COURT: MAGISTRATES COURT OF TASMANIA (Coronial Division)

CITATION: *Investigation into the Deaths of Dr Robert Bo Xu and Mr Jarrod Robert Davies*

FILE No(s): H0358/2019, H0046/2020

DELIVERED ON: 3 May 2023

DELIVERED AT: Hobart

HEARING DATE/S: 24 April 2023

DECISION OF: Webster R

CATCHWORDS: Magistrates – Coroners – Inquests and inquiries – Proceedings at inquest or inquiry – Scope of inquest – Request for particulars-Ruling.

Coroners Act 1995 (Tas), ss28, 50, 51.

Re State Coroner; ex parte The Minister For Health [2009] WASCA 165; (2009) 38 WAR 553; *R v South London Coroner; ex parte Thompson* (1982) 126 Sol Jo 625 at 628; *Annetts v McCann* [1990] HCA 57; (1990) 170 CLR 596; *R v North Humberside Coroner; ex parte Jamieson* [1995] QB 1; *Harmsworth v The State Coroner* [1989] VR 989; *R v Associated Northern Collieries* [1910] HCA 61; (1910) 11 CLR 738; *Priest v West* [2012] VSCA 327, (2012) 40 VR 521.

REPRESENTATION:

***Counsel*:**

Counsel Assisting:	K. Read SC
Mr and Mrs Davies:	**S** Ruffin
Mr Ian Vaughan:	P. Jackson SC and C Sluiter
Commissioner for Licensing:	M. Jehne
Tasmanian Ports Corporation Pty Ltd:	T. Cox
Hobart City Council:	N. Readett
Tasmania Police:	M. Miller

Police Association of Tasmania:	C. Riley

Solicitors:

Counsel Assisting:	Nil
Mr and Mrs Davies:	Ruffin Lawyers
Mr Ian Vaughan:	HWL Ebsworth
Commissioner for Licensing:	Office of the Solicitor General
Tasmanian Ports Corporation Pty Ltd:	Barry Nilsson
Hobart City Council:	Simmons Wolfhagen
Tasmania Police:	Tasmania Police
Police Association of Tasmania:	Nil

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INVESTIGATION into the DEATHS of DR ROBERT BO XU and MR JARROD ROBERT DAVIES

REASONS FOR DECISION **WEBSTER, R**

Introduction

1. The evidence obtained in respect of the deaths of Dr Xu and Mr Davies suggests both men drowned in the waterfront area of Hobart after they each consumed a considerable amount of alcohol. Dr Xu died on 7 November 2019 whereas Mr Davies died between 9 and 11 February 2020. The evidence suggests they each entered the water in the early hours of the morning. Because of the circumstances surrounding each man's death and the fact they occurred within approximately three months of each other it is appropriate that their deaths be investigated at the one inquest. Accordingly the Chief Magistrate made a direction in those terms pursuant to s50 of the *Coroners Act* 1995 (the Act).

2. Counsel assisting the Coroner, Mr Ken Read SC, distributed to the parties a proposed scope of inquest which sets out the matters which he proposed I examine so that I could comply with my statutory duties as set out in s28 of the Act.

3. These inquests were therefore subsequently listed for a case management conference[1] on 24 April 2023 at which time I heard submissions from the parties with respect to the proposed scope. Prior to the case management conference counsel for a number of the parties had filed written submissions which some of them spoke to.

4. At the outset Mr Riley, on behalf of the Police Association of Tasmania, indicated his organisation did not wish to appear and be heard at the inquest.

5. Ms Ruffin appeared at the case management conference with Mr Davies' parents via a Zoom link. Dr Xu's brother, Louis, and Mr Davies' sister, Jess Payne, although not participating in the proceedings were also linked in via Zoom. All other parties appeared in person.

The Proposed Scope

6. The proposed scope which was distributed to interested parties by Counsel Assisting was, subject to consideration of further submissions from those parties, as follows:

[1] Held pursuant to r22 of the *Coroners Rules* 2006.

