COURT: SUPREME COURT OF TASMANIA

CITATION: *Tkalac v Cooper* [2023] TASSC 7

PARTIES: TKALAC, Faith Evelyn
v
COOPER, Simon (Coroner)
THE HONOURABLE ELISE ARCHER, ATTORNEY-GENERAL FOR THE STATE OF TASMANIA

FILE NO: 1840/2021

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JUDGMENT OF: Brett J

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Coroners Act 1995 (Tas), s 26.
Veitch v The State Coroner [2008] WASC 187; *Clancy v West* [1995] VICSC 207; [1996] VicRp 92; [1996] 2 VR 647; *Taing and Nuon v Territory Coroner and Attorney-General for the Northern Territory* [2011] NTSC 58; *Wuridjal v Northern Territory Coroner* [2001] NTSC 99 [2001] 165 FLR 317; *Attorney General v Copper Mines of Tasmania* [2019] TASFC 4; *Perre v Chivell* [2000] SASC 279; (2000) 77 SASR 282, referred to.
Aust Dig Magistrates [1373]

REPRESENTATION:

***Counsel*:**
Applicant: F Cangelosi
Respondent: No Appearance
Attorney-General : G Chen
Solicitors:
Applicant: Bold Lawyers
Attorney-General: Office of the Solicitor-General

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FAITH EVELYN TKALAC v CORONER SIMON COOPER and THE HONOURABLE ELISE ARCHER, ATTORNEY-GENERAL FOR THE STATE OF TASMANIA

REASONS FOR JUDGMENT

BRETT J
4 May 2023

1 In the early hours of 29 February 2020, Jari Wise died instantly when he was struck by a motor vehicle on Wilmot Road at Huonville. The motor vehicle was driven by his partner, Melissa Oates. They had been together at the nearby residence of a friend earlier that night. Both had consumed a substantial quantity of alcohol, and Mr Wise had left the premises after an argument between them. Ms Oates left the premises soon after, in order to travel to a nearby service station to purchase food. It seems that the collision occurred as Mr Wise was making his way home on foot, and Ms Oates was travelling back to her friend's residence. She did not stop after the collision. She continued to the house, but later returned to the scene of the collision.

2 Ms Oates was subsequently charged with the crime of dangerous driving contrary to s 172A of the *Criminal Code*, and the offences of driving a motor vehicle whilst exceeding the prescribed alcohol limit and failing to stop and assist in case of an accident. A blood sample taken from her less than two hours after the collision revealed alcohol in her blood in the concentration of .152g of alcohol per100ml of blood. Ms Oates pleaded guilty to the charges and on 22 April 2021, Geason J imposed a sentence of 14 months' imprisonment, with six months suspended, for the crime of dangerous driving and fines and disqualification in respect of the other offences. At the sentencing proceedings, the prosecution confirmed that it did not allege that Ms Oates was legally responsible for Mr Wise's death. The necessary inference is that it was not alleged that her dangerous driving of the motor vehicle had caused his death.

3 Mr Wise's death is a reportable death within the meaning of s 3 of the *Coroners Act* 1995 (the *Act*). The coroner, therefore, has jurisdiction to investigate the death: s 21 of the *Act*. Upon the death being reported, Coroner Simon Cooper commenced an investigation. Section 24 confers a discretion on the coroner to conduct an inquest as part of the investigation if he "considers it desirable to do so". By s 26, if the coroner decides not to hold an inquest, then he must record the decision in writing, specify the reasons for the decision and, as soon as practicable after making the decision, notify the senior next of kin in writing of the decision and the reasons for it. On 14 July 2021, Coroner Cooper notified Mr Wise's mother, who is the senior next of kin and the applicant in these proceedings, of his decision not to hold an inquest into the death. The reasons recorded in the notification are as follows:

> "• The death is not one referred to in section 24 of the *Coroners Act* 1995;
>
> - An inquest is not considered necessary or desirable in the interests of justice;
> - An inquest is unlikely to reveal any additional, significant information about the death; and
> - I have sufficient information to make findings about the matters required by section 28 of the *Coroners Act* 1995."

4 Section 26(2) provides that within 14 days after receiving such a notice, the senior next of kin may apply to this Court for an order that an inquest be held. By s 26(3), the Court may make an order

that an inquest be held if it is satisfied that it is necessary or desirable in the interests of justice. On 30 July 2021 the applicant made such an application to this Court. As would be expected in accordance with usual practice, Coroner Cooper has filed a notice of submission. However, on 14 September 2021, the Attorney-General was made a party to the application pursuant to s 58(1)(j) of the *Supreme Court Civil Procedure Act* 1932. The Attorney's ultimate submission is that the Court cannot be satisfied that an inquest is necessary or desirable in the interests of justice and, accordingly, the application should be refused.

