INQUEST INTO THE DEATH OF SCOTT JOHNSON

SUBMISSIONS OF COUNSEL ASSISTING ON THE QUESTION OF THE STATE CORONER'S JURISDICTION TO HOLD A FRESH INQUEST UNDER SECTION 83 OF THE *CORONERS ACT* AND AS TO WHETHER A FRESH INQUEST SHOULD BE HELD UNDER THAT PROVISION

BACKGROUND

1. At approximately 11am on Saturday 10 December 1988, the body of Mr Scott Johnson was discovered by a fisherman on the rocks at the base of North Head, Sydney, near Blue Fish Point.

2. Two inquests have been held into Mr Johnson's death. The first inquest was held in 1989, before then Deputy State Coroner Derek Hand ("the first inquest"). On 16 March 1989, his Honour found that Mr Johnson died between 8 and 10 December 1988 at North Head Manly, north of Blue Fish Point, after intentionally jumping from the cliff with a view to taking his own life.

3. A second inquest was held before Deputy State Coroner Forbes on 27 June 2012 ("the second inquest"). Evidence was given in the second inquest that Mr Johnson was a homosexual man, and that he had been located in the vicinity of what police now know to be a "gay beat". In her Honour's findings in respect of the second inquest, Deputy State Coroner Forbes indicated that the investigation preceding the inquest had "not taken the case any further" but noted that information about some additional deaths in the Bondi area connected with gay hate crime had "sown a seed of doubt as to that positive finding made of suicide".

4. Her Honour then proceeded to make the following "formal findings", as required by s. 81 of the *Coroners Act*:

> "Accordingly, I find that the evidence adduced in Mr Johnson's death does not enable me to make a finding as to how he fell

> off the cliff and I make an open finding and refer his file to cold cases for further investigation in accordance with police procedure and protocol. The formal finding that I make is that Mr Scott Russell Johnson died between 8 and 10 December 1988 at North Head, Manly, north of Blue Fish Point from the effects of multiple injuries he sustained as a result of falling from a cliff. The evidence does not allow me to make a finding as to how he fell."

5. It can be seen from the above that, in the second inquest, Deputy State Coroner Forbes made the statutorily required findings of date, identity and cause of death. Her Honour's finding as to manner was in part a finding that the deceased had sustained injuries in a fall, but was an open finding insofar as her Honour was unable to say whether the fall was accidental, intentional, or self-inflicted.

6. A New South Wales Police Force ("NSWPF") strike force was subsequently established to further investigate Mr Johnson's death. Further material has also been provided to NSWPF by Mr Johnson's family. Detective Chief Inspector Pamela Young of the Unsolved Homicide Team has prepared a detailed statement for the Coroner, together with a supplementary statement, concerning the further material that has been obtained by NSWPF. NSWPF has advised that these statements contain material of a confidential nature, such as information concerning details of a registered source. For this reason, the Commissioner of Police seeks that a non-publication order (and / or an order under s. 65(4) of the *Coroners Act*) be made in respect of the statements.

7. In view of the new material which has been provided, Mr Johnson's family seeks that a further fresh inquest be held into Mr Johnson's death under s. 83 of the *Coroners Act*. However, the previous inquest concluded with an open finding as to manner of death. Prior to your Honour's consideration of whether a third inquest should be held into Mr Johnson's death pursuant to s. 83, it is necessary to consider whether Deputy State Coroner Forbes remains seized of jurisdiction. If Deputy State Coroner Forbes does remain seized of jurisdiction by virtue of the open finding, then it would be necessary for Deputy State Coroner Forbes to consider whether there should be any further

oral hearings in the inquest. On the other hand, if Deputy State Coroner Forbes does not remain seized of jurisdiction, it would be appropriate for your Honour to consider whether a fresh inquest should be held under s. 83 of the *Coroners Act*.