1. The service of alcohol to Dr Xu and Mr Davies on the evening before each died and the extent to which that service might be characterised as causing or as a cause of the death of either Dr Xu or Mr Davies.
2. In respect of Mr Davies did the assault and/or the care afforded to him thereafter cause or contribute to his death.
3. What conditions were specified in the licences issued to each of the premises – ss.7,8,9, *Liquor Licensing Act* 1990.
4. Whether the service of alcohol to Dr Xu and Mr Davies was in accord with the *Liquor Licensing Act* 1990 and any conditions specified in the licence of the premises concerned.
5. Whether recommendations should be made as to the conditions specified in licences of the types issued.
6. Whether procedures in place to ensure compliance with the Act and with conditions specified in the licences were adequate. This will include each of the procedures of the licensee, the Police and authorised officers (s.209, *Liquor Licensing Act* 1990).
7. Whether recommendations should be made as to procedures to ensure compliance with the Act and conditions specified in the licences.
8. The safety features of the Hobart waterfront and the extent to which the layout of the Hobart waterfront ought be characterised as causing or as a cause of the death of either Mr Xu or Mr Davies.
9. Whether recommendations should be made for improvement of safety features of the Hobart waterfront.

Suggested Amendments

7. Mr Jackson SC indicated he took no issue with paragraphs 1 – 4 and 7 – 9 of the proposed scope listed in paragraph 6. He did however take issue with the breadth and what he called the unqualified terms of paragraphs 5 and 6.

8. In so far as his client was concerned Mr Jackson SC submitted that *"[t]hroughout almost the entire time that Mr Davies was in the Observatory Bar on 9 February 2020 the Bar was operating under the terms of an out of hours permit that was in force from 13 May 2019 to 12 May 2020, and that was subject to conditions specified in that permit. It is understood that those conditions were, and such conditions still are, generic conditions in all such permits."*

9. He submitted paragraph 5 of the proposed scope should become:

> *Whether (and if so what) recommendations should be made, with a view to preventing further deaths in like circumstances, as to conditions that ought to be generically specified in out of hours permits issued pursuant to s12 of the Liquor Licensing Act 1990.*

10. In so far as paragraph 6 of the proposed scope was concerned Mr Jackson SC submitted the enquiry must focus on the relevant licence, which in the case of Observatory Bar was the out of hours permit that was in force from 13 May 2019 to 12 May 2020, and compliance with the conditions of that permit. Accordingly he submitted paragraph 6 should have clear, discrete parts which in so far as the first sentence in Counsel Assisting's proposed scope and his client is concerned should be as follows:

    (a) Whether procedures in place at Observatory Bar on 9 February 2020 to ensure compliance with conditions specified in its out of hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies' death.

    (b) Whether procedures in place at Observatory Bar on 9 February 2020 to ensure compliance with relevant provisions in Division 5 of Part 2 of the Liquor Licensing Act 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies' death.

11. Mr Jackson SC confirmed he was not directly concerned with the inquest involving Dr Xu or any enquiry concerning the Police and "authorised officers" but said consistent with the approach he proposed in respect of his client's procedures he submitted a further sub paragraph be inserted into paragraph 6 as follows:

    (c*) Whether any failure on the part of any Police officer or of any authorised officer under s209 of the Liquor Licensing Act 1990 to take steps to enforce compliance by the licensee of Observatory Bar on 9 February 2020 with conditions specified in its out of hours permit, or with relevant provisions in Division 5 of Part 2 of the Liquor Licensing Act 1990, resulted in non-compliance that caused or contributed to Mr Davies' death.*

12. Mr Read SC indicated he agreed with the amendments suggested by Mr Jackson SC and mirror provisions should be incorporated into paragraph 6 to cover Mobius Lounge Bar and the Evolve Spirits Bar; the latter bar being located at MACq01 Hotel.

The Respective Positions of the Other Parties

13. Mrs Ruffin indicated she had no submissions to make with respect to the proposed scope.

14. Mr Cox focused on paragraphs 8 and 9 of the proposed scope. Accordingly I infer he had no difficulties with respect to paragraphs 1 to 7 of the proposed scope or the amendments outlined by Mr Jackson SC which are set out above. Although conceding an examination of safety features of the Hobart waterfront was a relevant enquiry his complaint was that he had not been provided with any particulars of the safety features that caused or contributed to either man's death or which were deficient.

15. Mr Readett indicated he did not wish to be heard with respect to the proposed scope.

16. Mr Miller made no submissions with respect to paragraphs 1 – 4 and 8 of the proposed scope. As to paragraph 6 he agreed there was an issue as to who was responsible in relation to enforcement and therefore that is a relevant matter to investigate. He also said the Commissioner of Police acknowledges the relevance of paragraphs 5, 7 and 9 as it was clear I was considering those issues in relation to what, if any, findings I am obliged by statute to make.