Necessary or desirable in the interest of justice

5 The test under s 26(3) does not appear to have been the subject of judicial consideration in this State previously. However similar, albeit not always identical, formulations have been the subject of judicial consideration in other Australian jurisdictions.

6 Although the legislation is not identical, and cases are often dealing with a test to be applied in a different procedural context, for example, where a Court is reviewing a decision of a coroner not to re-open an inquest or hold a second inquest, the following matters of principle and guidance seem to me to be generally endorsed:

- A decision as to what is necessary or desirable in the interests of justice involves a discretionary value judgment. The Court is not constrained in the exercise of that discretion, but must consider the policy and objects of the statutory scheme. See *Veitch v The State Coroner* [2008] WASC 187, and cases referred to therein.

- The coroner has a "wide and unfettered" discretion as to whether or not to hold an inquest and the Court should exercise its jurisdiction to override that discretion "sparingly". See *Clancy v West* [1995] VICSC 207; [1996] 2 VR 647, *Taing and Nuon v Territory Coroner and Attorney-General for the Northern Territory* [2011] NTSC 58.

- However, the Court is not conducting a review of the coroner's reasons but rather undertaking "a fresh exercise in discretion". See *Wuridjal v Northern Territory Coroner* [2001] NTSC 99 [2001] 165 FLR 317.

- In exercising the discretion, a factor that has been regarded as significant in a number of cases is "whether there would be any benefit in holding an inquest and whether it would be expected to yield further information that thus far has not come to light". Per Blokland J in *Taing and Nuon v The Territory Coroner*. Her Honour explained this as follows:

> "What would make the holding of an inquest 'desirable' (in keeping with the overall objectives of the Coroners Act (NT))[54] is that there be some practical benefit to the next of kin in terms of better understanding of what occurred to the deceased, or that there be a benefit to the general public, a section of it, or to the overall administration of justice. An inquest should not be held where it would clearly be a futile exercise."

7 It follows, therefore, that an assessment of whether an inquest is "necessary or desirable", will be informed by its purpose and role within the statutory scheme. A fundamental function of the coroner under the *Act* is to investigate reportable deaths. The coroner's jurisdiction in this regard is purely inquisitorial, it will not involve proceedings between parties. See *Attorney General v Copper Mines of Tasmania* [2019] TASFC 4 and cases cited at [21]. The investigation has two ultimate purposes. Firstly, s 28 (1) requires the coroner to make certain findings, if possible. These include findings as to how the death occurred and the cause of death. Secondly, the *Act* provides for mandatory recommendations and discretionary comments by the coroner. See s 28(2) and (3). These concern ways in which future deaths can be prevented, as well as matters of public health or safety or the administration of justice.

8 It is clear that, under the statutory scheme, an inquest, if held, forms part of the coroner's investigation. The definition of "inquest" in s 3 describes it as "a public enquiry". Other provisions provide the coroner with power to summons witnesses to an inquest and require evidence to be given and questions answered on oath or affirmation. The coroner is not bound by the rules of evidence, and may be informed and conduct the inquest in any manner the coroner reasonably thinks fit. A person whom the coroner considers to have a sufficient interest may appear or be legally represented, and may call and examine or cross-examine witnesses and make submissions.

9 By s 24, the coroner must hold an inquest in certain defined circumstances. These include where the coroner "suspects homicide". Otherwise the coroner "may hold an inquest into a death…if the coroner considers it desirable to do so". (see s 24(2)).

10 It can be understood from these provisions that an inquest is intended to be a public investigative hearing that provides the coroner with wide and coercive evidence gathering powers. The desirability of holding an inquest is likely to be informed by its utility in advancing the investigation. Accordingly, in determining the desirability of an inquest, consideration should be given to any benefit that may accrue from the public nature of the proceedings and further whether the conduct of the inquest itself, which includes the power to compel evidence from witnesses and the advantages and opportunities which arise from the public examination and cross-examination of those witnesses, will assist the investigation and, in particular, make it more likely that it will be possible for the coroner to make the mandated findings.

11 In order to assess these questions as they apply to this case, it is first necessary to consider what evidence has already been made available to the coroner as a result of the investigation. That investigation has to this point been conducted by the police.