8. For the reasons outlined below, it is submitted that Deputy State Coroner Forbes' jurisdiction was exhausted by her statutory findings. Accordingly, it is appropriate for your Honour to consider whether to order that a fresh inquest be held under s. 83 of the *Coroners Act*.

9. In determining whether to hold a fresh inquest under s. 83 of the *Coroners Act*, it will be necessary for your Honour to consider material over which the Commissioner of Police seeks non-publication / non-disclosure orders (or a ruling of public interest immunity). It is submitted that, provided your Honour is of the view that Deputy State Coroner Forbes is *functus officio* and that your Honour has jurisdiction to consider whether a fresh inquest should be conducted, it would be appropriate for the orders sought by the Commissioner of Police to be made after the material has been tendered in the proceedings on 13 April 2015.

10. It is further submitted that it would be appropriate for your Honour to order that a fresh inquest be held under s. 83 of the *Coroners Act*.

WHETHER DEPUTY STATE CORONER FORBES IS *FUNCTUS OFFICIO*

The *functus officio* doctrine and open findings

11. In general, once a decision maker "has reached a final decision in respect to the matter that is before it in accordance with its enabling statute, that decision cannot be revisited because the tribunal has changed its mind, made an error within jurisdiction or because there has been a change of circumstances": *Minister for Immigration v Bhardwaj* (2002) 209 CLR 597 ("*Bhardwaj*") at 615, per Gaudron and Gummow JJ, quoting with approval the Canadian Supreme Court in *Chandler v Alberta Association of Architects*.

12. This principle, which is known as the *functus officio* doctrine, is based upon the principle that "once [a] statutory function is performed there is no further

function or act for the person authorised under the statute to perform": *Jayasinghe v Minister for Immigration and Ethnic Affairs* (1997) 48 ALD 265 at 274. The doctrine recognises the importance of finality in the decision making process: *Bhardwaj* at 603, per Gleeson CJ; *Kabourakis v Medical Practitioners Board of Victoria* [2006] VSCA 301.

13. It has long been accepted that a coroner is *functus* once the coroner has returned his or her verdict: *R v White* 3 E & E 137; 121 E.R; *Terry v East Sussex Coroner* [2002] Q.B. 312. The question that arises is whether the partial open finding as to manner of death is sufficient to render her Honour *functus officio*, so that it would not be open for her Honour to continue to hear further evidence in respect of the death.

14. Although the *Coroners Act* does not expressly make provision for the entry of an open finding, such findings (also known as "open verdicts") are well accepted at common law. In *Reg London Coroner*; *ex parte Barber* [1975] 1 WLR 1310 at 1315, Lord Widgery CJ emphasised the importance of open findings, stating:

> "I would impress upon coroners that if they find themselves compelled to return an open verdict, that is not in any sense a reflection on them. It does not suggest that they are not doing their job properly or are insufficiently perceptive. There are many, many cases where there is a real doubt as to the cause of death and where an open verdict is right, and where anything else is unjust to the family of the deceased."

See similarly, *R v HM Coroner v Northamptonshire; ex parte Anne Walker* (1989) 153 JP 356.

15. It is also noted that the possibility of an open finding has been referred to by the Supreme Court of New South Wales in *Lynette Cecil v Attorney General of New South Wales & Anor* [2012] NSWSC 1186 (at [60]) and in *Country Energy v Deputy State Coroner Paul MacMahon and Anor* [2010] NSWSC 943 (at [32]).

The text and structure of the *Coroners Act*

16. The question of whether a decision-maker is *functus officio* is ultimately a question of statutory interpretation: *Bhardwaj* at [8], per Gleeson CJ. Accordingly, it is convenient to first consider the structure of the *Coroners Act* in relation to the conclusion of coronial proceedings.