17. Mr Jehne relied upon his previously filed submissions to challenge the relevance of paragraphs 5,6 and 7 of the proposed scope. He made no submissions about paragraphs 1 to 4 and he said paragraphs 8 and 9 were of no interest to the Commissioner for Licensing.

The Coronial Jurisdiction

18. In Tasmania, a coroner has jurisdiction to investigate any 'reportable death'.[2] A 'reportable death' includes a death where the death occurred in Tasmania and it appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury.[3] Both the deaths of Dr Xu and Mr Davies meet that definition.

19. When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest is an inquisitorial proceeding. It is not a proceeding between parties: *R v South London Coroner; ex parte Thompson* (1982) 126 Sol Jo 625 at 628; *Annetts v McCann* [1990] HCA 57; (1990) 170 CLR 596 at 616; *R v North Humberside Coroner; ex parte Jamieson* [1995] QB 1 at 17; *Re State Coroner; ex parte The Minister For Health* [2009] WASCA 165; (2009) 38 WAR 553 at [21]. In *Annetts v McCann* (supra) Toohey J set out the following passage from the judgment of Lord Lane CJ in *R v South London Coroner; Ex parte Thompson* (which was reported in *The Times* on 9 July 1982, but quoted in Matthews P, Foreman JC (eds) *Jervis on the Office and Duties of Coroners* (10th ed, 1986) p6:

> *"Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. 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."*

20. A coroner is required to thoroughly investigate a death and answer the questions (if possible) that s28 of the Act asks. Those questions include who the deceased was, how he or she died, what was the cause of the person's death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions.

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[2] See section 21 of the *Coroners* Act 1995.
[3] See section 3 of the *Coroners Act* 1995.

21. A coroner does not have the power to charge anyone with crimes or offences arising out of the death the subject of an investigation. Nor does a coroner have power to determine issues associated with an inheritance or other matters arising from the administration of deceased estates.

22. As noted above, one matter the Act requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by s28(1)(b) upon the coroner.

23. A coroner may comment on any matter connected with the death into which he or she is enquiring. The power to make comment *"arises as a consequence of the [coroner's] obligation to make findings … It is not free ranging. It must be comment "on any matter connected with the death" … It arises as a consequence of the exercise of the coroner's prime function, that is, to make "findings"*.[4]

24. Section 25 of the *Coroners Act* 1996 (WA) is as follows:

> *25 . Findings and comments of coroner*
>
> *(1) A coroner investigating a death must find if possible —*
>
> *(a) the identity of the deceased; and*
>
> *(b) how death occurred; and*
>
> *(c) the cause of death; and*
>
> *(d) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1998 .*
>
> *(1A) However, a coroner is not under a duty to make a finding under subsection (1)(b) as to how death occurred, even if it is possible to do so, if —*
>
> *(a) there is no duty to hold an inquest into the death under this Act; and*
>
> *(b) the coroner determines that there is no public interest to be served in making a finding as to how the death occurred.*
>
> *(2) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.*
>
> *(3) Where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.*

[4] See *Harmsworth v The State Coroner* [1989] VR 989 at 996.

(4) Where a post mortem examination is held as part of the investigation of a death and a finding has not been made within 21 days after that post mortem examination, then the coroner must provide written information on that examination to any of the next of kin under section 37(5), unless it is not practicable to do so.

(5) A coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

25. Section 28 of the Act is in the following terms:

28. Findings, &c., of coroner investigating a death

(1) A coroner investigating a death must find, if possible –

(a) the identity of the deceased; and

(b) how death occurred; and

(c) the cause of death; and

(d) when and where death occurred; and

(e) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1999.

(f) . . . . . .

(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

(4) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.

(5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care.

26. Subsection 1 of s25 of the West Australian Act and s28(1) of the Act are identical apart from s28(1)(d) of the Act which has no West Australian equivalent. Section 25(2) is the same as s28(3). Section 25(3) is in similar terms to s28(5) as is s25(5) and s28(4) although the West Australian provision extends to a prohibition on a coroner commenting on civil liability. The power to make recommendations which is provided for in s28(2) of the Act is contained in s27(3) of the West Australian Act. The Act contains no provision similar to those contained in s25(1A) and s25(4) of the West Australian Act.

