



IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0262/2022

Promis No: 10160714

CORONERS' FINDINGS

Section 34 of the Coroners Act 1993

I, Elisabeth Armitage, Coroner, having investigated the death of **DOUGLASS MAGGIE** and without holding an inquest, find that the identity of the deceased was **Douglass Maggie**, born on **2 June 1976** and that his **death occurred on 31 October 2022, at Parap Road, Parap in the Northern Territory.**

Cause of death:

- | | | |
|------|---|---|
| 1(a) | Disease or condition leading directly to death: | Complications arising from hyperthermia |
| 1(b) | Morbid conditions giving rise to the above cause: | Alcohol intoxication and underlying co-morbidities |

An autopsy was conducted on 1 November 2022. Forensic Pathologist, Dr Althea Neblett provided the following comments:

Circumstances surrounding death

- The decedent was a 46-year-old man with history of epilepsy and hypertension.
- On October 31, 2022, he was reportedly with a group of persons, who were driving around. He was picked up, late in the morning and was allegedly already intoxicated. He reportedly continued to drink (alcohol) with these persons.
- He reportedly fell asleep in the vehicle, and the vehicle was parked along Parap road around 13:10 (CCTV timestamp). The other occupants reportedly went into a hotel. He was seen on close circuit television (CCTV) leaving a store around 13:35. He reportedly tried to buy alcohol and was refused service. Also seen on CCTV, he had tripped and fallen on the footpath, after leaving the store, and then he went back into the vehicle, which was parked across the road. One of the left passenger doors of the vehicle was opened.
- Approximately 30 minutes later another man closed the opened door and appeared to have electronically locked the vehicle. The camera angle was not able to clearly show if the windows of the vehicle were closed or opened as the rear of the vehicle was only clearly visible.
- The other occupants returned to the vehicle around 18:45 (CCTV time stamp), and the 46-year-old man appeared to be still asleep according to some members of the group, so they placed him on the nature strip, either for him to sober up or for the night patrol to pick him up and then they drove off.

(Comment: Police statements provided by the individuals who were in the car and had reportedly placed the 46-year-old man on the side of the road, were conflicting and contradictory, in regards to if he was awake or sleeping or unresponsive, when found in the car and, when he was left at the side of the road.)

- The individuals in the car returned to the nature strip and saw the 46-year-old man still lying on the strip. They called the police at 20:57. The CCTV showed him positioned on his back, on the strip and he was reportedly still in that position until the ambulance service arrived. The police and paramedics arrived around 21:00. He had absence of vital signs. His tympanic temperature was 38.9 degrees Celsius. Cardiopulmonary resuscitation was started around 21:00 and stopped at 21:24. He was declared deceased at that time. The tympanic temperature taken at 21:34 was 37.9 degrees Celsius
- The temperature inside of the vehicle, when the decedent was inside, was unknown. The highest ambient/external temperature recorded that day, between 12:00 to 23:30, was 34.6 degrees Celsius at 13:30.

Summary of main pathological findings and opinion as to cause of death

A full autopsy was performed on the decedent. At autopsy, the body was that of a middle-aged man. He had evidence of medical intervention, associated with cardiopulmonary resuscitation related injuries (fractures of the ribs and the sternum). There was no evidence of blunt impact head trauma. There was small bruise on the left side of the posterior chest wall (back), but no other evidence of blunt impact trauma. Internal examination revealed multi-organ congestion. There was no evidence of aspiration. There was no evidence rhabdomyolysis, or of coagulopathy (serosal petechiae, subendocardial haemorrhages and intramuscular haemorrhages) that could be seen in, but are not specific too, hyperthermia⁽¹⁾.

Postmortem biochemistry was not in keeping with biochemical findings in non-exertional hyperthermia (elevated blood urea and creatinine, elevated or decreased sodium and potassium), but does not rule out vehicular hyperthermia. Hyperthermia is diagnosed as a core body temperature of greater than 40 degrees Celsius and the elderly and children are most at risk. In addition, *"there are predisposing factors that may limit the body's ability to mount an effective thermoregulatory response to excessive heat including dementia, psychiatric illnesses, diabetes, hyperthyroidism, obesity, burns, alcohol consumption, and chronic alcohol misuse. These conditions complicate the usual dissipation of heat due to increased metabolism, decreased activity, increased subcutaneous fat, or the inability to peripherally vasodilate, sweat properly, and release excessive heat."*⁽²⁾

Antemortem body temperatures or temperatures at the time of death are often unavailable, and there are no specific postmortem (macroscopic, histologic, biochemical) findings. The presence of the non-specific findings that can be seen in hyperthermia are dependent on the period of survival, post exposure⁽²⁾. Hence, the diagnosis of hyperthermia is essentially based on scene investigation, the circumstances of death, and the reasonable exclusion of other causes of death.

