

SUPREME COURT OF QUEENSLAND

CITATION: *Hurley v Clements & Ors* [2009] QCA 167

PARTIES: **CHRISTOPHER JAMES HURLEY**
(appellant/first respondent)
v
ACTING STATE CORONER CHRISTINE CLEMENTS
(first respondent/not a party to the appeal)
TRACEY TWADDLE
(second respondent/first appellant)
**JANE DOOMADGEE, ELIZABETH DOOMADGEE
and VALMAI DOOMADGEE**
(third respondents/second appellants)
**MICHAEL LEAFE, LLOYD BENGAROO,
KRISTOPHER STEADMAN and DARREN ROBINSON**
(fourth respondents/not a party to the appeal)
**COMMISSIONER OF QUEENSLAND POLICE
SERVICE**
(fifth respondent/not a party to the appeal)
PALM ISLAND COUNCIL
(sixth respondent/third appellant)
**HUMAN RIGHTS AND EQUAL OPPORTUNITY
COMMISSION**
(seventh respondent/not a party to the appeal)
**ATTORNEY-GENERAL FOR THE STATE OF
QUEENSLAND**
(eighth respondent/second respondent)

FILE NO/S: Appeal No 494 of 2009
DC No 352 of 2007

DIVISION: Court of Appeal

PROCEEDING: General Civil Appeal

ORIGINATING COURT: District Court at Townsville

DELIVERED ON: 16 June 2009

DELIVERED AT: Brisbane

HEARING DATE: 25 May 2009; 26 May 2009

JUDGES: McMurdo P, Keane JA and Fraser JA
Judgment of the Court

ORDER: **1. Appeal allowed**
2. The whole of the finding of the Coroner as to how the deceased died which is excerpted at paragraph [22] of these reasons is set aside
3. The inquest is to be reopened

4. **The State Coroner is directed to appoint another Coroner, other than the Coroner below, to re-examine the finding set aside**
5. **The parties have leave to make written submissions in relation to costs in accordance with paragraph 37A of Practice Direction No 1 of 2005**

CATCHWORDS: MAGISTRATES – CORONERS – THE CORONER AND THE CORONER'S COURT – INQUESTS AND INQUIRIES GENERALLY – where Coroner made findings that first respondent punched the deceased and that those punches caused the injuries that caused the deceased to die – where undisputed medical evidence provided that "severe compressive force" caused the injuries that caused the deceased to die – where undisputed medical evidence provided that punches by first respondent could not have applied severe compressive force necessary – whether finding that punches by first respondent caused fatal injuries to deceased reasonably open on the evidence

MAGISTRATES – CORONERS – THE CORONER AND THE CORONER'S COURT – PROCEEDINGS AT INQUEST OR INQUIRY – IN GENERAL – where Coroner made findings as required by s 45 of the *Coroners Act* 2003 (Qld) – where Coroner to make findings as to what caused a person to die – where Coroner made findings that person's death not caused by a particular agent – whether Coroner permitted to make such findings by the Act

MAGISTRATES – CORONERS – THE CORONER AND THE CORONER'S COURT – PROCEEDINGS AT INQUEST OR INQUIRY – IN GENERAL – where State Coroner required to issue guidelines under s 14 of the *Coroners Act* 2003 (Qld) – where guidelines stipulate that *Briginshaw* standard of proof applies to proceedings – whether Coroner correctly applied standard of proof

MAGISTRATES – CORONERS – THE CORONER AND THE CORONER'S COURT – POWERS OF SUPERIOR COURT – OTHER MATTERS – where appellant applied to District Court to set aside findings of Coroner – where appellant argued that finding could not be reasonably supported by the evidence – where District Court judge set aside findings and appellants appealed to Court of Appeal – where District Court judge incorrectly approached matter by reference to reasonable hypotheses consistent with innocence – where Court of Appeal determines appeal by way of rehearing – where decision of District Court judge correct but process of reasoning flawed – what orders should be made by the Court of Appeal in exercising the powers of the District Court under s 50 of the *Coroners Act* 2003 (Qld)

Coroners Act 1985 (Vic), s 19, s 59
Coroners Act 2003 (Qld), s 14, s 45, s 50
District Court of Queensland Act 1967 (Qld), s 118
Uniform Civil Procedure Rules 1999 (Qld), r 766

Annetts v McCann (1990) 170 CLR 596; [1990] HCA 57, cited
Briginshaw v Briginshaw (1938) 60 CLR 336; [1938] HCA 34, cited
Hurley v Clements & Ors [2008] QDC 323, considered
Inquest into the Death of Mulrunji, unreported, Acting State Coroner Clements, Coroners Court at Townsville, Qld, 27 September 2006, considered
Keown v Khan & Anor [1999] 1 VR 69; [1998] VSC 297, considered
R v South London Coroner; ex parte Thompson, unreported, Lord Lane CJ, Watkins LJ, and Robert Goff J, Queen's Bench Division, 9 July 1982, cited
Shepherd v The Queen (1990) 170 CLR 573; [1990] HCA 56, cited

COUNSEL: T A Game SC, with G R Mullins and P Morreau, for the applicants
P H Morrison QC, with S W Zillman, for the first respondent
P J Davies SC, with J M Horton, for the second respondent

SOLICITORS: Boe Lawyers for the applicants
Gilshenan & Luton Legal Practice for the first respondent
Crown Law for the second respondent

- [1] **THE COURT:** Cameron Doomadgee (who was also known as Mulrunji, and to whom we will refer as "the deceased") was a resident of Palm Island. On 19 November 2004 he was found dead in a cell in the police station on Palm Island. A post-mortem examination showed that he had a black eye and broken ribs. His portal vein had been ruptured and his liver had been almost split in two.
- [2] Between February 2005 and August 2006 the Acting State Coroner (to whom we shall refer as "the Coroner") conducted an inquest into the death of the deceased under the *Coroners Act 2003* ("the Act").
- [3] On 27 September 2006 the Coroner published her findings. The Coroner found that the deceased died "from intra-abdominal haemorrhage due to, or as a consequence of, the rupture of his liver and portal vein".¹ She also concluded that Senior Sergeant Hurley, the senior police officer on Palm Island at the time of the death of the deceased, caused these injuries to the deceased.
- [4] In particular, the Coroner concluded that Mr Hurley and the deceased fell through the doorway of the police station onto the floor and then Mr Hurley, angered by the unruly behaviour of the deceased, hit the deceased "whilst he was on the floor a number of times in a direct response to himself having been hit in the jaw and then

¹ *Inquest into the Death of Mulrunji*, unreported, Acting State Coroner Clements, Coroners Court at Townsville, Qld, 27 September 2006 at 28.

falling to the floor".² The Coroner concluded that the fatal injuries suffered by the deceased were not caused in, or as a result of, the fall but by Mr Hurley punching the deceased after the fall.³

