CITATION: *Inquest into the death of Trevor Raymond Parkyn* [2000] NTMC 38

TITLE OF COURT:	Coroners Court
JURISDICTION:	Coroners
FILE NO(s):	9913561 70/99
DELIVERED ON:	1 June 2000
DELIVERED AT:	Darwin
HEARING DATE(s):	22, 23, May 2000
JUDGMENT OF:	Mr Greg Cavanagh

CATCHWORDS:

Coroners – Inquest – Police – Head injuries undetected

REPRESENTATION:

Counsel:

Assisting the Coroner: Ms Sally Sievers

Solicitors: Cridlands

Judgment category classification:	B
Judgment ID number:	[2000] NTMC 38
Number of paragraphs:	67
Number of pages:	16

IN THE CORONER'S COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 9913561
70-99

AN INQUEST INTO THE DEATH OF

TREVOR RAYMOND PARKYN

FINDINGS

(Delivered 1 June 2000)

Mr CAVANAGH, TERRITORY CORONER:

NATURE AND SCOPE OF THE INQUEST

1. Between 3.00am and 12.30pm on 12 June 1999, Trevor Raymond Parkyn (the deceased) died at 16 Raffles Road, Gray, in the Northern Territory of Australia. He was 37 years of age. He was a Caucasian male born on 7 September 1961 in North Adelaide, South Australia.

2. In the early hours of Saturday 12 June 1999 he received three injuries to his head, the most significant being a blunt injury to the back of his head that fractured his skull.

3. Section 14(1) of the Coroners Act reads:

> "A coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be a reportable death."

4. The phrase "reportable death" is defined in section 12 to include:

> (a) A death where –
>
> (i) the body of a deceased person is in the Territory

(ii) the death occurred in the Territory; or

(iii) the cause of the death occurred in the Territory.

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;

5. There is no doubt that the death occurred in the Northern Territory and the death was unexpected and violent. This death is therefore properly categorised as a reportable death.

6. The Coroner has the discretion to hold an inquest pursuant to either section 15(1A) or 15 (2):

> (1A) Where a coroner has jurisdiction to investigate a death, the coroner may, if he or she thinks fit, hold an inquest if -
>
> (a) the body of the deceased person is in the Territory or it appears to the coroner that the death, or the cause of death, occurred in the Territory; and
>
> (b) the coroner suspects unlawful killing.
>
> (2) A coroner who has jurisdiction to investigate a death may hold an inquest as the coroner thinks fit.

7. Having decided to hold an inquest, the coroner is required by s.34 to make findings and may make comment on matters set out in s.34(2).

8. It is important to note that the Coroner is prohibited by s34(3) from making a finding or commenting that a person is or may be guilty of an offence.

9. The provisions of sections 34 and 35 of the Coroners Act are set out in full:

> Section 34
>
> 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 register the death under the Births, Deaths and Marriages Registration Act; and

(v) any relevant circumstances concerning the death.

2. 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.

3. A Coroner shall not, in an investigation, include in a finding or comment, a statement that a person is or may be guilty of an offence.

4. A Coroner shall ensure that the particulars referred to in sub-section 1(a)(iv) are provided to the Registrar, within the meaning of the Births, Deaths and Marriages Registration Act.

Section 35

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.

3. A Coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner.

10. The public inquest commenced at Darwin Court House on Monday 22 May 2000 and concluded on Tuesday 23 May 2000.

11. Counsel assisting the Coroner was Ms Sally Sievers. The family of the deceased attended the inquest but did not seek leave to appear nor ask questions.

12. The following witnesses were called

Monday 22 May:

1. Detective Senior Constable Wayne F Whitlock – OIC of the investigation
2. Ashley Elix
3. Daniel Adam Borthwick
4. Andrew Scott Whitaker
5. Justin Starick
6. Matthew Steven McCourt
7. Pathologist Dr. R. Byron Collins by video link

Tuesday 23 May:

8. Nicole Canon
9. Charmaine Ryan
10. Constable Sandra Nash
11. Constable Adam Gould

13. The following exhibits were tendered

1. Coroner's Investigation file comprising report by Detective Senior Constable Wayne Whitlock dated 11 September 1999, together with statements, interviews and documents annexed thereto.

