CITATION: *Inquest into the death of John Russell Ralkurru Marika* [2008] NTMC 001

TITLE OF COURT: Coroner's Court

JURISDICTION: Nhulunbuy

FILE NO(s): D0020/2007

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HEARING DATE(s): 29 – 30 November 2007

FINDING OF: Mr Greg Cavanagh SM

CATCHWORDS:

Unexpected death, myocardial infarction (coronary heart disease), circumstances involving violence immediately prior to death.

REPRESENTATION:

Counsel:

Assisting: Dr Celia Kemp

Family: Mr Greg Smith (NTLAC) with assistance from Ms Anastasia Coroneo

Judgment category classification: B
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IN THE CORONERS COURT
AT NHULUNBUY IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0020/2007

In the matter of an Inquest into the death of

JOHN RUSSELL RALKURRU MARIKA
ON 3 FEBRUARY 2007
AT HOUSE 23 SKI BEACH COMMUNITY, NHULUNBUY

FINDINGS

(2 January 2007)

Mr Greg Cavanagh SM:

1. This Inquest inquired into the death of John Russell Ralkurru Marika who died early in the morning on Saturday 3 February 2007. His death was unexpected and was thus reportable to me pursuant to s.12 of the *Coroners Act*. The holding of a public Inquest was at my discretion pursuant to s.15 of that *Act*.

2. The deceased's family were legally represented by Mr Greg Smith of NTLAC, Darwin (assisted by Ms Anastasia Coroneo). I heard oral evidence from Senior Constable Roger D'Souza, Rarriwuy Marika, Paul Botharra Yunupingu, Christine Rarrumiya Dhamarrandji, John Garawan Wanambi, Martin Garrangunung Gaykamanu, Doris Rangimula Wanybarrangu, Dr Nigel Buxton (forensic pathologist) by video link and Dr Paull Botterill (forensic pathologist engaged by the family to provide a second opinion) by video link. I also had before me the brief of evidence compiled by the investigating police, the medical records of the deceased and the birth certificate of the deceased.

3. I would like to thank the family for the respect they showed to the Coronial process. Large numbers of family members were present throughout the inquest, as well as attending a meeting with Dr Kemp the day before the

Inquest. I would also like to thank Senior Constable Roger D'Souza for the assistance he provided to my office in organising witnesses for this inquest.

4. Section 34 of the *Coroners Act* sets out the matters that I am required to find, if possible, at an Inquest:

> "(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
>
> (v) any relevant circumstances concerning the death"

Section 34(2) of the *Act* operates to extend my function as follows:

> "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."

FORMAL FINDINGS

5. On the basis of the tendered material and oral evidence at the Inquest I am able to make the following formal findings as required by the *Act*.

(i) The identity of the deceased was John Russell Ralkurru Marika, born on 18 January 1964 in Yirrkala in the Northern Territory of Australia.

(ii) The place of death was at House 23, Ski Beach, Nhulunbuy. The date of death was 3 February 2007 and the time of death was between 1 am and 1:52 am.

(iii) The cause of death was a natural cause, namely a myocardial infarction secondary to coronary atherosclerosis.

(iv) Particulars required to register death:

1. The deceased was male.
2. The deceased's name was John Russell Ralkurru Marika.
3. The deceased was of Aboriginal Australian origin.
4. The cause of death was reported to the Coroner.
5. The cause of death was confirmed by post-mortem examination and was a myocardial infarction secondary to coronary atherosclerosis.
6. The pathologist was Dr Nigel Buxton.
7. The deceased's mother was Djerrkungu. The deceased's father was Daraingu.
8. The deceased lived at 7 Recreation Rd, Yirrkala, Nhulunbuy.
9. The deceased was employed as a Teacher's Aide.
10. The deceased was married to Linda Dhaypilil Marika. They had one child together, Liydia Marrayinga Marika, born on 22 June 1983.

6. Rarriwuy Marika, a cousin of the deceased, gave evidence about him. She told me that he attended school until he was 14 or 15. He had worked as a teacher's aide at the Yirrkala Community Education Centre. He was particularly known for running cultural workshops for kids, taking them out to important places and telling them stories. The deceased was a traditional cultural leader, a cultural custodian and played an important role in ceremonies. He was a popular and much loved member of the community. He was particularly popular with children. He had released a CD called 'Mamba' and was easily persuaded to sing his hit songs. He was a happy person. His family is very saddened and troubled by his unexpected death.