- [5] On 20 September 2007 Mr Hurley applied to the District Court under s 50(5)(d) of the Act to set aside the finding of the Coroner that the deceased died as a result of injuries inflicted by Mr Hurley punching the deceased after the fall. It was said that the finding could not reasonably be supported by the evidence. The application initially challenged only the finding that the fatal injuries were inflicted by Mr Hurley punching the deceased after the fall; but at the hearing in the District Court those appearing for Mr Hurley sought and obtained leave to amend his application to include a challenge to the Coroner's findings that Mr Hurley fell beside rather than onto the deceased and that the fatal injuries were not caused in the fall.
- [6] The District Court set aside the finding made by the Coroner "that [Mr Hurley] lost his temper and hit [the deceased] after falling to the floor inside Palm Island Police Station thereby causing the fatal injuries and that Hurley had responded with physical force" and that Mr Hurley "hit [the deceased] whilst he was on the floor a number of times".⁴ It is not clear how his Honour intended to dispose of the application insofar as it concerned the other "findings" which were, by leave, brought within the scope of Mr Hurley's application.
- [7] His Honour went on to order that the State Coroner direct another Coroner to reopen the inquest to re-examine "the finding".⁵ Once again, because of the uncertainty attending the scope of the decision to set aside the findings which were challenged in the proceedings before him, the scope of his Honour's order is not as clear as it might have been.
- [8] Finally, the District Court also ordered the participating respondents, namely the deceased's spouse, members of his family and other residents of Palm Island, to pay Mr Hurley's costs of the proceedings in the District Court.

The application and appeal to this Court

- [9] The appellants in this Court are the "participating respondents" in the proceedings in the District Court. They seek leave to appeal to this Court to have the decision of the District Court set aside and thereby restore the findings of the Coroner. The respondents in this Court are Mr Hurley and the Attorney-General for the State of Queensland.
- [10] An appeal to this Court from a decision of the District Court under s 50 of the Act lies only by grant of leave under s 118(3) of the *District Court of Queensland Act 1967* (Qld). It was not disputed that leave should be granted having regard to the importance of the issues which arise in this case. The Court granted leave to appeal at the outset of the hearing.
- [11] Mr Hurley supports the decision of the District Court. The Attorney-General, in his written submissions, advanced no positive case in favour of, or in opposition to, the

² *Inquest into the Death of Mulrunji*, unreported, Acting State Coroner Clements, Coroners Court at Townsville, Qld, 27 September 2006 at 30.

³ *Inquest into the Death of Mulrunji*, unreported, Acting State Coroner Clements, Coroners Court at Townsville, Qld, 27 September 2006 at 30.

⁴ *Hurley v Clements & Ors* [2008] QDC 323 at [89].

⁵ [2008] QDC 323 at [90].

appeal, but made submissions on matters of law concerning the nature of the proceedings in this Court and the test to be applied by the District Court when asked to set aside a finding made by a coroner.

- [12] In oral argument on the hearing of the appeal, however, Mr Davis SC, who appeared with Mr Horton of counsel on behalf of the Attorney-General, made a submission which highlighted a difficulty implicit in the terms of the decision of the District Court and, in particular, with the uncertainty as to the findings of the Coroner which his Honour set aside. That submission was that, upon the findings of the Coroner that the injuries which proved to be fatal to the deceased were not suffered in the fall and that the deceased and Mr Hurley fell side by side, and if the finding of the Coroner that the fatal injuries suffered by the deceased were inflicted by punching had been rightly set aside, it would inevitably be found by any Coroner to whom the matter was remitted that the fatal injuries suffered by the deceased were inflicted by the application of deliberate force by Mr Hurley, other than by punching after the fall, the most likely scenario being that Mr Hurley dropped his knee into the upper abdomen of the deceased.
- [13] In this Court the appellants and Mr Hurley made extensive submissions, in writing and orally, in relation to the evidence given at the inquest. These submissions canvassed the accounts of various witnesses of the circumstances of the arrest of the deceased by Mr Hurley. This Court was regaled at length with arguments directed to the relative credibility of witnesses and as to the likely explanations, favourable and unfavourable, for the inconsistencies and improbabilities of the accounts given by the various witnesses who gave evidence before the Coroner.
- [14] Regrettably, much of the argument advanced on behalf of both Mr Hurley and the appellants was of little assistance to the Court. The wide-ranging submissions advanced by these parties concerning possible views of the evidence of the various witnesses paid scant regard for the limited fact-finding role of the District Court under s 50 of the Act and of this Court sitting on appeal from the District Court.
- [15] Counsel for the appellants, evidently prompted by the submission made on behalf of the Attorney-General, submitted in their oral argument in reply, and contrary to the position explicitly taken by them in their argument in chief, that the District Court had not set aside the Coroner's findings that the deceased and Mr Hurley fell side by side, and that the deceased's fatal injuries were not suffered in the fall.
- [16] Putting to one side for a moment the uncertainty as to which findings of the Coroner the District Court actually set aside, one issue which indisputably arises for determination by this Court is, as it was for the District Court, whether the Coroner's finding that the injuries which led to the death of the deceased were caused by Mr Hurley punching the deceased was a finding "reasonably supported by the evidence". Much of the evidence canvassed before this Court was irrelevant to this issue. As will appear, the resolution of this issue turns in the end upon the undisputed medical evidence which was before the Coroner concerning the likely cause of the injuries to the liver and portal vein of the deceased. For that reason, and because it would be undesirable for this Court to indicate, even by implication, a view as to the weight to be attributed to the evidence of any particular witness, we do not propose to set out the evidence of the various witnesses who gave evidence beyond making necessary references to the summary of evidence contained in the reasons of the Coroner.

- [17] Argument addressed the following broad issues:
- (a) the function of the Coroner under s 45 of the Act;
 - (b) the function performed by the District Court under s 50(5) of the Act;
 - (c) the evidence as to how the deceased died which was before the Coroner and the findings made by the Coroner on that evidence; and
 - (d) the course which this Court should take in the disposition of the appeal.
- [18] We shall consider these issues in turn.

The function of the Coroner under s 45 of the Act

- [19] Section 45 of the Act provides relevantly as follows:
- "(1) A coroner who is investigating a suspected death must, if possible, find whether or not a death in fact happened.
 - (2) A coroner who is investigating a death or suspected death must, if possible, find—
 - (a) who the deceased person is; and
 - (b) how the person died; and
 - (c) when the person died; and
 - (d) where the person died, and in particular whether the person died in Queensland; and
 - (e) what caused the person to die.
 - ...
 - (4) The coroner must give a written copy of the findings to—
 - (a) a family member of the deceased person who has indicated that he or she will accept the document for the deceased person's family; and
 - (b) if an inquest was held—any person who, as a person with a sufficient interest in the inquest, appeared at the inquest; and
 - (c) if the deceased person was a child—the children's commissioner; and
 - (d) if the coroner is not the State Coroner—the State Coroner.
 - (5) The coroner must not include in the findings any statement that a person is, or may be—
 - (a) guilty of an offence; or
 - (b) civilly liable for something.
 - (6) This section applies whether or not an inquest is held."