27. Buss JA, with whom Martin CJ and Miller JA agreed, analysed s25(1)(b) and (c) of the West Australian Act in *Re The State Coroner; ex parte The Minister For Health* (supra). In considering those provisions his Honour noted at [25] the provisions in s 25(1)(a)-(d) "are, relevantly, identical to the provisions of s 19(1)(a)-(d) of the *Coroners Act* 1985 (Vic)"[5]. Buss JA also noted the *Coroners Act* 2003 (Qld) is based on and largely reproduces the 1985 Victorian Act. His Honour therefore looked at a number of Victorian and Queensland decisions which discussed these provisions. At [40]-[42] Buss JA discusses the meaning of the phrase "how death occurred", which appears in s 28(1)(b) of the Act, in the following terms:

> *"40 The dictionary meaning of the expression 'how death occurred' is in what way or manner or by what means the death happened or took place. See The Macquarie Dictionary (4th ed, 2005) 694; The Shorter Oxford English Dictionary (5th ed, 2002) 1279.*
>
> *41 However, 'how death occurred' in s 25(1)(b) of the Act must be construed not merely by reference to its dictionary meaning, but also in the context of the other provisions of s 25(1) and the Act as a whole. For example, the Parliament plainly intended that a finding of 'how death occurred' within s 25(1)(b) would be different from a finding of 'the cause of death' within s 25(1)(c).*
>
> *42 In my opinion, s 25(1)(b) confers on the coroner the jurisdiction and obligation to find, if possible, the manner in which the deceased happened to die. This does not refer only to the means or mechanism by which the death was suffered or inflicted. It extends to the circumstances attending the death. In my opinion, a construction of s 25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation (especially an investigation into deaths where one or more of the conditions in s 22(1) of the Act are satisfied). Also, this construction is consistent with the decision of the Court of Appeal of Queensland in Atkinson[6] on a comparable statutory provision."*

28. In discussing the phrase "cause of death", which appears in s28(1)(c) of the Act, Buss JA said the following at [44]-[47]:

> *" 44 The coroner, in finding, if possible, 'the cause of death', is not confined or restricted by concepts such as 'direct cause', 'direct or natural cause', 'proximate cause' or the 'real or effective cause'. Similarly, a coroner is not confined or restricted to a cause that was reasonably foreseeable. See WRB Transport v Chivell [1998] SASC 7002; (1998) 201 LSJS 102 [20] (Lander J, Mullighan J agreeing).*
>
> *45 In WRB Transport, Lander J said, in the course of considering the coroner's jurisdiction under s 12 of the Coroners Act 1975 (SA) to ascertain 'the cause or circumstances of the ... death of any person ... ':*

[5] The relevant provision in Victoria is now s67 of the *Coroners Act* 2008. The power to make recommendations is contained in s72(2) of that Act.
[6] Atkinson v Morrow [2005] QCA 353; [2006] 1 Qd R 397.

> *The Coroner ... has to carry out an inquiry into the facts surrounding the death of the deceased to determine what, as a matter of common sense, has been the cause of that person's death. The inquiry will not be limited to those facts which are immediately proximate in time to the deceased's death. Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of the death of the deceased. But there will be other facts less proximate in time which will be seen to operate, in some fact situations, as a cause of the death of the deceased. That is a factual inquiry which only has, as its boundaries, common sense [21].*
>
> *His Honour added that the coroner's jurisdiction to determine the cause of a deceased's death is in addition to his or her jurisdiction to determine the circumstances of the deceased's death [22] - [25]. See also Saraf v Johns [2008] SASC 166; (2008) 101 SASR 87 [18] - [19] (Debelle J).*
>
> *46 Section 25(1)(c) does not, however, authorise a coroner to undertake a roving Royal Commission for the purpose of inquiring into any possible causal connection, no matter how tenuous, between an act, omission or circumstance on the one hand and the death of the deceased on the other. See R v Doogan; Ex parte Lucas-Smith [2005] ACTSC 74; (2005) 193 FLR 239 [28] (Higgins CJ, Crispin & Bennett JJ).*
>
> *47 It will be necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of the death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case. See March v E & MH Stramare Pty Ltd [1991] HCA 12; (1991) 171 CLR 506, 515 (Mason CJ), 522 (Deane J); WRB Transport [21]; Saraf [18] - [19]; Doogan [29]."*