2. Map of Palmerston CBD with the locations the deceased was observed marked in red.

3. Affidavit of Identification of Deceased Person, sworn by Ashley Carl Elix of 16 Raffles Road, Gray on 12 June 1999 (the copy is found at Part 2 of Coroner's Investigation file), Toxicology Report – Peter Harpas dated 2 September 1999 and Initial Notification of Death for Coroner.

4. Autopsy Report of Dr Byron Collins, dated 19 November 1999.

FORMAL FINDINGS

14. The formal findings pursuant to s34 (1)(a) are as follows:

(i) The Identity of the Deceased Person

The deceased is Trevor Raymond Parkyn, a male Caucasian Australian, born on 7 September 1961 at Calvary Hospital, North Adelaide

(ii) The Time and Place of Death

The deceased died at 16 Raffles Road, Gray between 3.00am and 12.30pm 12 June 1999 aged 37.

(iii) The Cause of Death

The deceased died from traumatic intracranial haemorrhages/brain damage and fractured skull.

(iv) The Particulars required to register the death are

1. The deceased was a male.

2. The deceased was of Australian origin.

3. The cause of death was reported to a coroner.

4. The cause of death was confirmed by a post-mortem examination.

5. Traumatic intracranial haemorrhages/brain damage and a fractured skull caused the death.

6. The pathologist viewed the body after death.

7. The pathologist was Dr R. Byron Collins, Consultant Forensic Pathologist, of Independent Forensic Services, Melbourne, Victoria.

8. The father of the deceased was Raymond Parkyn; the mother Moiya Parkyn.

9. The usual address of the deceased was 16 Raffles Road, Gray, Northern Territory.

10. The deceased was unemployed.

THE RELEVANT CIRCUMSTANCES OF THE DEATH

15. It is clear that the deceased had been drinking consistently from 8pm on 11 June 1999 until 1.00am the next day and that he was intoxicated when he left the Palmerston Tavern. The evidence of Mr Elix is that the deceased also smoked some marijuana at his home during this evening.

16. Whilst Mr Elix does not describe himself and Mr Parkyn as "staggering drunk" he concedes they "had had a few". The youths that observed the deceased at the shopping centre were aware that the deceased had been drinking.

17. Blood samples taken from the deceased during the autopsy show he had a alcohol reading of 0.113% which supports the observations that he was affected by alcohol at the time of the incident. However, as the time of death is uncertain it is not possible to calculate a more accurate reading.

18. The deceased on leaving the Palmerston Tavern approached a group of young people of which Mr Matthew McCourt was a member. Mr Parkyn knew Mr McCourt, as he had been a friend of the deceased's niece, Rachelle. Mr Parkyn initiated the contact for the reason of ascertaining his nephew Daniel's whereabouts. He had left Daniel at home with instructions not to go out.

19. The deceased's conduct after he approached Matthew McCourt is described by a number of witnesses, including Matthew McCourt, as aggressive and abusive. He swore loudly and used abusive language towards Mr McCourt for approximately 5 to 10 minutes. Mr McCourt's evidence and the evidence contained in other witness statements clearly sets out the type of language used.

20. The deceased stood very close to Mr McCourt as he spoke to him. In the conversation he indicated he wanted to fight Mr McCourt. Statements from the other youths also support the evidence in Mr McCourt's statement (tab 7 ex 1) that there was an indication from the deceased that he was prepared to fight Mr McCourt.

21. Throughout what was an aggressive exchange, Mr Justin Starick was standing to Matthew McCourt's left. It is clear from the transcript of the record of Mr Starick's conversation with the police that that he believed that the aggressive behaviour of Mr Parkyn was directed towards both himself and Matthew McCourt. (ROI page 4).

22. Mr Starick was called to give evidence at the Inquest. Upon attending he declined to answer questions upon the grounds that it may incriminate him in a criminal offence. The Coroner does not have the power to compel answers where this may be the case, indeed s38 of the Coroner's Act states that a person shall not, under this Act, be compelled to answer a question that may tend to incriminate the person. I am however, entitled to have regard to the evidence of his record of interview with the police that was tendered during the Inquest.