- [20] There can, we think, be little doubt that the reference in s 45(4) and (5) to "findings" are to the matters required to be "found" in s 45(2) of the Act. It is clear from the text of the Act that these "findings" are the ultimate findings which a coroner is required to make by s 45(2). In *Keown v Khan & Anor*,⁶ Callaway JA, with whom Ormiston and Batt JJA agreed, said of s 19(1) and s 59 of the *Coroners Act 1985* (Vic) which are broadly analogous to the provisions of s 45 and s 50 of the Act respectively:

⁶ [1999] 1 VR 69 at 74 [12].

"the 'findings' referred to in s 59 are the same as the findings referred to in s 19(1) ... those findings are ultimate findings, that is to say decisions as to the identity of the deceased, how death occurred, the cause of death ... That is why it is appropriate to treat them ... as entities that are capable of being declared 'void' [under s 59(1) and (2)]. A coroner may make many findings in the sense that he or she takes a view of the evidence or particular aspects of it, but they are not the 'findings' referred to in ss 19(1) and 59. The latter are restricted to ultimate findings as to the identity of the deceased, how death occurred and so on."

[21] Of course, under the Act, a finding for the purposes of s 45(2) is not an entity "capable of being declared 'void'", but it is capable of being "set aside" under s 50. While the analogy between the Victorian provisions discussed by Callaway JA in *Keown v Khan* and s 45 and s 50 of the Act is not perfect, the view taken by Callaway JA of the nature of the "findings" referred to in the Victorian provisions accurately describes the nature of the findings contemplated by s 45(2) and s 50 of the Act.

[22] It is convenient to set out here what appears to be the statement of the Coroner's ultimate findings for the purposes of s 45(2) of the Act. We speak in this qualified way because the Coroner did not give the precise statement of her ultimate conclusions required by s 45(2) but rather jumbled those conclusions together with the reasons which led her to reach them including her views on the credibility of witnesses. The Coroner said:⁷

"Conclusions from the evidence

- a) The Deceased is Cameron Francis Doomadgee, known by his tribal name Mulrunji.
- b) The Deceased died from intra-abdominal haemorrhage due to, or as a consequence of, the rupture of his liver and portal vein. He had also sustained four broken ribs.
- c) The Deceased died at approximately 11.00a.m. on 19 November 2004.
- d) The Deceased died in the police watch house on Palm Island, Queensland.

I find that [the deceased] did punch Senior Sergeant Hurley outside the police station as he tried to resist being taken into the police station. I accept the evidence of Mrs Sibley, which was supported to an extent by Alfred Bonner. Senior Sergeant Hurley did respond to [the deceased's] punch by himself punching [the deceased]. I am satisfied that this was somewhere to the body area rather than to the head and occurred as the two men struggled outside the station. I reject Senior Sergeant Hurley's denial as untruthful.

I find that both men fell through the entrance door of the police station. There was a concrete step before the door. The floor was concrete and covered with lino. The men had hold of each other before the fall.

⁷ *Inquest into the Death of Mulrunji*, unreported, Acting State Coroner Clements, Coroners Court at Townsville, Qld, 27 September 2006 at 28 – 31.

I have considered carefully whether or not Senior Sergeant Hurley fell onto [the deceased] at this time. Senior Sergeant Hurley told Sergeant Leafe he had not. He repeated this version to every investigating police officer and the investigating officer from the Crime and Misconduct Commission. He told all of them that he had fallen to his left hand side, with [the deceased] to the right hand side.

I am not persuaded by Dr Lampe's opinion that people are not able to recall exactly what happened in complex events. Senior Sergeant Hurley was quite clear on every occasion, until he came to court, that he had not fallen on [the deceased]. Indeed it would seem commonplace that anyone would be able to say whether they had got up from a fall, either removing themselves from on top of another person, or up from a hard, flat, lino covered concrete surface.

In his evidence to this court Senior Sergeant Hurley merely said he must have fallen on [the deceased]. What has brought this change of recollection after repeated adamant accounts that he fell to the left hand side? The reality is that Senior Sergeant Hurley has become aware exactly of the nature of [the deceased's] injuries causing death. If he had not otherwise caused such injury to [the deceased], then the injury must be explained in the fall.

In considering the plausibility of this belated recollection and reinterpretation of what must have happened, I consider the following.

Senior Sergeant Hurley still asserted that he was not put out by the fall and did not react against [the deceased]- a most unlikely response from a man who considered his lawful authority and personal position of power was being challenged, and in his own police station. Constable Steadman heard Senior Sergeant Hurley yelling in an abusive tone to [the deceased] immediately after they had fallen through the door.

From his position outside the door, Steadman then saw [the deceased's] feet being dragged along towards the cells. He could only see feet. He saw no more and waited for things to 'settle down' before entering the police station.

I find that Roy Bramwell was quite excited in giving his account at the re-enactment and there is some embellishment, but the basis of what he saw is credible given the overall sequence of events and the injury sustained. Despite a steady demeanour in court, Senior Sergeant Hurley's explanation does not persuade me he was truthful in his account of what happened.

I note Senior Sergeant Hurley's response to Roy Bramwell's allegation of three punches. Roy Bramwell could only see Senior Sergeant Hurley's elbow going up and down three times from where he was seated in the yellow chair. The photos, (photo 10) of this view show it was partly obstructed by the filing cabinet. But Senior

Sergeant Hurley is a very large man. In the re-enactment tape he dwarfs even the tall Inspector Williams and makes Inspector Webber look very small. His head nearly touches the doorframe. He is 200.66 centimetres tall. Roy Bramwell [sic] said he could only see [the deceased's] feet and part of his legs as he lay on the floor. Senior Sergeant Hurley's evidence was that he did not see that Roy Bramwell was sitting in the yellow chair when he and [the deceased] fell through the doorway. Mr Bramwell said Senior Sergeant Hurley was bending over [the deceased] with his elbow going up and down three times. He couldn't see where Senior Sergeant Hurley's hand was, relative to [the deceased's] body. He was led into the suggestion by police that [the deceased] was being hit in the head. He also referred at this time to [the deceased's] shirt being ripped. And, most significantly he said these actions were accompanied by Senior Sergeant Hurley saying '*Do you want more Mr Doomadgee, do you want more?*'

Senior Sergeant Hurley's response was to deny the accusation of punching and to explain it as an attempt to lift [the deceased] by the shirt. The shirt kept ripping, thus causing him to perform a repetitive action which he says was misinterpreted by Roy Bramwell as punching. Both men have described in physical terms the action of the elbow going up and down. The description is reminiscent of what is frequently seen in football matches when hot headed players seemingly grab at shirtfronts, but take the opportunity to punch the opposition in doing so.

Contrary to his evidence I find that Senior Sergeant Hurley was angry when he was hit in the jaw by [the deceased] as he came out of the back of the police van. He expressed it himself that he was shocked at the challenge to his authority on Palm Island.

I reject Senior Sergeant Hurley's account that he then simply got up from the heavy fall through the doorway and went to assist the man who had just punched him and caused him to fall over. I find that he did respond with physical force against [the deceased] while [the deceased] was still on the floor.

I accept Roy Bramwell's evidence to the extent that he saw Senior Sergeant Hurley leaning over [the deceased] with his elbow going up and down three times. In particular I note that Roy Bramwell's account to the police recorded on the re-enactment video occurred prior to the release of the autopsy information, whereas Senior Sergeant Hurley's changed recollection and reconstruction of where he had fallen, occurred after he knew exactly what injury had caused [the deceased's] death.