Postmortem toxicology revealed an elevated blood alcohol concentration that was not potentially lethal, but could cause moderate to strong intoxication in the habitual or social drinker, respectively. Of note, the blood alcohol concentration might have been higher earlier in the day, when he was observed to be "very intoxicated" and because of ongoing alcohol metabolism, following cessation of drinking prior to death, it could have decreased. The presence of the elevated blood alcohol concentration in the decedent, who was in an enclosed, potentially hot compartment (vehicle), could have contributed/predisposed to death.

The circumstances do not indicate that the decedent was found in a position that could have affected his respiration, leading to positional asphyxia. He was seen lying on his back after he was placed on

the grass, along the roadway; however, the position that he was found in, whilst in the car, was not described. If he were initially found in a position that could impair respiration, his blood alcohol concentration could have possibly affected his ability to remove himself from such a position. The decedent also had a history of epilepsy and was reportedly non-compliant with medications. It is not known if he had seizures, whilst in the car, prior to his death.

The clinical condition of the decedent, after his removal from the car was unclear, and the possibility exists that he was not simply "sleeping" but possibly deceased, comatose, or post-ictal. Therefore, based on the circumstances, the actual time of his death remains unclear. In view of the history, circumstances and postmortem examination findings, death is undetermined. Death due to vehicular hyperthermia, positional asphyxia or epilepsy, in the context of alcohol intoxication cannot be ruled out.

(1) Sweeney K. M Heat-Related Deaths. J Insur Med 2002; 34: 114-119. <https://www.aaimedicine.org/journal-of-insurance-medicine/jim/2002/034-02-0114.pdf>

(2) Palmiere C, Mangin P. Hyperthermia and postmortem biochemical investigations. Int J Legal Med. 2013 Jan; 127(1):93-102. doi: 10.1007/s00414-012-0722-6. Epub 2012 Jun 5. PMID: 22669324.

Past medical history

Review of the Northern Territory electronic clinical case records (HRN: 0784912), showed he had the following current and remote medical conditions:

- Epilepsy thought to be due to Brain abscess in 2013:
 - Recent admission with Status epilepticus (October, 3 2022-October 5, 2022) due to non-compliance with medications.
 - He was treated for community-acquired pneumonia also.
 - EEG on prior admission epileptiform activity in right frontoparietal area.
- Hypertension
- Dyslipidaemia
- COPD/bronchiectasis
- Motor vehicle collision (January 2022) with multiple facial, left wrist and rib fractures, and liver laceration.

Specimens were taken for toxicological analysis:

Results: Forensic Science Case Number: 2205205

1. 0.16% alcohol was detected in the blood (preserved).
2. Detected in the blood (preserved):
 - (1) Amlodipine.
3. Valproic Acid was not detected in the blood (preserved).
4. No other drugs listed in the Scope of Analysis were detected in the blood (preserved).

Police investigation:

A coronial investigation by police found no suspicious circumstances surrounding this death.

Circumstances:

Mr Maggie was born at Balgo Hills Mission, Western Australia to mother, Nora Maggie. His father is not listed on his birth certificate. He had a significant medical history including epilepsy with seizures, hypertension, dyslipidaemia, and COPD/bronchiectasis and was often non-compliant with

his medications. He was married to Patricia Gordon and they lived between Western Australia and Northern Territory.

On the morning of Monday 31 October 2022, Mr Maggie was at a unit complex at Victoria Drive in Gray where he was staying in Darwin. He was described as being happy and drunk¹ that morning. At around 9.30am Mr T. Rose arrived at the unit complex in a Toyota Landcruiser Prado to visit family. A short time later, Mr T. Rose, Mr Maggie, Mr W. Bumblebee/Njana, Ms V. Nanala, Mr D. Walker, and Mr D. Daniels/Bush left in the Prado and travelled to various locations around Darwin, purchasing and drinking alcohol and visiting family. Mr Maggie shared a 2 litre box of chardonnay with one of the other passengers and was observed drinking it from a water bottle whilst they drove around². After stopping at various houses the following persons travelled together to the Parap Tavern, Mr T. Rose, Mr D. Daniels/Bush, Mr Maggie, Mr D. Walker, Ms V. Nanala, Mr W. Bumblebee/Njana and Mrs M. Hargreaves³.