17. Part 6.5 of the *Coroners Act* deals with the "resolution of coronial proceedings." This Part provides for an inquest to conclude in three different ways: first, an inquest may be "terminated" where the coroner's finding or jury verdict is that the person did not die (s. 80); second, an inquest may be "concluded", at which time findings must be made (s. 81);[1] and third, an inquest may be "suspended" where there is evidence that is capable of giving rise to criminal charges (s.78).

18. The *Coroners Act* makes provision for an inquest to be resumed following a suspension (s. 79); but no statutory provision is made for the "resumption" of "terminated" or "concluded" inquests. Rather, where an inquest is "terminated" or "concluded", a "fresh inquest" may (or in certain circumstances must) be held pursuant to s. 83 of the *Coroners Act*; or the Supreme Court may order a fresh inquest pursuant to s. 84 of the *Coroners Act*. It may also be observed that s. 33 of the *Coroners Act* enables an uncompleted inquest to be referred to another coroner (or for the State Coroner to direct that another coroner hold the inquest) where the first coroner is "unavailable". This is the only provision in the *Coroners Act* for a coroner to "take over" the continuing inquest of another coroner.

19. When considered in the context of this structure, it is possible to discern a number of indications in the text of the *Coroners Act* which suggest that Parliament intended an open finding to conclude the exercise of jurisdiction by a Coroner:

    (1) Section 81 of the *Coroners Act* provides for written findings to be recorded at the "conclusion" or "suspension" of an inquest. As

[1] Any recommendations made under s. 82 must also be made at this time: *X v Deputy State Coroner for New South Wales* [2001] NSWSC 46.

outlined above, it has been long recognised that, in many cases, it may be impossible for a coroner to reach a verdict, and that in such a case, it is appropriate for a coroner to record an open finding. As s.81 does not provide for findings to be made in part, if the recording of an open finding does not satisfy s. 81, the consequence would be that in those cases, the coroner's jurisdiction would never be exhausted.

(2) Section 83 of the *Coroners Act* provides for the holding of a fresh inquest where a previous inquest has been concluded. The language of s. 83 of the *Coroners Act* is consistent with an interpretation of an open verdict as concluding the exercise of the coroner's jurisdiction, in that it provides that a "fresh inquest" may be held where "a previous inquest was concluded and the coroner's finding, or the jury's recorded verdict, was that ... it is uncertain whether the person had died".

(3) An open finding is a finding that has historically been a finding available to a jury, and which continues to be available to a jury under the present Act. It is unlikely that Parliament intended that a jury that has delivered an open finding should remain seized of jurisdiction in respect of the inquest. In this respect, an open finding is analogous to a "hung jury" in a criminal trial. That is, a trial court may discharge a jury for failure to reach a verdict: *Jones v. State* (1989), Ind., 540 N.E.2d 1228, 1229; *Ayad v. State* (1970), 254 Ind. 430, 431-2, 261 N.E.2d 68, 69, *reh. denied*; and upon discharge, a jury is *functus officio*, so that any action of the jury after its discharge is null and void: *West v. State* (1950), 228 Ind. 431, 438, 92 N.E.2d 852, 855. The word "finding" (or "findings"), in respect of a coroner's decision, is used in an equivalent sense to the word "verdict", in respect of a jury's decision, in the *Coroners Act* (see, for example, ss. 75, 80, 81 and 83), and there is no textual basis for giving a different effect to an open verdict of a jury in comparison to an open finding of a coroner.

(4) The nature of coronial findings is such that there is no bright line between a clear finding and an open finding, particularly in respect of findings as to manner of death. As observed at para 5 above, the

finding as to manner of death in the present case is only a partially open finding: her Honour was satisfied that Mr Johnson's death was caused by the fall, but could not say how the fall came about. It is not uncommon for findings as to manner and cause of death to comprise of aspects which are known and aspects which are not known. A coroner cannot retain jurisdiction over an inquest simply because there are some aspects of the death, which despite full investigation, cannot be ascertained, even on the civil standard.