The police investigation

12 Police were called to and arrived at the scene of the collision shortly after its occurrence. They then conducted a detailed investigation of the circumstances surrounding and leading up to the collision. The brief of evidence accumulated as a result of the investigation was provided to the Director of Public Prosecutions and the coroner. It is clear that the coroner was in possession of this material at the time he gave notice of his decision not to hold an inquest.

13 A summary of the evidence obtained by police and available to the coroner is as follows:

- Mr Wise and Ms Oates had been in a relationship for several years and had two young children. Police records reveal a prior history of reported family violence against each other. At the time of the relevant events, each was subject to a family violence order which prevented contact with the other.

- Despite these orders, they arrived, with their children, at the home of a friend, Jessica Hosking, at around 7.00pm on 28 February 2020. This was for a social gathering and they both consumed a considerable amount of alcohol. At around 11.55pm, Brody Scott, who had been at the house earlier in the evening but had then gone to another location, made a telephone call to Ms Hosking and told her that he had been in a fight and had received a blow to the head with a bottle. Mr Wise overheard the conversation and wanted to go to his location to provide assistance. This caused an argument between Ms Oates and Mr Wise. Shortly after the argument started, Mr Wise left the property, taking some beer with him. As he was leaving, he yelled at Ms Oates from outside the property, and smashed a bottle of beer against her car.

- According to Mr Scott, Mr Wise arrived at his location and they had some alcoholic drinks together. Mr Scott's statement says that Mr Wise "seemed to be in good spirits". He left after the drinks, telling Mr Scott that he was going to walk home.

- At least one witness saw him walking along nearby streets at about 12.30am. It is clear that he made his way to Wilmot Road.

- In the meantime, shortly after Mr Wise left Ms Hosking's house, Ms Oates drove away in her van, stating that she intended to buy some food from a local service station. There is CCTV footage from a nearby service station which shows her vehicle driving into the forecourt at 12.58am. There is also CCTV footage from a location at Wilmot Road which shows the van travelling in a northerly direction along Wilmot Street at around 1.01am and then returning past the same location in a southerly direction approximately ten minutes later. Police have recovered call records from Ms Oates' telephone which show a number of calls and messages between her and Mr Wise. The last one is at 1.10am and it is a missed call.

- It can be inferred that the van struck Mr Wise at a point on Wilmot Street shortly after that missed call. There is no eye witness to the accident other than Ms Oates, but it is clear that the police investigation located a number of persons who were in the vicinity at the time, who heard the impact and saw the vehicle shortly afterwards. They include three men who were withdrawing cash from a nearby ATM. Their evidence is in some detail and confirms that the vehicle was travelling at speed at the time of the collision and drove away at high speed after it.

- The statements of Ms Hosking and other witnesses establish that Ms Oates returned to Ms Hosking's house immediately after the collision. According to Ms Hosking, Ms Oates said immediately on her return "You have got to help me. I think I have hit something or someone and I hope it is not Jari". She told Ms Hosking that she had been speaking to Jari on the phone while she was out and that he wanted her to come and get him. Ms Oates told Ms Hosking that she was on her way to meet him when she hit something.

- Ms Hosking and Ms Oates returned to the scene of the collision immediately. They located Mr Wise lying at the side of the road. Another person who arrived at the scene shortly after checked his pulse but could not locate one.

- Police and ambulance arrived at the scene at 1.27am. Ms Hosking and Ms Oates were present. One of the police officers said that Ms Oates "appeared highly intoxicated and was crying out 'Why did he jump in front of me?'". She told the officer a second time that Mr Wise had jumped out in front of her. She made a similar statement to a neighbour of Ms Hosking after she returned to that residence sometime later.

- Senior Constable Cordwell is a police officer with specialist training and experience in crash investigation. She arrived at the scene at 2.44am. She immediately commenced an investigation which included identifying and documenting the location of relevant debris, road markings and other features of the road. She has provided a detailed report to the coroner which records her investigation and sets out her conclusions and opinions. These include conclusions relating to the speed of the vehicle at the time of collision and the location of impact. The conclusions expressed by her include that Mr Wise "was walking north in the south bound lane facing the vehicle when he was struck". She noted his injuries which were largely on the right side of his body, and the damage to the motor vehicle which is predominantly to the passenger front hand side of the vehicle. Senior Constable Cordwell also arranged and participated in the conduct of visibility testing. The testing took into account the poor lighting in the vicinity and the fact that Mr Wise was wearing dark clothing. It concluded that a driver would have a very short time, between one and two seconds, of observation of a person on the roadway. The timing would depend on whether the lights were on low or high beam and the exact speed of the vehicle. Senior Constable Cordwell's conclusions support the inferences that the vehicle was travelling at high speed before and at the time of impact, that visibility was poor and that Ms Oates would have had little time from the point of seeing Mr Wise on the road to react to his presence.