Mr Cox's Application for Particulars

29. General allegations made in a pleading in the civil division of this Court or in a complaint lodged in the criminal division of this Court are ordinarily supplemented by particulars. The function of particulars was discussed by Issac J in *R v Associated Northern Collieries* [1910] HCA 61; (1910) 11 CLR 738 at 740-741 as follows:

> *"I take the fundamental principle to be that the opposite party shall always be fairly apprised of the nature of the case he is called upon to meet, shall be placed in possession of its broad outlines and the constitutive facts which are said to raise his legal liability. He is to receive sufficient information to ensure a fair trial and to guard against what the law terms "surprise," but he is not entitled to be told the mode by which the case is to be proved against him."*[7]

30. Accordingly in adversarial proceedings between parties a party is entitled to know every material fact on which his or her opponent relies. The nature and character of an allegation or charge must be known with precision so that the party can prepare a brief and not be taken by surprise.

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[7] See also Dare v Pulham [1982] HCA 70; (1982) 148 CLR 658 at 664 and Bailey v Federal Commissioner of Taxation [1977] HCA 11; (1977) 136 CLR 214 at 219,221, 227-228.

31. Particulars therefore serve the function of informing an opponent of the case to be met at trial and particulars limit the pleadings so as to more sharply define the issues in dispute in the case.

32. As explained above an inquest is not a proceeding between parties. It is an enquiry in which an attempt is made to find facts. There are no pleadings in which allegations are made against any person or entity. Particulars therefore have no role or function in this proceeding.

33. In making submissions about paragraphs 8 and 9 of the proposed scope Mr Cox indicated, after conceding an examination of the safety features on the Hobart waterfront was a relevant enquiry, he had not been provided with any particulars of the safety features that caused or contributed to either man's death or which were deficient.

34. His submission assumes safety features on the Hobart waterfront caused or contributed to either man's death or they were in some way deficient. No facts have been found to establish either proposition. Whether or not those facts are established will be determined at the inquest. I note what safety features were or were not present at the time of each man's passing is within the knowledge of his client.

35. In my view then Mr Cox's client is not entitled to particulars. I therefore dismiss his application.

Mr Jehne's Opposition to Paragraphs 5, 6 and 7 of the Proposed Scope

36. Paragraphs 5 and 6 of the proposed scope as suggested by Mr Jackson SC and as endorsed and expanded upon by Mr Read SC are as follows:

> 5. Whether (and if so what) recommendations should be made, with a view to preventing further deaths in like circumstances, as to conditions that ought to be generically specified in out of hours permits issued pursuant to s12 of the *Liquor Licensing Act* 1990.
>
> 6.(a) Whether procedures in place at Observatory Bar on 9 February 2020 to ensure compliance with conditions specified in its out of hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies' death.
>
> (b) Whether procedures in place at Observatory Bar on 9 February 2020 to ensure compliance with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies' death.
>
> (c) Whether any failure on the part of any Police officer or of any authorised officer under s209 of the *Liquor Licensing Act* 1990 to take steps to enforce compliance by the licensee of Observatory Bar on 9 February 2020 with conditions specified in its out of hours permit, or with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990, resulted in non-compliance that caused or contributed to Mr Davies' death.

(d) Whether procedures in place at Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 to ensure compliance with conditions specified in its out of hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(e) Whether procedures in place at Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 to ensure compliance with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(f) Whether any failure on the part of any Police officer or of any authorised officer under s209 of the *Liquor Licensing Act* 1990 to take steps to enforce compliance by the licensee of Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 with conditions specified in its out of hours permit, or with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990, resulted in non-compliance that caused or contributed to Dr Xu's death.

(g) Whether procedures in place at Mobius Lounge Bar on 7 November 2019 to ensure compliance with conditions specified in its out of hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(h) Whether procedures in place at Mobius Lounge Bar on 7 November 2019 to ensure compliance with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(i) Whether any failure on the part of any Police officer or any authorised officer under s209 of the *Liquor Licensing Act* 1990 to take steps to enforce compliance by the licensee of Mobius Lounge Bar on 7 November 2019 with conditions specified in its out of hours permit, or with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990, resulted in non-compliance that caused or contributed to Dr Xu's death.

37. Paragraph 7 of the proposed scope is:

> 7. Whether recommendations should be made as to procedures to ensure compliance with the Act and conditions specified in the licences.