7. I have before me the medical records of the deceased from both the Gove District Hospital and the Yirrkala Health Clinic. He was seen regularly at both places. There was no recorded history of heart disease. He had never

presented with chest pain. Neither his family, nor the deceased himself, were aware that he had heart disease. They considered him a healthy man. He was a heavy smoker of cigarettes and marijuana and drank substantial amounts of kava and alcohol. His wife, Linda Dhaypilil Marika, gave a statement to police which said that he smoked two packets of cigarettes a day.

CIRCUMSTANCES SURROUNDING THE DEATH

8. In the afternoon and evening of 2 February 2007, Daniel Dhundhan Yunupingu had a birthday party at his house, House 2, Ski Beach. Many friends and family came to drink alcohol and celebrate Daniel's birthday. Daniel gave a statement in which he says that the deceased came round at about 6 pm. He says the deceased was 'happy drunk' and he didn't see him fighting or arguing with anyone. Daniel says that at about 8 pm the alcohol ran out, people started leaving and he went inside the house. He didn't see the deceased after that.

9. At some stage after that the deceased made his way to House 23, Ski Beach. Paul Yunupingu and his wife Christine Dhamarrandji were looking after that house for Florence Mununggurr who was unwell. She was also living there, as was her partner Shaun Quilty. All four were at that house that evening, along with Martin Garrangunung Gaykamanu and his wife Doris Rangimula Wanybarrangu, John Wanambi and Robert Gurruwiwi.

10. Florence and Shaun both retired to bed to watch videos, and then go to sleep, fairly early in the evening. Everybody else was sitting on the verandah at the back of the house drinking. At some stage early the next morning, that is on 3 February 2007, Paul Yunupingu became annoyed with the deceased and gave him a push. The deceased ended up going over the verandah, which was 95 cm high, and landed on the dirt on his back. He never got up again.

11. For a short while no-one realised anything was wrong. However when the deceased didn't get up the others became concerned. Paul Yunupingu went to look at him and he wasn't breathing. Paul first tried to revive him by putting ice on his face and chest. However when this failed to have any effect, Paul began cardio pulmonary resuscitation (CPR)– giving the deceased mouth to mouth and then pushing on his chest. He gave evidence he had read about CPR in a book but this was the first time he had ever had to do it. He felt for a pulse but couldn't feel one. After some cycles of CPR Christine used Doris' mobile to call '000'. She ended up making three calls. I have before me the transcript of the calls and the records of the Joint Emergency Services Communications Centre in Darwin that received those calls. There were clear communication difficulties between the operator and Christine. However the operator obtained the address very quickly and dispatched an ambulance very promptly. The call was received a 1:52 am and an ambulance was called for at 1:53 am. The communication difficulties occurred subsequent to the dispatch of the ambulance and thus did not result in a slower response time.

12. After the CPR failed to work those present realised that the deceased was dead. He was placed on a sheet and they sat on the verandah and continued drinking as they waited for the police and the ambulance to come. Police arrived at about 2:10 am and commenced CPR. The ambulance arrived at 2:16 am, and ambulance officers were at the deceased's side at 2:18 am. He was clearly dead.

13. This inquest examined two issues – what was the cause of the death and what were the circumstances of the death.

CAUSE OF DEATH

14. Dr Nigel Buxton, forensic pathologist, thoroughly examined the body of the deceased. He concluded that the cause of death was blockages in the arteries that supply the heart ie coronary atherosclerosis. In simple terms

the deceased had a heart attack. The deceased had a blood alcohol level of 0.311% when he died ie he was very intoxicated.

15. Dr Buxton found two bruises on the vertex of the head of the deceased. They were very shallow. He did not find any fracture to the skull, or any bleeding or swelling inside the skull. He said that the bruises were too trivial to have caused death. He said it is likely that the deceased sustained the bruises when his head hit the ground as he fell. Dr Buxton also found three bruises to the back of the deceased's neck. They were similarly very shallow and Dr Buxton said they would not have caused death, and were likely caused by either when the deceased landed on the ground or during the attempts at CPR. Dr Buxton thoroughly examined the deceased for any signs of trauma that could have contributed to his death and was unable to find any.