- Senior Constable Cordwell did not locate any road markings or other evidence consistent with Ms Oates taking evasive action before impact.

- I have already noted that Ms Oates was required to provide a blood test for analysis within two hours of the collision. It returned an alcohol result of .152 grams per 100ml of blood. It can be inferred that this level of alcohol in her body may well have reduced her capacity to react to the presence of a person on the road even further.

- It was a condition of Ms Oates driver's licence that she wear visual aids because of limitations associated with her uncorrected vision. She was not wearing these aids at the relevant time.

- An autopsy was conducted by State Forensic Pathologist, Dr Donald Ritchey. The autopsy report has been provided to the coroner. Dr Ritchey concludes that the cause of death is multiple injuries sustained by collision with a motor vehicle. He also states as follows:

  > "These findings are interpreted by me to suggest that WISE was struck whilst upright as a pedestrian on the front of the body with several severe impact sites including the bilateral lower legs, the medial left thigh and the central upper abdomen and lower chest. Secondary impact of the face with the windscreen appears likely after which the body came to rest face down on the gravel verge. The severity of these injuries would have resulted in near instantaneous death."

- During the autopsy, a sample of Mr Wise's blood was taken for analysis. It reveals the presence of a significant amount of alcohol and THC (cannabis). This is consistent with other evidence which suggests that he had been drinking heavily before, and may have been intoxicated at the time of the collision.

- Ms Oates engaged in an interview with police. However, she did not answer questions concerning the events surrounding the collision.

14 Ms Oates' statements to a number of people, including a police officer, in the aftermath of the collision that Mr Wise had jumped or run in front of her car immediately prior to impact was given considerable attention in the police investigation. Katie Shead, Mr Scott's partner, says in her statement that she had been told by both Mr Wise and Ms Oates "about three or four years ago" that Mr Wise had jumped out in front of Ms Oates while she was driving. She was told that there had been an argument and Mr Wise had gotten out of the car. Ms Oates went up the road, turned around and came back and as she got near Mr Wise, he jumped out in front of the vehicle. He suffered a bruised leg. Amber Lovell is Ms Oates' cousin. She states that on 21 February 2020, just over a week before Mr Wise's death, she was driving Ms Oates' motor vehicle when Mr Wise "stepped out in front of the car". It was dark and she did not see him until the last moment. She was forced to take evasive action, and it was only when she braked that Mr Wise moved towards the side of the road. This occurred after she, Ms Oates, Mr Wise and others had been together. There had been a disagreement and Mr Wise had walked off.

15 The material provided to the coroner includes the advice of the Director of Public Prosecutions as to whether and, if so, what, charges should be laid against Ms Oates. It is clear that the Director concluded that although there was ample evidence that Ms Oates had been driving the motor vehicle dangerously at the time of impact, it could not be proved beyond reasonable doubt that the dangerous driving had caused Mr Wise's death. In particular, the Director opined that it would be impossible to exclude the possibility that Mr Wise moved on to the road way in front of the car at a time when it was impossible for Ms Oates to take evasive action or stop. In this respect, the Director clearly regarded the evidence of Ms Shead and Ms Lovell as influential. Accordingly, the Director determined that there was no reasonable prospect of convicting Ms Oates on a charge of manslaughter, or any charge which includes causation of death as an element.

16 In the sentencing proceedings before Geason J, the prosecution, of course, informed his Honour of the collision and Mr Wise's consequent death. However, the prosecutor stated the following:

