CITATION: *Inquest into the death of Maxwell Theo Murphy* NTMC [2004] 008

TITLE OF COURT:	CORONERS COURT
JURISDICTION:	Coronial
FILE NO(s):	D011/2002
DELIVERED ON:	16 February 2004
DELIVERED AT:	Darwin
HEARING DATE(s):	1,2,3 December 2003
JUDGMENT OF:	Mr Greg CAVANAGH SM

CATCHWORDS:

Coroners Inquest: Death following a physical fight, commission of offences, referral to DPP and Commissioner of Police

REPRESENTATION:

Counsel:

Counsel Assisting:	Ms Elizabeth Morris
For Jason Rogers	Mr Alan Woodcock

Judgment category classification:	B
Judgment ID number:	NTMC [2004] 008
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Number of pages:	10

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

No. D011/2002

In the matter of an Inquest into the death of

MAXWELL THEO MURPHY
ON 16 JANUARY 2002
AT ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered on 16 February 2004)

Mr GREG CAVANAGH:

1. Maxwell Theo Murphy (the deceased) died in the Intensive Care Unit of the Royal Darwin Hospital at 23:03hrs on Wednesday the 16th of January 2002. He had not regained consciousness after six days in hospital following an injury received at about 06:45 hrs on the 10th of January 2002. His death is thus a "reportable death" pursuant to section 12 of the *Coroners Act* 1993 (NT) ("the Act"), having been caused by an "accident or injury". A discretionary public inquest was held pursuant to s.15 (2)

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

> **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."

3. The details of the inquest were advertised in the "Northern Territory News" on the 8th of September 2003. The public inquest was held at the Darwin Magistrates Court, on Monday the 1st of December, 2003 and continued until Wednesday the 3rd of December. Counsel assisting me was Deputy Coroner Elizabeth Morris.

4. Mr Alan Woodcock made application and was granted leave to appear pursuant to *the Act*, for Mr Jason Rogers, a person involved in the circumstances surrounding the death of the deceased.

5. Members of the deceased's family were present at the Inquest and heard the evidence as it unfolded.

6. Twelve witnesses were called. Three exhibits were tendered, including the Coronial brief of evidence, the deceased's birth certificate and the deceased's hospital records. The brief included numerous statements and other documentary records, and was very thorough. Detective Senior Wayne Whitlock conducted the investigation.

7. On Monday I heard from the police witnesses, as well as Jason Rogers and Sheralie Shadforth, the deceased's de facto wife at the time of his death. Little turned on the police evidence in relation to the circumstances surrounding the injury received by the deceased. The three main witnesses to those events are Mr Rogers, Ms Shadforth and Ms Vanessa Clay. I heard from Ms Clay on Tuesday. I also heard from two St John Ambulance officers on that day.

8. I was also assisted by the forensic evidence given by Dr Derek Pocock and by the medical evidence of Dr Darren Foreman.

CORONERS FORMAL FINDINGS

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

   i. Identity: The Deceased is Maxwell Theo Murphy, a male Aboriginal Australian, who was born on the 26th of January 1973 in Carlton.

   ii. The time and place of death: The Deceased died at Royal Darwin Hospital Intensive Care Unit at 23:03 hrs on the 16th of January 2002.

iii. The cause of death: The cause of death was cerebral contusions and a fractured skull following a blow to the back of the head.

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

a) The Deceased was a male;

b) The Deceased was an Aboriginal Australian;

c) A post mortem examination was carried out on 17 January 2002 and the cause of death was cerebral contusions and a fractured skull.

d) The pathologist viewed the body after death;

e) The pathologist was Dr Derek Alan Pocock, Locum Forensic Pathologist at the Royal Darwin Hospital;

f) The father of the Deceased is William Sariago;

g) The mother of the Deceased is Helen Ann Murphy (nee Stoner);

h) The Deceased resided at Jabiru at the time of his death; and

i) The Deceased was employed as a tour guide at the time of his death.

Personal circumstances of the deceased

10. The deceased was a young man of 28 at his death. He had been in a de facto relationship with Ms Sheralie Shadforth for some four years. Whilst born and raised in Melbourne, he had in the year prior to meeting her, come to the Northern Territory. They had no children at the time of his death, but Ms Shadforth has subsequently borne the deceased a son.

11. He was employed as a tour guide on the East Alligator river. He enjoyed his work, which was seasonal, and appeared to be a well thought of employee. He was part of a large family group within the Darwin area.