16. Dr Buxton examined the deceased's heart. He found that the deceased had very severe coronary atherosclerosis in his four main coronary arteries. The main artery supplying the left ventricle was 80% occluded. Dr Buxton described the deceased's heart as being in a 'very bad condition' (p 61 transcript) and the deceased as a 'walking time bomb for heart disease' (p 61 transcript) stating that he could have died suddenly and without warning at any moment from his heart condition. He explained that it was common for people's first presentation with coronary atherosclerosis to be death, and that is it was not unusual that the deceased had had no symptoms and did not in fact know he had heart disease.

17. He spoke in detail about the risk factors for coronary atherosclerosis, including cigarette smoking, a family history of the disease and diabetes. He spoke about the ways that the risk can be reduced, such as taking daily aspirin, treating with medications to lower blood pressure and cholesterol and reducing dietary fat intake.

18. Dr Botterill was engaged by the family to provide a second opinion. He was provided with Dr Buxton's report, and various slides and photographs taken

during the autopsy. He also concluded that the cause of death in this case was coronary atherosclerosis.

19. He gave evidence about other options that he had considered. He said that sometimes a blow to the head can cause a loss of consciousness without causing changes detectable at autopsy, and that if someone is unconscious they have a reduced ability to protect their airway. It is thus possible that the deceased was unable to breath because of the position he fell in or because of vomitus or something else blocking his airway. However he said this was much less likely than heart disease as a cause of death as no foreign object or vomitus was found and there is no evidence that the blow that caused the bruise was hard enough to cause a loss of consciousness.

20. He also described a condition called 'commotio cordis' where the heart can stop in response to a sudden blow to the chest. He said this was rare, and it has not been described in response to a 'push' to the chest.

21. The family were concerned about black magic. This is something that is generally outside the scope of this forum. However Dr Buxton did say that he examined the heart very thoroughly and there was no bone, or wire, present. In addition he examined the outside of the deceased's body very closely and there was no break where such a foreign object could have entered.

22. I therefore find that the cause of death was coronary atherosclerosis.

23. Dr Buxton gave evidence that a heart attack often occurs just after a stressful event, rather than in the middle of it. Dr Botterill was asked whether an argument preceding the push could have contributed to the death and said *it's hard to say for sure but it's certainly a reasonable suggestion that the stress of the further conflict…raises one's blood pressure temporarily and also increases one's heart rate. The heart has to beat faster and harder to get blood around to the areas of the body that needs them. And that can lead to strain on the heart* (p 84 transcript). I find that the

stress of the situation leading to the push, the stress from the push and the fall and the winding that was likely caused by the landing may well have been precipitating factors for the heart attack in this instance. However, there is no certainty about this, as the deceased's heart disease was so bad that the heart attack may have happened without any of the precipitating causes.

24. I find that it is likely that the deceased died within minutes of Paul Yunupingu going to see him and noticing that he wasn't breathing. However it was difficult to get accurate estimates of when exactly this occurred and the time period between him landing on the ground and the ambulance being called, which occurred at 1:52 am. I find that the deceased died between 1am and 1:52 am but am unable to be more precise about the time.

CIRCUMSTANCES SURROUNDING THE DEATH

25. There was less consensus about this aspect of the evidence and a lot of contradictory evidence before me. There are many reasons for this. The first was that the witnesses were all very drunk which has impaired their ability to remember what occurred. In addition there is great sadness, some anger and some blaming in response to this death meaning that witnesses may well have felt less free to tell their story. Finally there was some evidence that some culturally offensive comments were made on the evening, and this is a topic that is shameful and inappropriate to discuss, perhaps resulting in an unwillingness to fully detail what happened.

26. However I am able to make findings on some key points. Firstly I find that the deceased said something that upset Paul Yunupingu. I am unable to find what exactly this was. Paul and Christine told police in their statements and then gave evidence that the deceased was angry when he arrived, and during the course of the evening was swearing at various people. They both also give evidence that the deceased was humbugging Paul for grog. John Wanambi does not remember either of these things occurring. However his

evidence was that he was not sitting close enough to have heard what the deceased was saying. In addition his evidence overall does not fit with what everyone else says, nor what was told to police on the night, and I find that he was not a reliable witness, probably due to the state of his intoxication on that evening. Doris Wanybarrangu did not describe any trouble, stating that she was sleeping when it occurred. Martin Gaykamanu was unable to remember anything and I find that he was extremely intoxicated and asleep in a chair during these events.