23. Justin Starick stated at a number of points in his record of interview (pages 10 –12 & 28) that he believed the deceased was going to hit Matthew McCourt. He states in his record of interview (page 10 to 12) that he saw the deceased clench his fist and start to bring his arm back as if to hit Matthew, and that the deceased had an angry expression on his face.

24. At the time of the exchange between the deceased and Mr McCourt, a number of the youths approached Mr Elix who was a short distance away in the carpark, and an incident ensued involving him.

25. The evidence is consistent and clear that Mr Justin Starick punched the deceased with his right fist, in a jab like motion hitting the deceased on the left side of his jaw. The deceased then fell backwards onto the cement footpath.

26. The descriptions of the fall vary significantly but they consistently state that the deceased fell backwards onto the concrete surface. Some say he staggered and then fell, others that he buckled at the knees and then fell.

27. The deceased did little to break his fall and his arms remained in front of him. The deceased's head hit the ground. However just how hard, and if this lead to the significant injury which caused his death cannot be positively established. It is possible and in my view probable, that the blunt head injury to the back of the deceased's head located by the Pathologist Dr Collins, occurred at this stage.

28. The observations of those who saw the deceased after he fell to the ground are that he was "knocked out" or was unconscious for some time. One of the very young members, Leon Rotumah (tab 15, Ex 1) then nudged/tapped Mr Parkyn around the head or chest area a number of times with his foot to see if he was all right.

29. Mr McCourt then poured water onto the deceased's face to help him (tab 29, ex 1 page 5). Approximately 4 or 5 of the witnesses refer to water being poured onto the deceased. However the evidence and statement of Charmaine Ryan are that Mr McCourt also threw the water bottle onto Mr Parkyn's chest.

30. There is one witness, Nicole Canon, who attended at the Palmerston Shopping Centre independently of the majority of the other young people

who were there at the time of the incident. She saw someone over the body of the deceased, punching the upper half of his body towards the upper chest area just after he fell to the ground. She gave evidence of what the person was wearing but was unable to identify who it was.

31. The actions of the youths whilst the deceased was on the ground were cowardly. However it appears that by this stage the life threatening injury to the back of Mr Parkyn's head had already been incurred and that their actions did not contribute to the cause of death.

32. Ms Canon also states that when she saw the additional blows, she approached her friends to leave the area. She says that as she passed the deceased she saw a mark on his cheek, about his cheekbone. She made her way to the minibus parking area and into a minibus. At this time she saw the deceased roll over as if to get up.

33. Mr Andrew Whitaker who was working at Coles bakery also saw the deceased around this time. He took his early morning break between 1 and 1.30am. He was alerted to the fact that there had been an incident by two young women who came past the bakery entrance looking upset.

34. Mr Whitaker's evidence was that he approached the deceased as he could see a person lying on the concrete path. His head was near the guttering to the carpark about 20 to 30cm from the edge. He was lying on an angle across the path with both his arms and legs outstretched and his eyes open. The deceased was staring straight upward into the sky and had a vacant expression on his face. He was not blinking and there did not appear to be eye movement.

35. Mr Whitaker spoke to him and asked the if he was alright. He did not get any response. He had a look at him to see if there was any blood or obvious injuries to him, and could not see any.

36. Mr Whitaker then returned to the bakery and it was about this time that he saw the person on the ground starting to move. He put his arms across his chest and raised himself up on his right elbow. Mr Whitaker did not see the deceased again.

37. Mr Parkyn was not seen by anyone that the police have been able to locate until two young women observed him on the footpath at Temple Terrace outside Woolworths, Palms City Oasis. He was lying on his side, his head was leaning on his arms and his hands covered his face. Charmaine Ryan approached him and asked him if he needed any help and he looked up and nodded. She saw Mr Parkyn's face and did not observe any injuries on him.

38. Her friends then called her away from Mr Parkyn. She gave evidence that she then saw him get up and go over to the telephone box. He was staggering as he moved to the phone boxes.

39. The deceased was not then seen by any witness that the police have been able to locate, until 2.05am when Constables Nash and Gould found him in the car park at Palms City Oasis.