The relevant circumstances concerning the death

12. From the evidence I find that the deceased spent the evening of the 9th of January 2002 at Unit 7/6 Timpson Court, Gray. This was the residence of Vanessa Clay. Ms Shadforth was also present, as was Ms Clay's young daughter. He had consumed some alcohol but was not unduly affected. He went to sleep in the lounge room of the residence near Ms Shadforth. Ms Clay slept in her bedroom.

13. At around 0500hrs on the 10th of January Mr Jason Rogers visited the unit. He was there to see his girlfriend, Ms Clay. Mr Rogers did not like the deceased or Ms Shadforth, although this was a surprise to Ms Shadforth, who had thought up until then that they got on fine.

14. Ms Clay told Mr Rogers that the deceased and Ms Shadforth were staying overnight and that they had car trouble on their way in from Jabiru. Mr Rogers went into the lounge room, and woke the deceased by shaking him with his hand, (I prefer the evidence of Ms Shadforth to Mr Rogers in that respect). He was angry with the deceased and either asked him to "get up" or to leave. He desisted when Ms Clay reminded him that there were children in the unit, and went with Ms Clay to her room.

15. After a time Ms Clay and Mr Rogers went for a walk. They argued over various things during this time. It was during this walk that Mr Rogers said to Ms Clay that he was going to kill Max. Ms Clay became distraught whilst giving this evidence, and I find that she was truthful in her recall of this conversation. However even though I find that these words were spoken I do not think that they were more than bravado or an indication of ill feeling, rather than any indication of real intent to deprive Mr Murphy of his life.

16. Upon their return to the unit they both agreed that Mr Rogers should leave. Whilst Ms Clay remained outside, Mr Rogers went inside and gathered his two bags. Mr Rogers told the Court that he did not speak to the deceased at this time, however I find that it is probable that he did go into the lounge area where the deceased was, and said something to him. If these words were some kind of invitation to fight I believe Ms Shadforth would have immediately walked out after both men, in an attempt to intervene. From her evidence she did not. The remarks may have been mere insults, I am unable to determine exactly what they were.

17. What occurred therefore is to be found in the evidence of the three witnesses, viz. Rogers, Shadforth and Clay. Two of these witnesses did not see all events unfold and one of whom, Mr Rogers, was in my view downplaying his role in the altercation with the deceased. Even given those provisos, the evidence was relatively complementary. The deceased followed Mr Rogers to the gate area of the unit, who then turned and dropped his bags. Because of the closeness of the deceased Mr Rogers assumed that the deceased was about to punch him. Mr Rogers threw a couple of punches at the deceased. He then moved backwards into the courtyard area. The deceased, having been hit by Mr Rogers, moved forward and attempted a few hits himself, none of which connect. However Mr Rogers threw a few more punches, some of which did connect.

18. Ms Shadforth had come out by this time, and attempted to intervene, but was told to get out of the way by Mr Rogers. She then attempted to either distract him or punish him, I am undecided, by throwing a rock at his car which was in the court yard.

19. Mr Rogers kicked the deceased in an attempt to disable him, but this did not work. Mr Rogers told me that the deceased then rushed Mr Rogers in a rugby style tackle. Both Ms Shadforth and Ms Clay saw the two men in a position which is consistent with this, ie, the deceased was bent slightly

and had his head into the chest area of Mr Rogers. Mr Rogers told me that around that time the deceased then took a firm hold of his testicles. This caused him a considerable amount of pain. In an effort to force the deceased to release his grip, he pulled his hair and punched the deceased on his chin.

20. From the evidence I find that it is probable that this punch caused the deceased to lose consciousness. This accords with the evidence of Ms Clay, who saw the deceased fall "like a jelly" and Ms Shadforth, who saw the deceased with his arms loose at his side. Mr Rogers then pushed the deceased away from him. They were both near the garden plot alongside the fence at the front of the units. I am unable to find whether the deceased fell solely due to the push of Mr Rogers, or if he stumbled as well. It was the deceased striking his head as a result of this fall that caused the fatal contre-coup injury.

21. Ms Shadforth and Ms Clay immediately attended the deceased, who was obviously seriously injured. Ambulance and police officers were called and attended in a short space of time. The deceased was taken to hospital, where, despite medical intervention, he passed away in the Intensive Care Unit of the Royal Darwin Hospital at 2303hrs on the 16th of January 2002 without regaining consciousness.

22. I have no adverse comments to make about anyone connected to the medical treatment of the deceased. The medical care that the deceased received from both St John Ambulance and Royal Darwin Hospital was appropriate and adequate.

23. Dr Pocock, a senior and experienced forensic pathologist, performed a post mortem examination on the deceased. He gave evidence before me by video conference. He found no bruising or other evidence that the deceased had been in a fight. Dr Pocock also found that the deceased was not as healthy as he appeared as a young man of 28, in that he had heart

disease, and that there was evidence of past lung disease. In Dr Pocock's opinion, this disease may have complicated the fatal outcome.

