held in custody immediately before his or her death.

Care, Supervision and Treatment

22. The deceased was imprisoned at the age of 34 years. He spent the next eight years in Alice Springs and Darwin Correctional Facilities. He exercised each day and was considered to be fit and healthy. However at the age of 42 he died as a result of coronary artery disease. That is, while in a prison setting he died of natural causes.

23. After his death the Central Australia Health Service undertook a Root Cause Analysis into the medical care Mr Riley received. The analysis was excellent as was the report and recommendations.

24. It was identified that some of the documentation was poor or missing and that the follow up and referral of Mr Riley could have been improved. For instance it was noted that on 28 February 2015 the pathology results showed an elevated cholesterol (HDL 6.2) an elevated HbA1c (6.2) and an abnormal ECG in that his heart rate was slow.

25. The doctor did a repeat ECG on 11 April 2015. It was normal. A year later on 14 April 2016 his blood tests were repeated. His cholesterol had reduced to HDL 5.9 and his HbA1c had reduced a little but remained high at 5.9. There was no referral or any follow up.

26. He had only one complete adult health check while in prison. That occurred on 28 February 2017. It was noted that he had an abnormal heart rhythm. However there was no evidence of any follow up or referral.

27. The analysis indicated that a uniform, documented and consistent approach in relation to reviewing pathology results would give a better chance of detecting health issues. I commend the Health Service on their desire to learn from the death of Mr Riley and improve.

28. The evidence indicates that the response of the other prisoners, the prison officers and medical staff when Mr Riley collapsed in the recreation room was fast and commendable.

29. In my view, on all of the evidence, the care, treatment and supervision of the deceased was adequate. I make no recommendations.

Dated this 27th day of September 2019.

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GREG CAVANAGH
TERRITORY CORONER