Senior Sergeant Hurley's evidence was that he considered [the deceased] was still causing him a problem by not getting up. He was asked to respond to what Roy Bramwell had told police. Senior Sergeant Hurley explained that he was lifting [the deceased] and, as he did so, the shirt was ripping. There is evidence that indeed the

shirt was ripped, but I am not satisfied with Senior Sergeant Hurley's account of how this occurred. Critically, there is what Roy Bramwell alleges he heard Senior Sergeant Hurley say- '*Do you want more, Mr Doomadgee. Do you want more?*' I accept that Senior Sergeant Hurley did say this.

I am satisfied that on the basis of Roy Bramwell's account of what he saw and heard, together with the immediately preceding sequence of events, that Senior Sergeant Hurley lost his temper and hit [the deceased] after falling to the floor.

I find that Senior Sergeant Hurley's repeated clear statements that he fell to the left hand side of [the deceased] are in fact what occurred.

I find that Senior Sergeant Hurley hit [the deceased] whilst he was on the floor a number of times in a direct response to himself having been hit in the jaw and then falling to the floor.

I do not necessarily conclude that this force was to [the deceased's] head as stated by Mr Bramwell. He could not have been in a position to see [the deceased's] head from where he was seated. [The deceased's] feet and part of his legs was all he could see. It is open on Bramwell's evidence that the force was applied to [the deceased's] body rather than his head. This is also consistent with the medical evidence of the injuries that caused [the deceased's] death. It is also most likely that it was at this time that [the deceased] suffered the injury to his right eye.

After this occurred, I find there was no further resistance or indeed any speech or response from [the deceased]. I conclude that these actions of Senior Sergeant Hurley caused the fatal injuries.

Sergeant Leafe returned from opening the cells and [the deceased] was dragged away and deposited in cell number two. Patrick Bramwell was then similarly brought in and dragged to the cells.

There was no attempt whatsoever to check on [the deceased's] state of health after the fall and its sequelae. The so called checks on the two intoxicated prisoners in the cells was woeful, even excluding the possibility of serious injury having occurred. Neither officer remained in the cell for more than seconds on each occasion they entered to check the prisoner. It was not until Sergeant Leafe suspected that [the deceased] might in fact be dead, that any close scrutiny was made. No attempt at resuscitation was made by any police officer even when there was a degree of uncertainty about whether [the deceased] had died.

I find, in reliance on all the medical evidence and the video tape that [the deceased] was indeed deceased when Sergeant Leafe checked on him at the time recorded by the tape as twenty past eleven that morning.

I find that Senior Sergeant Hurley avoided the issue and sent family members away from the station after knowing that [the deceased] was deceased."

- [23] It is apparent that the Coroner intended that what followed her finding in subparas (a) to (d) in this passage were to be understood as her "finding" for the purposes of s 45(2)(e) of the Act. In our respectful opinion these conclusions by the Coroner were related to the requirement in s 45(2)(b) of the Act rather than the requirement in s 45(2)(e). A finding that a death was not caused by a particular agent is, by definition, not a finding as to what caused the person to die. That was the view that Callaway JA took in *Keown v Khan & Anor*.⁸ As to the issue posed for a coroner by s 45(2)(b) of the Act, however, it may not be possible to make a finding that a person died in a particular way without, at the same time, making a finding that the person did not die in a different way. Callaway JA recognised that this was so, saying "it will often be necessary for a coroner to make more than one finding in order to discharge his or her obligations under para (b) [of s 19(1)]", ie the Victorian analogue of s 45(2)(b) of the Act.⁹
- [24] Much of the difficulty in this case arising from the uncertainty as to the scope of the decision of the District Court stems from the Coroner's failure to state her ultimate conclusion in relation to s 45(2)(b) in a succinct and precise way. We will need to refer to these difficulties and the solution to them in this case in due course. It is sufficient at this stage to note that, although the Coroner's findings in relation to s 45(2)(b) of the Act were not stated in conformity with the Act, no challenge was made to those findings on the ground of error of law in that regard, and it may be that, as counsel for the Attorney-General argued, a challenge on such a basis would fall outside the scope of s 50(5)(d) of the Act.
- [25] A further general observation which may be made here is that all parties accepted that findings were to be made on the balance of probabilities in conformity with the sliding standard of satisfaction explained in *Briginshaw v Briginshaw*.¹⁰ That position was adopted, no doubt, because the guidelines issued under s 14 of the Act¹¹ contain the following statement:¹²

"The particulars that a Coroner must if possible find under s 45 need only be made to the civil standard but on the sliding *Briginshaw* scale (*Anderson v Blashki* [1993] 2 VR 89 at 96 and *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73). That may well result in different standards being necessary for the various matters a Coroner is required to find. For example, the exact time and place of death may have little significance and could be made on the balance of probabilities. However, the gravity of a finding that the death was caused by the actions of a nominated person would mean that a standard approaching the criminal standard should be applied because even though no criminal charge or sanction necessarily flows from such a finding, the seriousness of it and the potential harm to the reputation

⁸ [1999] 1 VR 69 at 74 – 75 [13].

⁹ [1999] 1 VR 69 at 75 [14].

¹⁰ (1938) 60 CLR 336.

¹¹ Under s 14(4) of the Act a coroner must comply with the Guidelines when investigating a death "to the greatest practicable extent".

¹² Office of the State Coroner, *State Coroners Guidelines* (2003) [8.8] (citation footnoted in original).

of that person requires a greater degree of satisfaction before it can be safely made."

- [26] Two things must be kept in mind here. First, as Lord Lane CJ said in *R v South London Coroner; ex parte Thompson*,¹³ in a passage referred to with evident approval by Toohy J in *Annetts v McCann*:¹⁴

"... an inquest is a fact finding exercise and not a method of apportioning guilt ... In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use."

- [27] Secondly, the application of the sliding scale of satisfaction test explained in *Briginshaw v Briginshaw* does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not. That this is so is apparent from the following passage from the reasons of Dixon J, as he then was, in *Briginshaw v Briginshaw*:¹⁵

"When, in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is, according to the better opinion, the same as upon other civil issues (*Doe d. Devine v. Wilson* ((1855) 10 Moo PCC 502, at pp 531, 532; 14 ER 581, at p 592); *Boyce v Chapman* ((1835) 2 Bing NC 222; 132 ER 87); *Vaughton v London and North Western Railway Co.* ((1874) LR 9 Ex 93); *Hurst v Evans* ((1917) 1 KB 352); *Brown v McGrath* ((1920) SALR 97); *Motchall v. Massoud* ((1926) VLR 273); *Nelson v. Mutton* ((1934) 8 ALJ 30); *Gerder v Evans* ((1933) 45 L1 L Rep 308, at p 311); *sed quoere* as to the statement of Swift J. in *Herbert v Poland* ((1932) 44 L1 L Rep 139, at p 142; see, further, *Wigmore on Evidence*, 2nd ed (1923), vol v p 472, par 2498 (2) (1)). But, consistently with this opinion, weight is given to the presumption of innocence and exactness of proof is expected.

