



STATE CORONER'S COURT OF NEW SOUTH WALES

Inquest:	In the Matter of Rhyan Dickson
Hearing dates:	28 August 2014
Date of findings:	26 February 2016
Place of findings:	New South Wales State Coroners Court, Glebe
Findings of:	Deputy State Coroner E.Truscott
Catchwords:	Coronial Law-Cause and manner of death-
File number:	2013/00004981
Representation:	Sgt Samantha Ferguson, Advocate Assisting the Coroner
Findings:	That Rhyan Dickson died on 4 January 2013 at Canterbury Hospital Canterbury from complications of blunt force head injuries caused by Darryl John Stacey on 16 October 2011 at Elizabeth Street Waterloo
Recommendations:	None

1. This is an Inquest into the death of Rhyan Dickson born 2 August 1989. Rhyan's death was reported to the Coroner by police on 4 January 2013. He died at Canterbury Hospital on that date. Rhyan was hospitalised and did not recover from head injuries sustained on 16 October 2011. Rhyan who was just 22 years old, was walking home on the footpath when without any provocation or apparent reason, he was punched by Daryl Stacey who was also walking home after having attended a wedding reception. Rhyan was punched about 3 times to the face and body, he fell backwards and his head struck the concrete kerb resulting in a fractured skull and severe brain injury.
2. From 16 October 2011, Rhyan, underwent numerous successful life-saving medical interventions. However, he continued to suffer profound neurological impairment. His respiration was enabled by a tracheostomy tube and he was never considered to be a candidate for its removal. At the time of his death Rhyan was in palliative care and on 3 January 2013 he entered respiratory distress and then arrest in the early hours of the following day.
3. Throughout this time Rhyan's mother, Lynette Bowers, his father and brother have suffered with Rhyan and now bear a great loss that can never be filled.
4. Under s27(1)(a) of the Coroners Act 2009 an Inquest is required to be held if it appears to the Coroner that the person died or might have died as a result of a homicide. Rhyan's family, requested an Inquest so that the Coroner would enter a finding that Rhyan died from the injuries received when punched by Mr Stacey.
5. I have received a brief of evidence which founded the prosecution of Mr Stacey. The brief also includes evidence that on 13 July 2012 Daryl Stacey was sentenced to a 6 year 9 month term of imprisonment for an offence under s35(2) of the Crimes Act. A non-parole period of 4 years and 9 months was imposed. The sentence commenced on 21 October 2011 and Mr Stacey will be eligible to be considered for parole on 20 July 2016.
6. Following the Report to the Coroner, the Coroner directed that the Brief be served by 5 April 2013 and made orders for a post mortem examination. A report from Dr Orde who carried out that examination dated 29 April 2013 provides an opinion that the direct cause of Rhyan's death as "complications of blunt force head injuries". Following receipt of that Report, the Officer in Charge wrote to the Office of the Director of Public Prosecutions with the view of ascertaining whether the police should lay a homicide charge against Mr Stacey.
7. By letter of 4 December 2013 Ms McNamara, on behalf of the Office of the DPP advised Detective Hanson that there was insufficient evidence to charge Mr Stacey with murder and though, subject to further inquiries, there may be sufficient evidence to charge Mr Stacey with manslaughter and no legal impediment in doing so, the Director would not prosecute Mr Stacey for manslaughter. A copy of that letter is found at Tab 3 of the folder of Brief of evidence.

8. There is no indication as to what Ms McNamara considered to be those “further inquiries” but it may relate to matters raised by Dr Orde , where he says on page 4 of his Report *“It is advised that opinions be sought from medical and nursing personnel who had been treating the deceased prior to death. Efforts should also be made to clarify the observations made by the persons who discovered the deceased in respiratory arrest and attempted resuscitation on the morning of 4 January 2013. It would also be prudent to seek expert opinions from an independent neurosurgeon with in-depth experience in the long-term management of persons with head injury, and a doctor with expertise in clinical chemistry and parenteral nutrition. In light of this further information it may be possible for the autopsy pathologist to refine the proffered cause of death”*.
9. I am of the view that no such refinement is necessary. In any event on 28 August 2014 I suspended the inquest and referred the matter to the Office of the Director of Public Prosecutions under section 78(1)(b) of the Coroners Act 2009. I indicated at that time that I expected that there would be no further prosecution but that I did not have a discretion to not refer the matter for that reason.
10. On 18 March 2015 the Office of the Director of Public Prosecutions wrote to me indicating that due to the sentence imposed on Mr Stacey a decision had been made not to further prosecute Mr Stacey. I do not know why but that letter was not brought to my attention until 20 December 2015 upon which I determined to resume the inquest under s79 of the Act solely for the purpose to complete my findings, a course which I had indicated to Rhyans’s family and Mr Stacey at the time the inquest was suspended. Notice was provided as to what my finding was to be.
11. Accordingly, relying on the evidence to which I have already referred I now enter the finding as follows: That Rhyan Dickson died on 4 January 2013 at Canterbury Hospital Canterbury from complications of blunt force head injuries caused by Darryl John Stacey on 16 October 2011 at Elizabeth Street Waterloo.

Magistrate E Truscott
Coroner
26 February 2016