The decision in *Fairfax v Abernethy*

20. The only Australian authority that has considered the question of whether an open finding renders a coroner *functus officio* is the decision of Adams J in *John Fairfax Publications v Abernethy* [1999] NSWSC 820 ("*Fairfax v Abernethy*"). *Fairfax v Abernethy* concerned the inquest into the death of Caroline Byrne, whose body was found on the rocks below The Gap at Watson's Bay. The then Senior Deputy State Coroner ("the Coroner"), John Abernethy, made findings that Ms Byrne had died as a result of multiple injuries sustained when she impacted with the rocks below The Gap. The Coroner found that the evidence did not permit him to say how Ms Byrne came to impact with the rocks. At the time of making these findings, his Honour made reference to the continued interest of police and of the Coroner in the death, and stated that police would "analyse the evidence and see what more can be done. If anything comes out, of course they will follow it up."

21. Several months after the open finding was made, the Coroner held a hearing at which he received evidence of the ongoing police investigation into Ms Byrne's death. During that hearing, the Coroner stated that he was "re-opening" the inquest and made a non-publication order in relation to the evidence received. Fairfax Pty Ltd subsequently sought a declaration in the Supreme Court that the Coroner did not have power to make the non-publication order.

22. In dismissing Fairfax's application for a declaration, Adams J found that the Coroner had jurisdiction to reopen the inquest. His Honour identified two possible sources of that power. First, his Honour expressed the opinion that because the Coroner had delivered an open finding as to manner of death,

his jurisdiction had not been exhausted. At paragraph [14], Adams J commented:

> "The statutory function of the inquest in this case is to arrive at findings, if possible, as to the deceased's identity, the date and place of that person's death and, except as provided by s.19 relating to indictable offences, the manner and cause of the person's death... Here, the Coroner made findings as to the identity of the deceased and the date, place and cause of her death, but not as to its manner... Although it might have well been the case that the inquest, considered as a hearing, had concluded, I am of the view that the Coroner's jurisdiction with respect to Ms Byrne's death had not been exhausted since he had not been in a position to make a finding as to the manner of her death."

23. At para [15], his Honour continued:

> "....there was no finding as to the manner of Ms Byrne's death and I cannot see, therefore, how the Coroner could be functus officio in that respect. I referred earlier in this judgment to the language used by the Coroner at the conclusion of the hearing on 11 February 1998. Whether the inquest was then concluded is to be determined by reference to the statutory functions the Coroner was exercising. To my mind, his use of the term "open finding" and his reference to the continuing investigations in which the "Coroner is still very interested", establish that the inquest had not itself concluded, for all that the evidence then available had been adduced and no more hearings were immediately proposed. That this was the intention of the Coroner is made clear by his language (which I have quoted above) when re-opening the inquest. The statement on this occasion that "[the] inquest was concluded on 11 February" does not, when read in context, qualify this conclusion. At all events the issue is determined by substance, not merely form and the most material consideration is that a substantial outstanding issue required a finding that had not been made."

24. Despite these comments as to the *functus* question, his Honour went on to find that the Coroner also had power to hold a fresh inquest under s. 23 of the *Coroners Act 1980*. Subsection 23(1) of the *Coroners Act 1980* provided as follows:

> "Notwithstanding that an inquest concerning the death or suspected death of a person:
>
> (a) is terminated under section 21 (1) (a), or
>
> (b) is concluded and the coroner's findings are, or the jury's verdict recorded under section 22 is, that the person has not died or it is uncertain whether the person has died,
>
> a fresh inquest concerning the death or suspected death may subsequently be held under this Act."