These illustrations show the good sense of Professor *Wigmore's* statement that, in civil cases, it should be enough to say that the extreme caution and the unusual positiveness of persuasion required in criminal cases do not obtain.

But the development of the two standards of proof or persuasion is the work of the common law. In jurisdictions which do not derive from the common law there has been some uncertainty as to their recognition or adoption. In the ecclesiastical courts before the passing of the *Matrimonial Causes Act 1857* no attempt had been made to define the degree of certainty which should be felt before finding a spouse guilty of adultery. But, as the issue in most cases

¹³ *R v South London Coroner; ex parte Thompson*, unreported, Lord Lane CJ, Watkins LJ, and Robert Goff J, Queen's Bench Division, 9 July 1982.

¹⁴ (1990) 170 CLR 596 at 616.

¹⁵ (1938) 60 CLR 336 at 363 – 364.

depended upon circumstantial evidence and as the testimony was taken out of court, it was natural that the reasons given by the court for its decision in particular cases often should contain general observations as to the nature and amount of evidence required to justify a finding. Many expressions and statements of Lord *Stowell* upon the subject are reported. Thus:—"The court representing the law draws that inference which the proximate acts unavoidably lead to' (*Elwes v Elwes* ((1796) 1 Hag Con 269, at p 278; 161 ER 549, at p 552). 'It is undoubtedly true that direct evidence of the fact is not required, as it would render the relief of the husband almost impracticable; but I take the rule to be that there must be such proximate circumstances proved, as by former decisions, or on their own nature and tendency, satisfy the legal conviction of the court that the criminal act has been committed' (*Williams v Williams* ((1798) 1 Hag Con 299, at pp 299, 300; 161 ER, at p 559). 'The only general rule that can be laid down upon the subject is that the circumstances must be such as would lead the guarded discretion of a reasonable and just man to the conclusion; for it is not to lead a rash and intemperate judgment, moving upon appearances that are equally capable of two interpretations, neither is it to be a matter of artificial reasoning, judging of such things differently from what would strike the careful and cautious consideration of a discreet man' (*Loveden v Loveden* ((1810) 2 Hag Con, at p 3; 161 ER, at pp 648, 649)). 'To prevent ... the possibility of being misled by equivocal appearances, the court will always travel to this conclusion with every necessary caution; whilst, on the other hand, it will be careful not to suffer the object of the law to be eluded, by any combination of parties, to keep without the reach of direct and positive proof' (*Burgess v Burgess* ((1817) 2 Hag Con 223, at p 227; 161 ER 723, at p 724)."

The function of the District Court under s 50(5) of the Act

[28] Section 50 of the Act relevantly provides:

" Reopening inquests etc.

(1) A person dissatisfied with a finding at an inquest may apply to the State Coroner or District Court to set aside the finding.

...

(5) The District Court may set aside a finding if satisfied—

- (a) new evidence casts doubt on the finding; or
- (b) the finding was not correctly recorded; or
- (c) there was no evidence to support the finding; or
- (d) the finding could not be reasonably supported by the evidence.

...

(7) If the District Court sets aside a finding, the District Court may order—

- (a) the State Coroner to—
 - (i) reopen the inquest to re-examine the finding; or
 - (ii) hold a new inquest; or
- (b) the State Coroner to direct another coroner to—

- (i) reopen the inquest to re-examine the finding;
or
- (ii) hold a new inquest.

..."

- [29] We are in no doubt that the reference in s 50 to "a finding at an inquest" is a reference to a finding of the kind required by s 45(2) of the Act. No other kind of finding is referred to in the Act; and it is inconceivable that the reference to "a finding" in s 50 could encompass every conclusion on every issue of fact made by a coroner on the way to making a finding of the kind referred to in s 45(2) of the Act. Counsel for Mr Hurley urged us to adopt that view, but we are unable to attribute such caprice to the legislature.
- [30] As we have already mentioned, on the application to the District Court pursuant to s 50(5) of the Act in this case, the issue posed for that court was whether it was reasonably open to the Coroner to find:
- (a) that the deceased died as a result of Mr Hurley punching him;
 - (b) that Mr Hurley and the deceased fell side by side rather than Mr Hurley falling onto the deceased; and
 - (c) that the fatal injuries were not caused in the fall.
- [31] Counsel for the appellants and for the Attorney-General submit that the learned District Court judge erred in that his Honour approached the issue before him by addressing himself to a consideration of the competing possibilities as to the circumstances in which the deceased's injuries were suffered, and, in particular, to questions concerning relative credibility of the witnesses. Counsel for Mr Hurley resisted that submission, arguing that the District Court judge's approach was in conformity with the strictures of s 50(5)(d) of the Act.
- [32] Reference to his Honour's reasons shows that his Honour did indeed address himself to a broader review of the evidence than was necessary or appropriate to a consideration pursuant to s 50(5)(d) of the Act as to whether the Coroner's findings were reasonably open on the evidence.¹⁶ In particular, his Honour held that the Coroner erred in failing to keep "in mind that alternative hypotheses needed to be considered and excluded before inferences adverse to Hurley could be drawn from proven facts".¹⁷ That approach was not in conformity with s 50(5)(d) of the Act. Counsel for Mr Hurley argued that his Honour's approach was in conformity with the requirements of *Briginshaw v Briginshaw*; but as the passage set out above from that case shows, a state of satisfaction on the probabilities appropriate to the gravity of the consequences of a finding does not involve the need to exclude competing possibilities.
- [33] In any event, the language of s 50(5)(d) of the Act permits the District Court to set aside a finding by a coroner only if satisfied that "the finding could not be reasonably supported by the evidence". In the application of this test, the circumstance that the evidence reasonably supported possible findings different from those made by the Coroner would not warrant the setting aside of the finding made by the Coroner if that finding too was reasonably supported by the evidence.

¹⁶ [2008] QDC 323 at [4], [29] – [31], [50], [61], [72], [73], [78](e), [79], [85] and [88].

¹⁷ [2008] QDC 323 at [79].

[34] The approach applied by the learned primary judge does not conform to s 50(5)(d) of the Act. Rather, his Honour's approach was akin to that to be applied to determine criminal responsibility upon a trial for an offence or on an appeal from a conviction of a criminal offence. In a criminal trial, an accused must be acquitted if the evidence supports a reasonable hypothesis consistent with innocence.¹⁸ The inquest was not a criminal trial in which Mr Hurley was accused of the unlawful killing of the deceased, and the Coroner was not concerned with whether or not Mr Hurley was criminally responsible for the death of the deceased. Section 45(5) of the Act makes it expressly clear that the Coroner's task of making findings as to the circumstances of a death was not concerned with questions of criminal responsibility.

[35] We are obliged to conclude that the reasoning of the District Court was affected by error. It is necessary now to consider whether, notwithstanding the error of the District Court, the Coroner's finding was rightly set aside on the footing that it was not reasonably supported by the evidence. We turn, therefore, to a consideration of that question.