At 1.11pm Mr T. Rose (wearing a black t-shirt with Biggie on the front and black and white basketball shorts⁴) parked the Prado opposite the Parap Road Store. This was captured on a fixed police CCTV camera situated at the intersection of Parap Road and Hingston Street in Parap. The camera is set to automatically pan from left to right covering the area between the Parap Tavern and the Parap Road Store. Mr Maggie was sitting in the middle seat in the row behind the driver's seat and was awake⁵.

At 1.15pm Mr Maggie (wearing a moroon Bronco's shirt and blue shorts⁶) is seen on the CCTV exiting from the vehicle whilst drinking from a clear bottle. He appears unsteady on his feet as he walks back and forth several times between the Prado and Parap Road Store. The others exit and leave the vehicle. (Ms V. Nanala was wearing a black t-shirt with a white and green square on the front, light blue shorts and black thongs⁷.)

At 1.21pm the CCTV shows Mr Maggie entering the Parap Road Store to purchase more alcohol but he was declined service by the store attendant due to his intoxication⁸. As Mr Maggie leaves the store at 1.25pm he can be seen stumbling down a step and falling onto the concrete. He later makes his way back to the Prado.

At 1.52pm the CCTV shows Mr D. Daniels/Bush returning to the Prado and he recalled that the windows were down. Whilst looking for loose change in the car he said he saw Mr Maggie, sleeping in the front, snoring. He gave him a drink of water and noticed he was sweating⁹. He then closed both the rear driver's side door and the rear passenger side door and used the remote central locking device to lock the vehicle before returning to the Parap Tavern.

At 2.02pm, 2.14pm and again at 2.52pm the hazard lights on the Prado are observed flashing on the CCTV footage. This may be caused either by the hazard lights button being pressed or the alarm system being activated. During this time, a number of people are seen approaching the vehicle, knocking on the window and appearing to gesture to someone inside.

At 5.19pm Mr D. Daniels/Bush is seen on CCTV returning to the Prado and opening the front passenger door. He is observed standing at the vehicle for a couple of minutes before walking back to

¹ Statutory Declaration Mr Rose, 1/11/2022, [22]; Statutory Declaration Mr Bush, 1/11/2022, [10]; Statutory Declaration Ms Nanala, 1/11/2022, [9]

² Statutory Declaration Ms Nanala, 1/11/2022, [14]

³ Statutory Declaration Ms Nanala, 1/11/2022, [13]

⁴ Statutory Declaration Mr Rose, 1/11/2022, [20]

⁵ Statutory Declaration Mr Rose, 1/11/2022, [10]

⁶ Statutory Declaration Mr Bush, 1/11/2022, [10]

⁷ Statutory Declaration Ms Nanala, 1/11/2022, [33]

⁸ Statutory Declaration Ms D. Lee, 1/11/2022, p2

⁹ Statutory Declaration Mr Bush, 1/11/2022, [15-16]

the Parap Tavern. When the camera pans around to show the vehicle again, all of the doors are closed.

At 6.00pm Mr D. Daniels/Bush is observed walking back to the Prado and opening the driver's door which had the window half way open. When the camera pans back to the vehicle about two minutes later, Mr D. Daniels/Bush is seen walking back towards the Tavern drinking from a can. All doors of the vehicle are closed.

At 6.35pm an unknown female is observed approaching the Prado and looking into the vehicle before walking towards the Tavern.

At 6.41pm the CCTV shows Mr T. Rose, Mr D. Daniels/Bush, Ms M. Tims, and Ms V. Nanala¹⁰ leaving the Tavern and walking back to the Prado. As the group approaches the vehicle, the vehicle's hazard lights flash twice indicating the unlock function had been operated from the remote central locking device. As the doors are opened, the CCTV shows the windows on the front and rear passenger doors were half way open.

They found Mr Maggie in the front passenger seat. He appeared to be sleeping, he was said to be snoring¹¹. Ms V. Nanala thought he was "full drunk because we couldn't wake him up"¹². Mr T. Rose and Mr Daniels/Bush¹³ lifted him out of the car and placed him on the grass verge so that Night Patrol could pick him up or he could walk home when he was sober¹⁴. Mr Daniels/Bush said he sat up and and said he didn't want to come with them¹⁵. The group then left in the Prado. When the camera pans back to the vehicle at 6.45pm Mr Maggie is lying on his back on the grass nature strip.