27. Paul Yunupingu told me during his evidence that the deceased had said something culturally offensive to Doris that breached the avoidance relationship between the two of them. Christine expanded on this in her evidence, stating that the deceased had asked Doris to go to the bedroom with him and that this was very offensive. Doris was asked about this and said she was asleep through the evening and she didn't hear anything much.

28. Overall I find that Paul was upset about something the deceased said. As to whether it was swearing, humbugging for grog, culturally inappropriate words to Doris or a combination of these I am unable to say.

29. Paul was the occupier of the house. The deceased was no longer welcome because of what he was saying. I find that Paul pushed the deceased using two open hands to the deceased's chest with moderate force, as described by both Paul and Christine. John Wanambi's version of events – that Paul came up behind the deceased with two arms under the armpits of the deceased and *gently threw* him from the verandah is not only inconsistent with what Paul and Christine say, but it is also inconsistent with Mr Wanambi's statement to police and thus I do not accept it.

30. I find that the deceased was sitting on a plastic chair near the end of the verandah immediately before the push. I find that he was in the process of standing up when he was pushed by Paul Yunupingu. There is some evidence that he stumbled then fell. It is clear that he was very drunk and thus likely to be very unsteady on his feet. A combination of the force from

the push and his unsteadiness meant he stumbled and fell backwards from the verandah, landing on his back on the ground.

31. I find that Paul Yunupingu intentionally pushed the deceased and that his intent was that the deceased should stop saying the things that were upsetting him. It is unclear on the totality of the evidence whether Paul intended that the deceased go over the verandah. It is clear that Paul had no intent to kill the deceased. This is shown by his evidence, but also by the commendable efforts he made to try to resuscitate the deceased.

32. I have some concerns about the initial police investigation of this matter. In my view, there was an early presumption made that the death was an accident with no suspicious circumstances. I believe this presumption was made too early in the investigation. No notes were made of what the witnesses said when police arrived, and thus Senior Constable D'Souza was unable to tell me who had said what. The witnesses weren't separated and interviewed separately. The area was not declared a crime scene and formal interviews were not done expeditiously. As it turned out, the initial presumption, in my view, was correct ie this was not a homicide but from the information the police had on arrival it could easily have been (for instance if the cause of death had been a bleed inside the head caused by the fall).

RISK TO OTHER FAMILY MEMBERS

33. I note the evidence from the forensic pathologists that heart disease has a genetic link. I encourage those related to the deceased by blood to have regular contact with health services in relation to their hearts, and to stop smoking.

REFERRAL TO OTHER AGENCIES

34. I have given some consideration as to whether I should refer this case to the Commissioner of Police and the Director of Public Prosecutions pursuant to s 35 of the *Coroner's Act*. The central question is whether Mr Yunupingu's

push satisfies the test in section 35 of the *Coroners Act*, that is, that a crime may have been committed in relation to this death.

35. Given my findings on the cause of death, I do not consider that there is sufficient evidence that the push from Mr Yunupingu caused the death. Thus there are no offences in relation to the death of the deceased. It was put to me that the push with both hands by Mr Yunupingu may constitute an aggravated assault. For this to be so it must have caused 'harm' as defined in s IA *Criminal Code.* There is evidence before me that could possibly satisfy this definition. Therefore I am obliged to report this matter to the Director of Public Prosecutions and the Commissioner of Police pursuant to section 35 of the *Coroners Act* on the basis that Paul Yunupingu *may* have committed an aggravated assault pursuant to s 188 *Criminal Code.*

RECOMMENDATIONS

36. I report this matter to the Director of Public Prosecutions and the Commissioner of Police pursuant to section 35 of the *Coroners Act* on the basis that Paul Yunupingu may have committed the crime of aggravated assault pursuant to s 188 *Criminal Code.*

Dated this 2nd day of January 2008.

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GREG CAVANAGH
TERRITORY CORONER