The evidence as to how the deceased died and the Coroner's finding

[36] There was undisputed evidence that the deceased punched Mr Hurley while Mr Hurley was trying to move the deceased, who was drunk, from a police van into the police station. There was evidence from Mr Bramwell that Mr Hurley punched the deceased three times after the fall. The Coroner's finding was based on the acceptance, in part, of the evidence from Mr Bramwell that he saw Mr Hurley bending over the deceased and punching him three times in the head. Mr Bramwell said that he heard Mr Hurley saying: "Do you want more Mr Doomadgee? Do you want more?"

[37] Because Mr Bramwell's view of the incident was obscured, the Coroner proceeded on the basis that she was able to conclude, consistently with accepting his evidence generally, that the punches of which Bramwell spoke were applied, not to the head, but to the abdomen or torso of the deceased.

[38] On behalf of Mr Hurley, it was submitted to this Court that Mr Bramwell was not a particularly satisfactory witness: Mr Bramwell gave different versions of what he saw and it is difficult to see a convincing reason to prefer the versions inculpatory of Mr Hurley to the versions exculpatory of him. Further, Mr Bramwell spoke of punches to the head, and so it is said on Mr Hurley's behalf that the Coroner was not justified in treating his evidence as referring to blows to the torso or abdomen. But it is neither necessary nor appropriate for this Court to come to a firm conclusion as to the weight properly to be accorded by a tribunal of fact to Mr Bramwell's evidence.

[39] That is because, even if Mr Bramwell's evidence inculpatory of Mr Hurley were to be accepted, the conclusion that the punches of which Mr Bramwell gave evidence caused the rupture of the portal vein and the near-severing of the deceased's liver was a conclusion which was not reasonably open to the Coroner.

[40] The Coroner said that "[t]he consensus of medical opinion was that severe compressive force applied to the upper abdomen, or possibly the lower chest, or both together, was required to have caused [the] injury" to the deceased's liver and

¹⁸ *Shepherd v The Queen* (1990) 170 CLR 573 at 578.

portal vein.¹⁹ But none of the medical evidence supported the further finding that the punches spoken of by Mr Bramwell were likely to have supplied the compressive force said to be necessary to cause the rupture of the deceased's liver and portal vein. Indeed, the uncontroverted medical evidence was to the contrary, yet this evidence was not adverted to by the Coroner. It will be necessary to refer to the Coroner's reasons at some length to demonstrate that this is so. But before we refer to the relevant passage in the Coroner's reasons, it is necessary to refer to the uncontroverted medical evidence which was before the Coroner.

- [41] A report into the death of the deceased was prepared by Dr David Ranson, who conducted a second autopsy on the deceased on 30 November 2004. He summarised the circumstances of death as follows:

"In my opinion the death occurred from blood loss as a result of the liver being torn. I believe the liver injury was the result of forceful pressure being applied to the front of the upper abdomen or stomach area. This force squeezed the liver by pushing it up against the front of the spine so that it was nearly split in half.

In a person with some degree of blockage of the arteries that supply blood to the heart muscle, significant loss of blood can cause a drop in the supply of blood to the heart muscle causing it to fail to work properly. This natural disease process of the coronary arteries may have acted so as to quicken his death from the liver injury but in my opinion does not supplant the liver injury as being the medical cause of his death.

IMMEDIATE CAUSE OF DEATH

In my opinion the immediate cause of the death was the blood loss as a result of bleeding from the liver into the abdominal cavity.

UNDERLYING CAUSE OF DEATH

In my opinion the underlying cause of the death was due to rupture of the liver consequent upon blunt compressive force injury to the upper abdomen.

OTHER CONTRIBUTING FACTORS

The presence of focal coronary artery atheroma may have contributed to him dying more quickly from this injury."

- [42] Dr Ranson made the following pertinent statements in his report:

"The compressive forces capable of causing this type of injury usually require the body to be fixed against a hard surface such as a wall or firm ground when the pressure is applied to the upper abdomen. The application of the crushing force in these circumstances needs to occur over a relatively small area if the liver alone is lacerated. Force being applied over a large area might be expected to cause other internal lacerations, for example tears to the bowel mesentery. To cause this type of liver laceration, an extremely high degree of force would be required to be applied over the whole of the front of the body whereas a lesser degree of force would be

¹⁹ *Inquest into the Death of Mulrunji*, unreported, Acting State Coroner Clements, Coroners Court at Townsville, Qld, 27 September 2006 at 7.

required to cause this injury if the force was applied over a small area in the midline of the upper abdomen.

A simple fall on to a flat surface from a standing position in my opinion would not cause the liver laceration seen in this man.

A complicated fall where two individuals fall together from a standing position would not usually cause the liver laceration seen in this man unless during the process of the fall a small area of direct crushing pressure was applied to the front of the upper abdomen with the back or posterior lateral aspect of the body fixed against a hard surface. The circumstances in which this might happen are extremely variable but if a large person were to fall in an accelerated or uncontrolled fashion on top of an individual who was lying on their back on the ground, such that a small part of their body, for example, a knee applied a crushing type force to the upper abdomen, it is possible that such a liver laceration might be caused.

An alternative explanation for the mechanism in which this injury could occur would be if a person was lying face down on the ground on top of a small hard object which was positioned beneath their body in the vicinity of their upper abdomen and then force was applied across the back of the trunk of the individual. This would result in an opposing localised crushing force being applied to the front of the upper abdomen by the object on which the individual lay.

If the force causing the liver laceration was applied over a larger area that included the area over the rib fractures (perhaps some 10 cm to 20 cm away depending on the position of the trunk) the same crushing force application could have caused both injuries."

[43] Dr Ranson then referred to the findings of forensic pathologist, Dr Greg Lampe, who carried out two autopsies on the body of the deceased:

"I note that Dr Lampe states that:

'I can find no evidence to suggest the use of direct force (such as punching or stomping) to have caused the injuries; this does not exclude that either (or both) of those two possibilities may have occurred at some time prior to death.'

I would agree with this statement. However, whilst the autopsy revealed no bruising or abrasion over the front of the upper abdomen, which might be one source of evidence for direct force being applied in this area, the internal damage to the liver is evidence that there was direct force applied in this area. The absence of skin surface injuries or subcutaneous tissue and muscle bruising over the front of the upper abdomen suggests that the force was applied by or through a softer surfaced object and not applied by a hard edged irregular object making direct forceful contact with the skin.

The injuries to the right side of the front of the face could certainly occur in a fall on to the right side of the body but they could also

occur as a result of applications of blunt force to the right side of the head in other circumstances. Direct blows from a fist or other hard body part could cause such injuries although where abrasions are present contact with a rough surface may be a more probable explanation."

- [44] Dr Ranson referred to Mr Bramwell's account and Mr Bramwell's video re-enactment and said:

"In the Interview of Roy Bramwell with re-enactment (201104) the following dialogue is noted (page 2 of 10):

'B Cameron was behind the (UI) ... and he was dragged in. And Cameron, Cameron must've hit him outside and then Chris dragged him in and he laid him down here and started hitting him. All I could see from here just cause the elbow gone down, up and down, like that ... 'do you want more mister, mister Doomadgee, do you want more of these eh, do you want more. You had enough.' He's just gone like that'

Roy Bramwell's several descriptions of Senior Sergeant Hurley hitting Cameron Doomadgee, while he is on the floor inside the door of the police station, appears in many places in the materials. It is difficult to find a consistent version of this alleged incident as kicks and punches are described, but an account of three punches with a closed fist following Cameron Doomadgee's fall to the floor seems to occur regularly.