38. Mr Jehne submitted paragraphs 5, 6 and 7 of the proposed scope are beyond a coroner's power to consider because there is no causal link between the topics in each of those paragraphs and either death. In addition he submitted a coroner is obliged to exclude evidence which is only tenuously relevant; in other words, it is beyond a coroner's power to consider evidence which *"even if relevant… [i]s too remote from the event to be regarded as causative."*[8] The test for admissibility of evidence cannot be basal "relevance" as the cases he cites demonstrate that bar is

[8] R v Coroner Doogan; exparte Lucas-Smith [2005] ACTSC 74 [29].

too low. Rather, a coroner will be acting beyond jurisdiction should he or she entertain evidence which does not satisfy the "common sense" test of causation to matters on which a coroner is obliged to make findings. These submissions are based on the Victorian decision of *Harmsworth v State Coroner* [1989] VR 989. In that State at that time the Coroner, under the *Coroners Act* 1985, must find, amongst other things, if possible the identity of the deceased, how death occurred and the cause of death.[9]Those requirements are therefore very similar to s28 of the Act. While in each Act a Coroner may comment on any matter connected with the death including public health or safety or the administration of justice[10] they differ in that in Tasmania it is mandatory for a Coroner whenever appropriate to make recommendations with respect to ways of preventing further deaths and on any other matter the coroner considers appropriate[11] whereas under the Victorian legislation such recommendations were and still are discretionary.[12]

39. I disagree with the submission paragraphs 5, 6 and 7 of the proposed scope are beyond a coroner's power to consider. In addition to the findings a coroner must find, if possible, as set out in s 28(1) of the Act a coroner must, in accordance with s 28(2) of the Act, whenever appropriate make recommendations with respect to ways of preventing further deaths and on any other matter the coroner considers appropriate. In addition, in accordance with s 28(3) a coroner may comment on any matter connected with the death. Sections s 28(2) and (3) are couched in very wide terms. In relation to the receipt of evidence a coroner is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit.[13] The significance of the similarly worded provision in Victoria[14] was discussed by the Victorian Court of Appeal in *Priest v West* [2012] VSCA 327, (2012) 40 VR 521. In that case Maxwell P and Harper JA said, at [5]-[6]:

> *"[5]Under s 62(1) of the Act, the Coroner holding an inquest is expressly not bound by the rules of evidence. The subsection provides, moreover, that the Coroner 'may be informed ... in any manner that the Coroner reasonably thinks fit'. As Tate JA notes, the trial judge took the view that these and related provisions gave coroners 'considerable latitude as to the manner in which an inquest is conducted'. In his Honour's view, this statutory flexibility and 'wide discretion' told against the argument that the coroner in the present case was bound to have regard to the material in the disputed statements.*
>
> *[6] With respect, we think these provisions point to the opposite conclusion. While undoubtedly giving the Coroner (appropriately) broad scope to shape and direct an investigation, these provisions emphasise Parliament's intention that the coroner should not be constrained in carrying it out. It is precisely because the Coroner must do everything possible to determine the cause and circumstances of the death that Parliament has removed all inhibitions on the collection and consideration of material which may assist in that task. Parliament has, in particular, exempted the Coroner's processes from the rules*

[9] Section 19 *Coroners Act* 1985 (Vic).
[10] Section 28(3) of the Act and s19(2) of the *Coroners Act* 1985(Vic).
[11] Section 28(2) of the Act.
[12] Section 21(2) of the Coroners Act 1985 (Vic) and s72(2) of the Coroners Act 2008 (Vic).
[13] Section 51 of the Act.
[14] Section 62(1) of the *Coroners Act* 2008 (Vic).

> *which limit the admissibility of evidence in court proceedings. Far from justifying a narrow view of the scope of an investigation, these provisions oblige the coroner to take an expansive or inclusive approach, in our view." [Footnotes omitted.]*

40. In order to carry out the duties imposed by s 28 it is necessary to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of the death of Dr Xu and Mr Davies[15]. A coroner has the jurisdiction and obligation to find, if possible, the manner in which Dr Xu and Mr Davies happened to die. This does not refer only to the means or mechanism by which the death was suffered or inflicted. It extends to the circumstances attending the death[16]. In addition a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter the coroner considers appropriate[17] and a coroner may comment on any matter connected with the death[18].

41. Paragraph 5 of the proposed scope set out in paragraph 36 above is focused on the mandatory obligation to make recommendations pursuant to s 28(2) of the Act. It is not beyond a coroner's power to consider the issues raised by that paragraph.