25. As to s. 23, Adams J held:

> "... Even if the inquest had been relevantly concluded by the open finding, providing the prerequisites of s 13(1) were satisfied, I consider that s 23 gave jurisdiction to conduct a fresh inquest into Ms Byrne's death. In my view, the jurisdiction conferred by s 23 is not limited to the circumstances specified in ss 23(1)(a) and (b). Those events are mentioned simply to make it clear that the jurisdiction to hold a fresh inquest is unqualified, which reading interprets the word "notwithstanding" in the opening general words of s 23(1) in its primary sense of "without regard to or prevention by, not the less for" (see The Australian Concise Oxford Dictionary, Oxford University Press, (1987) or, more shortly, as 'even where'. Accordingly, the Coroner was, at the time that he made the non-publication order holding an inquest, the hearing of which commenced on that day and for the safeguarding of which he made the order."[2]

[2] It should be noted that s.23 was the subject of consideration by Rothman J in *Innes v NSW Deputy State Coroner* [2007] NSWSC 1209, and that his Honour came to a different view of s.23 than that of Adams J. This has no practical effect, however, given Rothman J's decision cannot override that of Adams J (as they are both single judges of the NSW Supreme Court).

26. Justice Adams did not clearly determine whether the Coroner's power to hold a fresh inquest was sourced in s. 23, or the Coroner had power to hold the inquest because his jurisdiction had not been exhausted by an open finding as to the manner of death. At paragraph [17] his Honour stated:

> "I think that the conclusion that the Coroner was holding the inquest (whether it was continuing or was fresh under s 23 of the Act) for the purpose of further inquiring into the death of Ms Byrne is the proper one on the whole of the evidence..."

27. This aspect of the decision in *Fairfax v Abernethy* was considered in *X v Deputy State Coroner for New South Wales* [2001] NSWSC 46. In *X*, O'Keefe J held that a coroner did not have jurisdiction to reopen an inquest that had been terminated pursuant to s. 19 of the *Coroners Act 1980* in order to make recommendations under s. 22A of the *Coroners Act 1980*. In so finding, O'Keefe J observed at [65] that:

> "The conclusion to which I have come is consonant with the conclusion reached by Adams J in *John Fairfax Publications Pty Limited v Abernethy* in which the findings required of the coroner by s.22(1) were incomplete in that, there being no cause for the application for s.19, the coroner had not yet found and recorded the manner and cause of death of the relevant person. As a consequence the inquest into the death of that person was incomplete. A resumption of the incomplete inquest was appropriate."

28. These comments were strictly *obiter*. Further, O'Keefe J did not make reference to the alternative basis upon which Adams J had found that the Coroner had power to reopen the inquest in *Fairfax v Abernethy*, namely, the operation of s. 23 of the *Coroners Act 1980*. However, given O'Keefe J's finding that the "primary duty" of a coroner is to make the statutory findings as to identity, date, place, manner and cause of death, it would also follow that it would not have been appropriate for a fresh inquest to be held simply for the purpose of making recommendations (*X* at para [60]).

29. In summary, in *Fairfax v Abernethy* it was determined that in circumstances where the Coroner had made an open finding as to manner of death, the

Coroner was permitted to make an order under s. 44 of the *Coroners Act 1980* to suppress the imminent publication of an article in the press in relation to details of the "continuing investigation". Adams J made this decision on the basis that he found that the inquest was on foot, either because the Coroner's jurisdiction had not been exhausted by the open finding, or because the Coroner was permitted to reopen the inquest under s. 23 of the Act. The exact basis upon which the decision was made is not clear from the judgment. In these circumstances, beyond the finding that there was a power to make a suppression order, there is no clear *ratio*, and Adams J's comments in *Fairfax v Abernethy* as to the issue of whether an open finding renders a coroner *functus officio* cannot be said to be binding on your Honour in this inquest.

Conclusion in relation to *functus officio* issue

30. In conclusion, the text, structure and purpose of the *Coroners Act 2009* indicates that the making of an open finding constitutes the "conclusion" of an inquest such as to render the coroner *functus officio*. It is submitted that the decision in *Fairfax* does not contain a binding *ratio* on this question. Accordingly, it is submitted that Deputy State Coroner Forbes' jurisdiction was exhausted by her statutory findings. It is therefore appropriate for your Honour to consider whether to order that a fresh inquest be held under s. 83 of the *Coroners Act*.