40. The Police became aware of an incident at the Palmerston Shopping Centre at 1.23am. They spoke with the some of youths involved, Justin Starick and Matthew McCourt, on the median strip of Temple Terrace, close to where it intersects with Essington Avenue. Mr Elix approached the police while they were talking to the youths in this area, at approximately 1.36am.

41. While Constable Nash drove the intoxicated Mr Elix home in his car, he described the deceased to her and that he had last seen him running down Temple Terrace trying to get away from " those kids". Constable Nash said to Mr Elix that the police would keep a look out for Mr Parkyn and if they found him, bring him home. Mr Elix was left at his home at 16 Raffles Road.

42. Constables Nash and Gould located the deceased some twenty minutes later at 2.05 am. They saw him as they drove towards the Temple Terrace exit at the Palmerston Oasis/Woolworths shopping centre. Mr Parkyn was sitting on the gutter leaning the bottom of his back on a light pole, which was not switched on. He had his knees drawn up with his elbows resting on his knees. His head was resting in the open palms of his hands. He was fast asleep.

43. The Constables got out of the van and assessed his condition using the light from their torches as they were aware he may have been in a fight. They saw that he was sweating around his neck and face, but they did not see any injuries. Constable Nash gently shook Mr Parkyn's right shoulder and got no response. She then shook him on two further occasions before she had a conversation with him ascertaining that he was Trevor. She asked him if he had been in a fight and he said, "No". She also asked, "Trevor, are you hurt or injured?" and he said, "No". When she asked him about his sweating, he said he was tired.

44. Constables Nash and Gould then offered to take Mr Parkyn home. Mr Parkyn got up and walked the 4 or 5 steps to reach the Police van and spoke to the officers. He climbed into the back of the Police van unaided. The Police drove him to 16 Raffles Road where they had earlier dropped Mr Elix.

45. When they got to the house there were two large dogs at the house. Constable Gould sounded the car horn to let Mr Elix know they had returned. The deceased with some urgency in his voice said, "Let me out. Let me out", as if he was going to vomit. Constable Nash opened the cage door and Mr Parkyn stepped out. He stepped up onto the footpath and as he was walking past a tree on the nature strip, brushed up against it with his right shoulder.

46. The Police watched him open the gate and let himself in, not letting the dogs out, and walk towards the house on the left side of the yard. He seemed to stumble. He then regained his balance. He headed towards the left side of the house where the lights were on. That was the last time the Police saw him.

47. Constable Nash gave evidence that she would not have taken him into protective custody as he was not significantly intoxicated. If she had, the options would have been to take Mr Parkyn to the sobering up shelter, which she knew was full or to the cells at Berrimah Police Station.

48. Constable Nash rather than just waking Mr Parkyn and telling him to move on felt she had made a commitment to Mr Elix to take Mr Parkyn home. The Police assumed that Mr Elix was home when they dropped Mr Parkyn off as the lights were on and they had dropped him off there shortly before. They were reluctant to enter the yard because of the two large dogs.

49. Constable Nash, an experienced police officer, gave evidence at some length of the measures she used to assess the deceased's condition. She did not locate the life threatening injury and she, like Mr Elix when he arrived home, did not notice the injury to the deceased's left jaw.

50. The Pathologist, Dr Collins gave clear evidence that he had to go to some lengths to locate the injury to the back of the deceased's head. It was not readily apparent and there was no surface bleeding. He had to comb the hair apart and only then did he see the 2-centimetre abrasion. It was not until he performed the internal examination during the autopsy that the full extent of the injury became evident.

51. The injury being thus hidden, I cannot make any adverse comment as to the police's actions in taking the deceased home. I note in this regard that the civilian witnesses Whitaker and Ryan (as well as Elix and Borthwick) did not notice any injuries to the back of the head. Whilst they were aware he

may have been involved in a fight, they were not aware of any possible head injury. It was not easily visible, and the deceased did not exhibit many signs of his injury.

52. The next people to see the deceased were, nephew, Daniel Borthwick, and his flatmate, Mr Elix, when they got home after going out to look for him. The deceased was lying in the driveway in front of the car (photo 2- Exhibit 1 tab 26). Mr Elix said he was lying on his back.

