CITATION: *Inquest into the death of Lindsay Ryan* [2003] NTMC 060

TITLE OF COURT:	CORONERS COURT
JURISDICTION:	Coronial
FILE NO(s):	D0229/2002
DELIVERED ON:	3 December 2003
DELIVERED AT:	Darwin
HEARING DATE(s):	3 November 2003
JUDGMENT OF:	Mr Greg CAVANAGH SM

CATCHWORDS:

Coronial Inquest, death in custody, death from natural causes,

REPRESENTATION:

Counsel:

Counsel Assisting:	Ms Elizabeth Morris

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

No. D0229/2002

In the matter of an Inquest into the death of

LINDSAY RYAN
ON 19 DECEMBER 2002
AT DARWIN CORRECTIONAL CENTRE

FINDINGS

(Delivered on 3 December 2003)

Mr GREG CAVANAGH:

1. This death is properly categorised as a death in custody. At the time of his death, Lindsay Ryan (the deceased) was a person lawfully committed to be detained at the Darwin Prison. The deceased, therefore, was a "person held in custody" within the definition in s.12 (1)(b) of the *Coroners Act* 1993 (NT) ("the Act"). His death is a "reportable death" which is required to be investigated by the Coroner pursuant to s.14 (2) of *the Act*; a mandatory public inquest must be held pursuant to s.15 (1)(c).

2. The scope of such an inquest is governed by the provisions of sections 26 and 27 as well as sections 34 and 35 of *the Act.* It is convenient and appropriate to recite these provisions in full:

"26. Report on Additional Matters by Coroner

(1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner –

(a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to

by injuries sustained while being held in custody; and

(b) may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

(2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.

27. Coroner to send Report, &c., to Attorney-General

(1) The coroner shall cause a copy of each report and recommendation made in pursuance of s 26 to be sent without delay to the Attorney-General.

34. Coroners' Findings and Comments

(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 subs (1)(a)(iv) are provided to the Registrar, within the meaning of the *Births, Deaths and Marriages Registration Act*.

35. Coroners' Reports

(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."

CORONERS FORMAL FINDINGS

3. In accordance with the statutory requirements under *the Act*, the following are my formal findings arising from this Inquest:

   i. Identity: The Deceased is Lindsay Ryan, a male Aboriginal Australian, who was born on the 17th of April 1969 in Katherine.

   ii. The time and place of death: The Deceased died at Darwin Correctional Centre at approximately 11:35 hrs on the 19th of December 2002.

   iii. The cause of death: The cause of death was coronary atherosclerosis, contributed to by cardiac hypertrophy.

   iv. The particulars required to register the death are as follows:

a) The Deceased was a male;

b) The Deceased was Aboriginal;

c) A post mortem examination was carried out on 21 December 2002 and the cause of death was coronary atherosclerosis, contributed to by cardiac hypertrophy;

d) The pathologist viewed the body after death;

e) The pathologist was Dr Terence John Sinton, Forensic Pathologist at the Royal Darwin Hospital;

f) The father of the Deceased is Jacky Daiwonga Naritj Rembarrnga Ryan;

g) The mother of the Deceased is Violet Mudu'Ula'Un Berlin Ngalkbun;

h) The Deceased resided at the Darwin Correctional Centre at the time of his death; and

i) The Deceased was not employed at the time of his death.

The relevant circumstances concerning the death

4. The details of the inquest were advertised in the "Northern Territory News" on the 25th of August 2003. The public inquest was held at the Darwin Magistrates Court, on Monday the 3rd of November 2003. Counsel assisting me was Deputy Coroner Elizabeth Morris.

5. The next of kin were not present at the Inquest, nor were they represented. I quote from Counsel Assisting:

> "…our office has found two people from the Beswick Community where he's from: Frederick Ryan, his brother, and Pam Weston, his auntie. Pam Weston was the person who organised his funeral arrangements on behalf of the community

> that he was from. Both of those people were notified by mail on 14 August that this inquest was going to be on today and did not contact our office in the interim period between now and then…..
>
> A brief and a letter was sent to the Director of KRALAS…on 15 September 2003. No contact was had from that office. A brief was also sent to Chris Howse of the Aboriginal Justice Advisory Committee…. No contact was had from him. I contacted the Director of KRALAS this morning, spoke to both him and one of the legal officers there, and I also rang the Beswick Community and left a message for Ms Weston who works near the Community Council offices. Ms Weston contacted KRALAS and they had also previously spoken to her.
>
> Through speaking to them, she informs us that she has no questions or issues. She's aware that should she wish to peruse the brief there's a copy held for her at KRALAS, but that she does not wish to attend the proceedings today".

6. I proceeded to hear the Inquest, in their absence, pursuant to regulation 9 of the Coroner's Regulations.

7. No witnesses were called. Four exhibits were tendered, including the Coronial brief of evidence, the deceased's birth certificate, the post mortem report and the deceased's hospital and prison records. The brief included numerous statements and other documentary records, and was very thorough. Detective Sergeant Stuart Davis conducted the investigation pursuant to Police General Orders covering deaths in custody. Some twenty eight witnesses were spoken to and completed recorded interviews.

8. From this evidence I find that the deceased was lawfully in custody, having been convicted of driving whilst disqualified and exceeding .08% BAC (0.124%) in the Katherine Court of Summary Jurisdiction on the 9th of October 2002. He was sentenced to imprisonment for seven months, which was backdated to the 14th of August 2002. He was due for release on the 13th of March 2003. This was his twelfth term of imprisonment at the Darwin Correctional Centre.

9. On the date of his death the deceased had been performing manual labour. He was driving a tractor and grass slashing. The deceased had performed this work before. During a break the deceased complained to his supervising prison officer, Mr Paul Williams, of chest pains and feeling dizzy. The officer immediately contacted the prison medical centre by telephone, informing them that he was bringing the deceased in with chest pains.

10. Whilst driving to the medical centre the deceased began to convulse. First aid was given until they arrived at the prison gates, where the prison medical team treated the deceased. They were unable to obtain a pulse or any vital signs. He was later conveyed by St John Ambulance to Royal Darwin Hospital, where he was formally declared deceased.

11. The post mortem examination revealed that the deceased, who was overweight, had extensive and severe coronary artery disease and coronary atherosclerosis. He had an abnormally enlarged heart (cardiac hypertrophy). His prison medical records reveal that his only consultations with them were in relation to unrelated minor complaints, such as a football injury. He did complain of "heartburn" on the 12th of November 2002, and was given Mylanta tablets. The deceased had not lived a healthy lifestyle, being a binge drinker and smoking a packet of cigarettes a day.

12. The deceased's sad death was untimely, given that he was still a young man. Whilst apparently relatively healthy, his heart had been labouring for some time, without any symptomatology or any warning that the deceased or others had or should have noticed.

13. I have no adverse comments to make about anyone in respect of this death. The medical care that the deceased received within the prison was appropriate and adequate. Prison officer Williams acted properly and quickly in relation to the complaint of the deceased prior to death.

14. There are no relevant recommendations arising from this Inquest pursuant to section 26 (2) regarding the prevention of future deaths and there was nothing untoward or improper in the care and supervision of the deceased prior to his death.

15. I find that there is no evidence of the involvement of any other person or any suspicious circumstances relating to the death of the deceased and, accordingly no report is required under s.35(3) of the *Act*. Furthermore, I find that the deceased did not sustain any injuries whilst being held in custody which caused or contributed to this death.

16. Given the circumstances of the deceased's death, there are no recommendations to be made pursuant to s. 35(2) of the *Act*.

Dated this day of December 2003

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Greg CAVANAGH

TERRITORY CORONER