NON-PUBLICATION ORDERS / ORDERS UNDER S. 65(4) OF THE *CORONERS ACT*

31. If it is accepted that your Honour has jurisdiction to consider whether to hold a fresh inquest under s. 83 of the *Coroners Act*, it is then necessary for your Honour to consider whether to make non-publication orders under s. 74 of the *Coroners Act* and / or an order prohibiting disclosure of coronial records under s. 65 of the *Coroners Act*. As to the former order, it is noted that an order may be sought under s. 74 of the *Coroners Act* in "coronial proceedings", which are defined in s. 46 of the *Coroners Act* to include "proceedings to determine whether or not to hold, or to continue to hold, an inquest or inquiry."

32. The statements of Chief Inspector Pamela Young contain confidential information relating to, *inter alia*, informers. It is agreed that at this stage of the proceedings, it would be appropriate for the following orders sought by the Commissioner of Police to be made by your Honour after the statements have been tendered in the proceedings on 13 April 2015:

    1. Pursuant to s. 65(4) of the *Coroners Act 2009*, direct by notation on the coroner's file on this matter that the statement of Detective Chief Inspector Young signed on 13 July 2014 ("Statement of DCI Young") and the supplementary statement of Detective Chief Inspector Young signed on 10 October 2014 ("Supplementary Statement of DCI Young") not be supplied to any person, until further order.

    2. Pursuant to s. 74(1) of the *Coroners Act 2009*, the Statement of DCI Young and the Supplementary Statement of DCI Young not be published, until further order.

    3. Orders (1) and (2) do not apply to the anonymised version, dated 21 November 2014, of the Statement of DCI Young, or the anonymised version, dated 21 November 2014, of the Supplementary Statement of DCI Young.

33. For clarity, it is confirmed that the effect of these orders would be that all interested parties who are granted leave to appear in the coronial proceedings would be provided with a copy of the anonymised versions of the Statement of DCI Young and Supplementary Statement of DCI Young.

SHOULD A FRESH INQUEST BE HELD UNDER S 83 OF THE *CORONERS ACT*?

34. Section 83 of the *Coroners Act* provides for the circumstances in which "a new inquest (a fresh inquest) concerning the death or suspected death of a person may be held even though the death or suspected death was previously the subject of another inquest (a previous inquest)." Section 83(4) provides that a fresh inquest must be held where:

    "(a) an application for a fresh inquest or inquiry is made under this section, and

(b) on the basis of the application, the State Coroner is of the opinion that the discovery of new evidence or facts makes it necessary or desirable in the interests of justice to hold a fresh inquest or inquiry."

35. By letter dated 18 March 2014, the NSWPF Homicide Squad referred this matter to your Honour indicating that "a further examination of the circumstances surrounding the death of Scott Johnson in light of the comprehensive investigations of the Homicide Squad Unsolved Homicide Team via Strike Force Macnamir would be in the public interest and indeed in the interests of justice". By letter to your Honour dated 14 July 2014, Detective Chief Inspector Young enclosed a copy of the Statement of DCI Young, and referred to "our application for a fresh inquest". The representative of the Commissioner of Police has advised that the Homicide Squad had not made an application for a fresh inquest, but subsequently indicated that the Commissioner will, if necessary as a practical means of advancing the matter, apply for a fresh inquest pursuant to s. 85(4) of the *Coroners Act*.

36. By letter dated 26 February 2015, the representative of the Johnson family has confirmed that the Johnson family (including Mr Steven Johnson) requests that a fresh inquest be held into the death of Mr Johnson. As Mr Johnson's family was granted leave to appear in the previous inquest, it is submitted that this satisfies ss. 83(4)(a) and 83(5) of the *Coroners Act.*

37. In these circumstances, your Honour must consider:

(i) Whether there is "new evidence or facts"; and

(ii) Whether such new evidence or facts makes it "necessary or desirable in the interests of justice to hold a fresh inquest or inquiry".