53. Mr Elix and Daniel picked Mr Parkyn up and carried him inside the house. He was groaning and mumbling a little. They put him on a couch and took his shirt off. Mr Elix checked him over for injuries. He did not see any injuries except "a bit of a black eye". Both Mr Elix and Daniel watched over Mr Parkyn until Mr Elix went to bed at 2.40am and Daniel at 3.00am. They left Mr Parkyn on the couch to sleep.

54. Mr Elix saw Mr Parkyn the next morning at 7:20am when he went to work. Mr Elix thought that Mr Parkyn looked like he was sleeping. Mr Elix rang home at about 10:30 and 11:00 to get Daniel to check Mr Parkyn. Daniel did this after the 11.00am call and he thought his uncle was just continuing to sleep. He did not touch Mr Parkyn except to take his boots off.

55. At 12:30pm when Mr Elix got home he felt Mr Parkyn and he was cold. Mr Elix then rang the ambulance. The police arrived and the matter was reported to the Coroner.

56. Dr. Byron Collins, a locum Forensic Pathologist at the Northern Territory Forensic Unit, carried out an autopsy in June 1999. The cause of death was determined to be traumatic intracranial haemorrhages/brain damage, and a fractured skull. Dr Collins gave clear evidence of the three injuries he observed on the exterior of Mr Parkyn's head being the bruising on the left cheek and the right eye and an abrasion on the left rear of the deceased's head.

57. Dr Collins investigated the injury to the back of the deceased's head during the autopsy, observing two haemorrhages, one on the outside of the skull, the other covering the casing of the brain; a fracture of the skull and the swelling of the brain. He also observed a fracture to the orbit of the right eye, but believes because of the type of fracture that this injury was separate to the injury to the back of the head and not caused by it. As to whether this injury was caused by punches, kicks or accidentally is a matter of speculation.

58. Dr Collins' evidence was that it was the injury to the back of the deceased's head that caused his death. The swelling of the brain and the damage to the vital structures of the brain resulted in Mr Parkyn's heart beat and breathing stopping.

59. The doctor was unable to assist with establishing the time of death even though he believed it would have been some time after the injury was incurred as it would have taken some time for the haemorrhages to form and for the brain to swell. The increased weight of the lungs also led him to this conclusion.

60. Dr Collins also provided general information on the difficulty of ascertaining a head injury in someone who has been drinking as their behaviour eg, slurring of words, sleepiness, unsteadiness on their feet, are similar for both people who have been drinking and those with significant head injury.

61. Dr Collins also said that if the deceased had received treatment for the swelling of the brain very soon after the injury had been received the outcome might have been different.

62. The deceased did not receive treatment in this case as no one detected the injury. Further the symptoms of the head injury may have been masked by the behaviour that the deceased displayed being attributed to alcohol. This

was, as counsel assisting the coroner has said, a very tragic combination of circumstances.

CONCLUSIONS

63. It is clear that the deceased was punched and fell to the ground at some time around 1 to 1.30am. However his movements after this are largely unaccounted for, as he is seen at only one further location before he is found and taken home by the Police at 2.05am. His flat mates later find him in the driveway of 16 Raffles Road sometime prior to 2.40am. The evidence available shows that the deceased had physical contact with Justin Starick and Leon Rotumah, but it is possible that contact was had with another unknown person at sometime during the night.

64. After the incident at Coles, Mr Parkyn travels some three hundred and seventy five metres or more to the Palmerston City Oasis. To reach this area he had to cross two main roads, pass numerous light poles, palm trees, substantial concrete guttering and many objects on which it is possible he could have fallen or knocked himself.

65. Whilst police inspected the sites, because of the time delay of some hours or days, no evidence which could assist me in ascertaining how his injuries were incurred was found.

66. The pathologist Dr Collins was also unable to assist or ascertain the role that either the injury to the deceased's right eye or to his left cheek played in him incurring the fatal injury to the back of his head. Dr Collins said the injury to the back of his head could have occurred when he received either of these injuries or from the result of any other fall.

67. However, it is probable that the fall to the concrete, after the deceased was punched, resulted in the blunt head injury, that fractured his skull and set in train the haemorrhaging and the swelling of his brain which ultimately lead to his death.

Dated this 1st day of June 2000.

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Greg Cavanagh

TERRITORY CORONER