Forceful punches with a fist could have caused the facial injuries and other soft tissue bruises seen at autopsy and depicted in the photographs. However these injuries could also have occurred in a wide variety of ways for example, in a complicated fall or by contact with the environment in the process of putting Cameron Doomadgee into the police vehicle or removing him from the vehicle and taking him into the police station whilst he was struggling.

Three jab like punches with a fist would not in my opinion be a sufficient explanation for the force that caused the liver injury.

A number of other descriptions of actions involving possible force being applied to Cameron Doomadgee are present in the documentary materials but for the most part these are covered in the examples given above.

In my opinion none of the alleged actions and activities attributed to Senior Sergeant Hurley and commented on above would be sufficient to cause a liver injury of this degree of severity to Cameron Doomadgee."

- [45] It can be seen that the effect of Dr Ranson's evidence was to exclude the punches described by Mr Bramwell as the cause of those injuries.

- [46] On behalf of the appellants, it was submitted that the medical evidence supported the possibility that the punches of which Mr Bramwell gave evidence caused the

fatal injuries suffered by the deceased. That submission is accurate only in the theoretical and abstract sense that a "full-blooded punch" might have caused the damage to the liver and portal vein if delivered with sufficient force. The issue which had to be resolved, on the evidence, was whether the punches described by Mr Bramwell did carry the necessary force. In this regard Dr Ranson expressed the opinion in his report that three "jab-like punches" described by Mr Bramwell would not have been able to generate sufficient force to rupture the deceased's liver and portal vein. His opinion was not disputed by any party at the inquest. None of the other doctors who gave evidence offered a contrary opinion. The other medical evidence was to the effect that, whatever the nature of the contact between Mr Hurley's body and the body of the deceased, it was necessary that the full weight of Mr Hurley's body needed to be behind the blow in order to cause internal injuries of the kind suffered by the deceased. Dr Lampe thought that a blow with a knee or a torso with the weight of Mr Hurley's body behind it might have carried sufficient force to inflict the fatal injuries suffered by the deceased; and Dr Lynch was of a similar view.

- [47] None of the medical witnesses nor any of the parties sought to dispute Dr Ranson's unequivocal rejection of the possibility that the punches described by Mr Bramwell could have caused the fatal injuries. But the Coroner did not refer to the unequivocal evidence of Dr Ranson or to the circumstance that his opinion was undisputed. That this is so is apparent from the following passage in the Coroner's reasons:²⁰

"The original autopsy examination of [the deceased's] body was performed by forensic pathologist, Dr Guy Lampe. This occurred on 23 November 2004 at the Cairns Base Hospital mortuary. A second autopsy was performed in Brisbane on 30 November 2004 by Associate Professor David Ranson. Professor Anthony Ansford and Dr Byron Collins were also in attendance together with Dr Guy Lampe.

The only external sign of injury was a small oval abrasion in the centre of the right eyebrow measuring 0.4 centimetres by 0.2 centimetres which was bleeding slightly. The right upper eyelid was swollen but there was no haemorrhage of the right eye. The second autopsy examined the right eye area below the skin surface. There was a small amount of contusion (bruising.) The second autopsy also found some deep bruising immediately adjacent to the right side of the mandible and a small (3 centimetre) scalp contusion on the right frontotemporal region of the scalp.

Dr Lampe noted that there was no abrasion or boot or shoe impression on the anterior (front) abdominal wall, or the lower chest.

The right sided rib cage showed lateral to anterolateral fractures of four ribs, from the sixth to the ninth inclusively. There was no associated contusion of the muscle area above the fractured ribs, but there was some internal haemorrhage of the muscles above and adjacent to the eighth and ninth rib fractures.

²⁰ *Inquest into the Death of Mulrunji*, unreported, Acting State Coroner Clements, Coroners Court at Townsville, Qld, 27 September 2006 at 7 – 9.

The most significant finding was in the peritoneal cavity. There was at least one and a half litres of blood and clot. The liver was virtually completely ruptured- '... *cleaved in two*' in Dr Lampe's words. The two halves of the liver were only connected by some blood vessels. The portal vein had an oval hole along its posterior surface measuring 1.5 by 0.7 centimetres which was along the line of the contusion extending through the soft tissue. There was localised haemorrhage to the pancreas adjacent to the peri-duodenal haemorrhage.'

Both autopsies concluded that the cause of death was intra-abdominal haemorrhage, due to the ruptured liver and portal vein.

The consensus of medical opinion was that severe compressive force applied to the upper abdomen, or possibly the lower chest, or both together, was required to have caused this injury.

I accept that evidence and rely upon it in considering the evidence in this inquest to explain how this injury was caused to [the deceased].

All the expert medical evidence also concurred that a fall together, side-by-side, of the two men onto a flat surface was unlikely to have caused the injury that occurred. **I accept that evidence.**

Medical witnesses were asked to consider whether the application of a knee or an elbow, whilst [the deceased] was on the hard flat surface, either during or separate to the fall could have caused the mechanism of injury. **This was accepted as a possible means by which the injury could have occurred.**

Dr Lampe noted that the reported changes in [the deceased's] behaviour from aggressive prior to the fall, to passive after the fall, suggests the events surrounding the fall are crucial.

It is noteworthy that the second autopsy did reveal bruising on the left index finger knuckle and right little finger. Again, this was said to be consistent with either punching, or injuries sustained in defensive moves, or during the fall onto the right side.

Finally there was a comment confirming that [the deceased's] blood alcohol content indicated he would have been significantly intoxicated. The blood alcohol level was 292 mg/100mL (0.292) His coordination would have been affected and he would have had less capacity to protect himself from injury in any altercation or fall.

Associate Professor Ranson's plain English language statement is helpful:

'In my opinion the death occurred from blood loss as a result of the liver being torn. I believe the liver injury was the result of forceful pressure being applied to the

front of the upper abdomen or stomach area. This force squeezed the liver by pushing it up against the front of the spine so that it was nearly split in half.'

Dr Ranson also said:

'A complicated fall where the two individuals fall together from a standing position would not usually cause the liver laceration seen in this man unless during the process of the fall a small area of direct crushing pressure was applied to the front of the upper abdomen with the back or posterior lateral aspect of the body fixed against a hard surface If a large person were to fall in an accelerated or uncontrolled fashion on top of an individual who was lying on their back on the ground, such that a small part of their body, for example a knee applied a crushing type force to the upper abdomen, it is possible that such a liver laceration might be caused.'

Associate Professor Stephen Lynch, who is a specialist general surgeon practising in the field of liver transplant surgery and treatment gave evidence. He discounted any physical possibility of [the deceased] having sustained the liver injury prior to the point of being removed from the police vehicle at the back of the police station. He said [the deceased] would not have been able to struggle, as the evidence suggests, if he had blood in his abdominal cavity at that time. His injuries must have occurred at the time of the fall or afterwards. This is again noteworthy because of the evidence that after the fall, and after Sergeant Leafe had returned from opening the cell door, [the deceased] was no longer resisting and required to be dragged to the cell.