At 8.54pm, the group returned in the Prado to check on Mr Maggie and discovered that he was not breathing. They contacted emergency services at 8.57pm¹⁶. (At this time Ms M. Wilson remained asleep on the back seat of the car¹⁷). At 9.03pm two St John Ambulance vehicles arrived. On their arrival he was noted to be hot to the touch (38.9°Celsius via tympanic thermometer), there was blood and copious amounts of bile in the airway, no spontaneous respirations, no pulse and he showed asystole (flatline). CPR was commenced but he was unable to be revived. He was confirmed deceased at 9.34pm.

A police investigation found that the temperature range that day was between 31.5 to 34.6°Celsius, with an apparent temperature of between 33.1 to 35.9°Celsius and a relative humidity of between 40% and 61%. Several studies have demonstrated internal temperature increases in vehicles sealed with various humidity and outside air temperatures. Publically available temperature charts indicates the temperature inside a **closed** vehicle in the above temperatures has the potential to reach 60 to 63°Celsius after approximately 60 minutes. Temperatures of this magnitude are extreme and may have led to hyperthermia.

On 1 November 2022 an autopsy was conducted. The examination confirmed no injuries or trauma. Given that the death occurred during conditions of extreme heat, consideration was given to the possibility of hyperthermia. The literature however indicates that in such deaths, autopsy findings are

¹⁰ Statutory Declaration Mr Rose, 1/11/2022, [13]; Statutory Declaration Ms Nanala, 1/11/2022, [18];

¹¹ Statutory Declaration Mr Rose, 1/11/2022, [11]; Statutory Declaration Mr Bush, 1/11/2022, [19]; Statutory Declaration Ms Nanala, 1/11/2022, [19]

¹² Statutory Declaration Ms Nanala, 1/11/2022, [19-20]

¹³ Statutory Declaration Mr Rose, 1/11/2022, [12]

¹⁴ Statutory Declaration Ms Nanala, 1/11/2022, [21]

¹⁵ Statutory Declaration Mr Bush, 1/11/2022, [19]

¹⁶ Statutory Declaration Mr Rose, 1/11/2022, [15]; Statutory Declaration Mr Bush, 1/11/2022, [21-24]; Statutory Declaration Ms Nanala, 1/11/2022, [26-27]

¹⁷ Statutory Declaration Ms Wilson , 1/11/2022, [6-7]; Statutory Declaration Police Officer B. Molloy, 21/7/2023, [25]

nonspecific or inconclusive and the diagnosis of hyperthermia is essentially based on scene investigation, the circumstances of death, and the reasonable exclusion of other causes of death.

The forensic pathologist was unable to rule out vehicular hyperthermia, positional asphyxia or epilepsy, in the context of alcohol intoxication as a cause of death. However, in light of the circumstances of prolonged heat exposure in a parked vehicle, his level of unresponsiveness when removed from the vehicle, and his body temperature when assessed by paramedics at 9.03pm, I consider it likely that complications from hyperthermia contributed to his death.

Report to the Commissioner of Police and the Director of Public Prosecutions

Pursuant to s 35(3) of the *Coroner's Act 1993* a coroner may report to the Commissioner of Police and the Director of Public Prosecutions if the coroner believes that an offence may have been committed in connection with a death. I am satisfied that the facts and circumstances disclosed by the investigation into this death warrant such a report. Accordingly, these findings will be reported to the Commissioner of Police and the Director of Public Prosecutions.

In light of that report and in the interests of transparency, these findings will also be published on the coronial website.

Decision not to hold an inquest:

I make no further findings with respect to the circumstances of this death as, pursuant to section 16(1) of the *Coroners Act 1993*, I do not consider that the holding of an inquest would elicit any information additional to that disclosed in the investigation to date and the investigations into the death disclosed:

- The time, place and cause of death;
- The relevant circumstances concerning the death; and
- The circumstances do not require a mandatory inquest because:
 - The deceased was not, immediately before death, a person held in care or custody; and
 - The death was not caused or contributed to by injuries sustained while the deceased was held in custody; and
 - The identity of the deceased is known.

Signature:

Elisabeth Armitage

CORONER

Date: 30 May 2024

NOTE:

Under section 16(2) of the *Act*, within 14 days after receiving notice of a decision not to hold an inquest, a person may apply to the Supreme Court for an order that an inquest be held.

Under section 16(3) of the *Act*, the Supreme Court may if it thinks fit, make an order that an inquest be held.