24. Counsel assisting me also put to the doctor (Transcript p.65):

> "Now in the – on the third page, the final page of your report, in your comments, you say: "Death is due to the head injury following a blow applied to the back of the head causing primary injuries to the opposite sides of the brain, contracoup –'is that how you say it – "injuries? ---that's correct
>
> And that means that, perhaps, doctor ---? ---If you're going to blow to one side – the back of the head, the injuries occur to the front because the brain moves inside the skull when an impact occurs. And so you get opposite side injury to the point of contact, if you like. So if you fall on the back of your head, as will be evidence in this instance, you will in actual fact bruise the front of your brain.
>
> You also note in that paragraph that there was a fracture at the back of the skull but the skull is noted to be thinner than normal; do you mean the thickness of the bone was a bit thinner than a normal human skull?---The thickness of the bone was about a third of the normal thickness of an adult skull, which means of course a relatively smaller blow or less severe blow is at risk of causing a fracture and then the complications that come from that.
>
> THE CORONER: I think they call it – are you suggesting he had a bit of an eggshell skull? ---Yes, but not- that's a rather gross exaggeration. ….
>
> It was going to be much easier to fracture than someone else?---Correct."

25. When asked about the degree of force used to cause the kind of injury that the deceased suffered, Dr Pocock opined that "…if he had been thrown, in other words if you like, an accelerated blow to the back of the head, I would've expected more damage to the skull. This to me is almost a simple falling backwards." (Transcript p.66)

26. Having made the above findings as to what occurred leading to the fatal injury of the deceased, I must turn my attention to my duty under the act to consider whether a crime has been committed.

27. The Act states that I shall report to the Commissioner of Police and the Director of Public Prosecutions if I believe "that a crime *may have* been committed in connection with a death."

> "The standard of proof for a coronial finding is on the balance of probabilities on the sliding "Briginshaw scale". This was confirmed by Gobbo J in *Anderson v Blashki* and Southwell J in *Secretary to Department of health and Community Services v Gurvich*. Thus even allegations of assault need to be proved only on the balance of probabilities even though they are of a criminal nature. However, "because of the gravity of the allegation, proof of the criminal act must be 'clear, cogent and exact and when considering such proof, weight must be given to the presumption of innocence.'" The result is that the distinction between the criminal and civil standards in such matters may not be of major consequence. Although in some jurisdictions coroners may still commit for trial, it is probable that in respect of coronial as opposed to committal findings the standard of proof is the civil standard, but on a scale that slides toward the criminal standard depending upon the seriousness of the findings made." (Ian Freckelton, "Inquest Law" in The Inquest Handbook, The Federation Press)

28. Considering the circumstances of the lead up to the altercation, I do not find that the deceased was the victim of an assault. An assault being (section 187 *Criminal Code*):

> "a) the direct or indirect application of force to a person without his consent or with his consent if the consent is obtained by force or by means of menaces of any kind or by fear of bodily harm or by means of false and fraudulent representations as to the nature of the act or by personation; or
>
> (b) the attempted or threatened application of such force where the person attempting or threatening it has an actual or apparent present ability to effect his purpose

and the purpose is evidenced by bodily movement or threatening words,

other than the application of force –

(c) when rescuing or resuscitating a person or when giving any medical treatment or first aid reasonably needed by the person to whom it is given or when restraining a person who needs to be restrained for his own protection or benefit or when attempting to do any such act;

(d) in the course of a sporting activity where the force used is not in contravention of the rules of the game; or

(e) that is used for and is reasonably needed for the common intercourse of life."

29. The evidence shows that the deceased followed Mr Rogers from the unit. Mr Rogers was clearly in the process of leaving, as he was carrying his bags. Whilst the deceased may have been struck first by Mr Rogers, he entered the fray by continuing to follow Mr Rogers out the gate and into the courtyard. He traded blows, and then came in close and pushed Mr Rogers backwards towards the fence.

30. The evidence of the forensic pathologist supports these findings, there being a lack of evidence of great force used against the deceased in order to cause his injury.

31. I find that there is insufficient evidence of a crime that may have been committed in connection to the death of the deceased and, accordingly no report is required under s.35(3) of *the Act*. The death of the deceased was accidental and unintended.

32. The deceased was a much loved member of his family. He was to be a father, and his de-facto, Ms Shadforth, has named their then unborn child after him. He did not deserve to die, and his sad death was untimely. It appears a senseless tragedy.

Dated this 16th day of February 2004

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GREG CAVANAGH

TERRITORY CORONER