42. Paragraph 6 the proposed scope set out in paragraph 36 above is concerned with the compliance by licensees who served alcohol to Dr Xu and Mr Davies with the conditions of their respective out of hours permits and with their obligations under the *Liquor Licensing Act* 1990, and whether there was any non-compliance with the conditions of their respective out of hours permits and with their obligations under the *Liquor Licensing Act* 1990 which caused or contributed to each man's death. In addition paragraph 6 proposes to consider whether any failure on the part of any Police officer or of any authorised officer under section 209 of the *Liquor Licensing Act* 1990 to take steps to enforce compliance by the named licensees with conditions specified in their respective out of hours permits or with their obligations under the *Liquor Licensing Act* 1990 resulted in non-compliance that caused or contributed to each man's death. Paragraph 6 of the proposed scope is focused on the mandatory obligation to make a finding pursuant to 28(1)(c) of the Act. It is not beyond a coroner's power to consider the issues raised by paragraph 6.

43. Paragraph 7 of the proposed scope set out in paragraph 36 above is focused on the mandatory obligation to make recommendations pursuant to s 28(2) of the Act. It is not beyond a coroner's power to consider the issues raised by that paragraph.

44. Accordingly I reject Mr Jehne's submissions.

Ruling

45. The scope of this inquest is therefore as follows:

    1. The service of alcohol to Dr Xu and Mr Davies on the evening before each died and the extent to which that service might be characterised as causing or as a cause of the death of either Dr Xu or Mr Davies.

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[15] *Re The State Coroner; ex parte The Minister For Health* [2009] WASCA 165; (2009) 38 WAR 553 [47].
[16] *Re The State Coroner; ex parte The Minister For Health* [2009] WASCA 165; (2009) 38 WAR 553 [42].
[17] Section 28(2) of the Act.
[18] Section 28(3) of the Act.

2. In respect of Mr Davies did the assault and/or the care afforded to him thereafter cause or contribute to his death.
3. What conditions were specified in the licences issued to each of the premises – ss.7, 8, 9, *Liquor Licensing Act* 1990.
4. Whether the service of alcohol to Mr Xu and Mr Davies was in accord with the *Liquor Licensing Act* 1990 and any conditions specified in the licence of the premises concerned.
5. Whether (and if so what) recommendations should be made, with a view to preventing further deaths in like circumstances, as to conditions that ought to be generically specified in out of hours permits issued pursuant to s12 of the *Liquor Licensing Act* 1990.
6. (a) Whether procedures in place at Observatory Bar on 9 February 2020 to ensure compliance with conditions specified in its out of hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies death.

   (b) Whether procedures in place at Observatory Bar on 9 February 2020 to ensure compliance with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies' death.

   (c) Whether any failure on the part of any Police officer or of any authorised officer under s209 of the *Liquor Licensing Act* 1990 to take steps to enforce compliance by the licensee of Observatory Bar on 9 February 2020 with conditions specified in its out of hours permit, or with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990, resulted in non-compliance that caused or contributed to Mr Davies' death.

   (d) Whether procedures in place at Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 to ensure compliance with conditions specified in its out of hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

   (e) Whether procedures in place at Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 to ensure compliance with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

   (f) Whether any failure on the part of any Police officer or any authorised officer under s209 of the *Liquor Licensing Act* 1990 to take steps to enforce compliance by the licensee of Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 with conditions specified in its out of hours permit, or with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990, resulted in non-compliance that caused or contributed to Dr Xu's death.

   (g) Whether procedures in place at Mobius Lounge Bar on 7 November 2019 to ensure compliance with conditions specified in its out of hours permit were

inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(h) Whether procedures in place at Mobius Lounge Bar on 7 November 2019 to ensure compliance with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(i) Whether any failure on the part of any Police officer or any authorised officer under s209 of the *Liquor Licensing Act* 1990 to take steps to enforce compliance by the licensee of Mobius Lounge Bar with conditions specified in its out of hours permit, or with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act* 1990, resulted in non-compliance that caused or contributed to Dr Xu's death.

7. Whether recommendations should be made as to procedures to ensure compliance with the *Liquor Licensing Act* 1990 and conditions specified in the licences.

8. The safety features of the Hobart waterfront and the extent to which the layout of the Hobart waterfront ought be characterised as causing or as a cause of the death of either Dr Xu or Mr Davies.

9. Whether recommendations should be made for improvement of safety features of the Hobart waterfront.