He agreed with other medical opinions that signs of the abdominal injury could be masked by the degree of intoxication.

Most importantly, Dr Lynch was clear that [the deceased's] injuries were so serious that, even if their true nature had been appreciated at the time, it would have been impossible to stabilise his condition sufficiently on Palm Island to allow safe transfer to Townsville, even if a doctor had been in attendance at the time of injury and had commenced resuscitation immediately.

Dr Lynch also agreed with other medical opinions that [the deceased's] injuries were inconsistent with a simple fall through the door of the watch house. He also concurred that the mechanism of injury was a compressive force of very considerable magnitude to the right lower rib cage with the rest of the body otherwise immobilised.

Therefore, he said, the four fractured ribs, liver laceration and portal vein rupture could have occurred as a result of a single injury involving the application of a very considerable force anteriorly over

the lower right ribs, with the torso otherwise immobilised (against the floor for example.)

Dr Lynch observed that [the deceased] was one hundred and eighty one centimetres tall and weighed seventy four kilos. He also observed that Senior Sergeant Hurley was approximately the height of the watch house door frame. Senior Sergeant Hurley himself informed the court that he was six foot seven inches tall (200.66 centimetres). His build was proportionate to that height.

Dr Lynch then indicated that the:-

'... combined mass of the two struggling men, falling together perhaps in an accelerated and less than controlled fashion through the doorway could generate considerable force. This force, if applied over a small surface area (for example a knee contacting the lower right ribs of the deceased) may have been sufficient to cause the injuries sustained.'

Dr Lynch was taken by Mr Callaghan SC through a discussion of the mechanics of such a fall that might result in such an injury. At page 648 of the transcript Dr Lynch agreed that the force applied to [the deceased's] body must have been from the front (anteriorly) of the body or perhaps the right hand side of the body. He agreed that this logically would mean [the deceased] was on his back or on his left hand side. It would be difficult in such a scenario to then explain the injury to the right eye as being incurred in the course of such a fall.

The evidence is clear that [the deceased] died due to blood loss caused by rupture of the liver consequent upon blunt compressive force to the upper abdomen." (emphasis in original)

- [48] We conclude that the finding of the Coroner that punching by Mr Hurley caused the fatal injuries sustained by the deceased was not reasonably open on the evidence. Accordingly, the decision of the District Court that this finding of the Coroner should be set aside was correct even though the process of reasoning whereby his Honour arrived at that decision was flawed.

What course should this Court take?

- [49] Pursuant to s 118(9) of the *District Court of Queensland Act*, an appeal to this Court from a decision of the District Court is an appeal "by way of rehearing". The scope of that rehearing is limited to the record in the District Court. On the determination of that appeal, it is open to this Court to make any order which ought properly to have been made by the District Court pursuant to s 50 of the Act. That is because this Court has, pursuant to r 766(1) of the *Uniform Civil Procedure Rules 1999* ("the UCPR"), "all the powers and duties of the court that made the decision appealed from".

- [50] It is now convenient to address the submission made on behalf of the Attorney-General and, opportunistically, on behalf of the appellants, that the only

finding of the Coroner set aside by the District Court was the finding that punching by Mr Hurley after the fall caused the fatal injuries suffered by the deceased.

- [51] We are of the opinion that the finding by the Coroner as to how the deceased died is not completely or accurately stated by saying that the death occurred as a result of injuries sustained by punching by Mr Hurley. The whole of that finding is the jumble of statements excerpted at para [22] of these reasons which, as we have said, related to s 45(2)(b) of the Act.
- [52] While it may be true to say, as counsel on behalf of the Attorney-General says, that the conclusions that Mr Hurley fell side by side with the deceased and that the fatal injuries were not sustained in the fall were supported by abundant evidence, the Coroner's conclusion negating one source of the fatal injury was truly the obverse of the conclusion that they resulted from punching by Mr Hurley after the fall. We have referred to the opportunistic change in the stance taken by counsel for the appellants on this point, not to advance a criticism of counsel but to draw attention to the common sense of the position originally adopted by the appellants' counsel and to the artificial – one might even say unrealistic – attempt to regard the Coroner's conclusions as standing independently of each other as findings for the purposes of s 45(2)(b) or (e).
- [53] It seems to us that the District Court judge may well have intended his decision to have that effect; but be that as it may, we consider that the Coroner's conclusions in this regard were an essential part of her statement of the finding she made for the purposes of s 45(2)(b) of the Act. The whole of that finding must be set aside. We pause here to note that counsel for the appellants disclaimed any objection that this view was not open to the Court because of the want of a notice of contention to this effect by Mr Hurley.
- [54] As we have noted, the Attorney-General and the appellants submitted that only the conclusion that Mr Hurley's punching the deceased after the fall caused the fatal injuries should be set aside. They submitted that it must then inevitably be found that the fatal injuries were suffered as a result of the deliberate application of force by Mr Hurley after the fall, eg by his dropping a knee into the torso or upper abdomen of the deceased. We do not accept that the setting aside of the first conclusion inevitably leads to such a finding against Mr Hurley. For example, Mr Bramwell's evidence might stand in the way of a conclusion that, after the fall, Mr Hurley deliberately dropped his knee into the torso or upper abdomen. It is at least arguable that Mr Bramwell's account does not leave room for such an occurrence. We emphasise that we are not to be taken as expressing a view as to what findings of fact should ultimately be made: that is not this Court's function.

Orders

- [55] For these reasons we consider that the appeal must be allowed and the whole of the finding of the Coroner as to how the deceased died which is excerpted at para [22] should be set aside. That is the order which the District Court judge should have made. We so order.
- [56] Section 50(7) of the Act allowed the District Court to order the reopening of the inquest to re-examine a finding which is set aside. It is appropriate that the inquest be reopened. We so order.

- [57] It was open to the learned District Court judge, and it is open to this Court, to direct the State Coroner that another coroner should be appointed to re-examine the finding which has been set aside. We so order.
- [58] Further, we direct that that other coroner should not be the coroner below. In this regard, we consider that it is open to the District Court under s 50(7) of the Act (and to this Court on appeal from the District Court) to order that the State Coroner direct "another coroner", being a coroner other than the State Coroner who is also not the coroner who conducted the original inquest, to re-open the inquest to re-examine the finding.
- [59] By way of explanation of the basis for this direction, we note that we see no good reason to read down the language of s 50(7)(b)(i) of the Act in a way which would limit the power of the District Court so that the question whether a coroner who conducted the original inquest should reopen the inquest is to be left exclusively to the determination of the State Coroner. We consider that the appointment of a different coroner will ensure that any positive finding as to how the deceased died is not tainted by any perceived preconceptions which might be argued to follow from the reasoning leading to the finding which has been set aside.
- [60] The parties have leave to make written submissions in relation to costs in accordance with para 37A of Practice Direction No 1 of 2005.