38. **As to (i)**, it may be observed that "new evidence" need not have been "secret or unknown at the time of the [previous] inquest" and may cover matters and issues dealt with at the time of the previous inquest: *Country Energy v Deputy State Coroner Paul MacMahon and Anor* [2010] NSWSC 943 at [48], per Schmidt J.

39. **As to (ii)**, it has been held that the words "in the interests of justice" are "plainly words of the widest possible reference. Indeed, there could scarcely

be a wider judicial remit. They enliven a discretionary judgement...": *Herron v Attorney General for New South Wales and Ors* (1987) 8 NSWLR 601 ("*Herron*") at 613 (Kirby P).

40. In *Herron*, McHugh JA observed (at 617) that:

> "In the forefront of matters to be considered in determining whether it is in the interests of justice to hold a fresh inquest ... is the existence of a reputable body of evidence which, if accepted, would indicate that the original finding as to the manner and cause of death ... was erroneous."

41. See also *R v HM Coroner for Derbyshire (Scarsdale); ex parte Fletcher* (1992) 156 JP 522 (the new evidence must be "credible", "relevant to an issue of significance" and it must be shown that the new evidence "might have made a material difference to the verdict recorded at the original inquest") and *Veitch v State Coroner* [2008] WASC 187 at [43] - [44] ("[I]t will be sufficient if there is a possibility that the result of a second inquest will be different from the first. There must be something more than mere speculation ... The reference in the cases to 'the possibility' of a different outcome must, I think, be read as a reference to a real or realistic possibility, not a merely theoretic possibility.")

42. In exercising the discretionary judgement there are also other legitimate considerations, which, in *Herron* included those noted by Kirby P at 613: the "community and the relatives have an interest in having the circumstances of the deceased's death fully exposed and thoroughly re-evaluated"; and see Abernethy et al, *Waller's Coronial Law and Practice in New South Wales* (4th ed, 2010) at [25.4] where matters relating to the Coroner's discretion under s.25(3) of the Act were noted to include: *"the wishes of the family or community members and whether an inquest may allay suspicions, rumour, or doubts or concerns held about the circumstances of a death"*. McHugh JA also noted in *Herron* at 616-7 the "paramount public interest in ascertaining the truth about the manner and cause of the person's death".

43. With these principles in mind, it is convenient to turn to a consideration of the present case. In the present case, there is new evidence, specifically new witnesses, whose evidence, if accepted, may indicate that the previous open

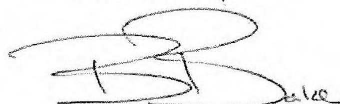
finding as to manner of death is erroneous. That new evidence is set out within the Statement of DCI Young and the Supplementary Statement of DCI Young. As the Commissioner of Police has indicated that non-publication orders (and / or orders under s. 65(4) of the *Coroners Act 2009*) are sought over various parts of these statements, which, at the time of the preparation of these submissions, has not yet been ruled upon, it is inappropriate for us to address this evidence in detail in these submissions at this time.[3] It is contended, however, that the evidence is of such a nature to give rise to a "possibility" of a different outcome.

44. In any event, in this matter other discretionary issues, referred to above at [42], are also relevant.

Conclusion in relation to fresh inquest issue

45. In all of the circumstances, it is submitted that it would be appropriate for your Honour to make an order for a fresh inquest under s. 83(4) of the *Coroners Act*.

Sarah McNaughton SC
Forbes Chambers
Ph: 9390 7777



Belinda Baker
Solicitor Advocate
For Crown Solicitor
Ph: 9224 5022

[3] If necessary, we are happy to provide further, more detailed written submissions addressing the new evidence once the non-publication / non-disclosure orders sought by the Commissioner of Police have been addressed.