> "The Crown does not assert that the accused is legally responsible for the death of Mr Wise, but his death is a relevant fact which is indicative of the risk that the accused posed to pedestrians and other road users by the manner of her driving. The reason why the Crown does not assert that the accused is legally responsible for the deceased's death is that if the deceased jumped out in front of the accused's vehicle it could not be said the accused's manner of driving (i.e. culpable negligence) was a cause of death. This is particularly the case when taking into account what witnesses have reported about Wilmot Road being very dark and the visibility not being good. At that hour of the morning a driver would not expect a pedestrian to be on the road in their lane. Thus, given the dark clothing worn by the deceased and the very poor visibility, it cannot be shown that the death would not have occurred even if a reasonable prudent driver had been driving the vehicle. Senior Constable Cordwell calculated that if travelling at 50 km/h it would take 12.5 metres to stop a vehicle. In addition, a person has to spend time to determine how he or she is going to react and that is, of course, if they were to see an obstruction. In this case, it would have been extremely difficult for a reasonable prudent driver to see the deceased at all.
>
> This is even more so the case if the deceased jumped out onto the roadway immediately prior to impact. It is Dr Ritchey's opinion that being struck by a vehicle at 50 km/h is more than sufficient force to sustain injuries sufficient to kill a pedestrian.
>
> Thus, in these circumstances, it cannot be said that the accused's manner of driving was a direct and immediate cause of the accident.
>
> On the evidence, it is a reasonable hypothesis that the deceased did jump out in front of the accused's vehicle:
>
> (a) The accused stated it was the case both to police and a friend shortly after the incident occurred.
>
> (b) The deceased had admitted to jumping out in front of the accused's vehicle in the past.
>
> (c) About a week before, the deceased had jumped in front of the accused's vehicle and on that occasion the driver almost hit him.
>
> (d) Given his previous tendency to behave in this manner and the fact that he was extremely intoxicated, it cannot be ruled out that on the night just before she drove past he jumped out in front of her vehicle.
>
> (e) No forensic evidence was found at the scene to disprove the accused's assertions that the deceased jumped out in front of her vehicle.
>
> (f) If this was the case, even if the accused had not been drinking or speeding or not wearing her glasses, the collision could not have been prevented. Therefore, the deceased's death would not have been caused by the accused's driving but by the fact that he jumped or ran out in front of her vehicle."

17 His Honour acknowledged these facts in his sentencing comments. He went on to say:

> "The Crown does not assert that you are legally responsible for Mr Wise's death, but that that result is indicative of the risk that you posed to pedestrians and other road users by your manner of driving. It has arrived at that conclusion, which I accept, on the basis that if the deceased jumped out in front of your vehicle it could not be said that your manner of driving was a cause of death. That hypothesis has regard to statements that you made to police and to a friend shortly after the incident that the deceased had admitted to jumping out in front of your vehicle in the past; that about a

> week before he had jumped in front of your vehicle; that given his previous tendency to behave in this way and the fact that he was extremely intoxicated – at the time of his death the deceased had a blood alcohol concentration of .220 – it cannot be ruled out that he jumped out in front of you; and there is no forensic evidence at the scene to disprove your assertions that the deceased did in fact jump out in front of you. This conclusion gives weight to the fact that witnesses have reported Wilmot Road being dark and visibility not being good, and the dark clothing worn by the deceased and that at that hour of the morning a driver would not expect a pedestrian to be on the road *in their lane* let alone to jump out onto the roadway immediately prior to the impact.
>
> In short it cannot be shown that the death would not have occurred even if a reasonable prudent driver had been driving the vehicle, without excessive alcohol, wearing visual aids and travelling at the speed limit. As to the final point I note that the medical evidence is that a pedestrian struck by a vehicle travelling at 50 km/h will sustain injuries sufficient to kill them."

The applicant's case

18 The suggestion that Mr Wise may have moved suddenly into the path of Ms Oates' motor vehicle is central to the applicant's argument in this case.

19 The applicant has sworn two affidavits, which she relies upon in support of the application. The affidavits do not contain any evidence of fact that relates to the circumstances surrounding Mr Wise's death. Indeed, the only matters in the affidavits which touch on this question are arguments. The applicant questions "the veracity and reliability of" the statements of Ms Lovell and Ms Shead. She argues that they were close friends of Ms Oates, did not provide their evidence until many months after the accident and that their statements have not been tested under oath. She makes a general statement that there are "other witnesses who could provide evidence of threats made by Ms Oates" which include "threats to kill Jari on the night of his death" and prior family violence perpetrated by Ms Oates against him. The witnesses are not identified, and no detail is provided concerning those allegations.

20 The gravamen of the applicant's argument is summed up in the following sentence: "…it has never been established whether Jari stepped out in front of Oates' vehicle or alternatively whether Oates deliberately caused the collision with Jari thereby causing his death". In submissions, the applicant's counsel asserted a similar argument. Mr Cangelosi submitted that it was desirable to conduct an inquest in order to determine that question.

21 The only other evidence submitted on behalf of the applicant is an affidavit by Professor Anthony Thomas, a pathologist. For the sake of this application, it can be accepted that Professor Thomas has appropriate qualifications in forensic pathology. He had access to and reviewed the evidence contained in the police investigation file and has attended the scene of the accident.

22 Professor Thomas challenges Senior Constable Cordwell's opinion that Mr Wise was "walking north in the south bound lane facing the vehicle when he was struck". He relies on the fact that the car damage is on the left hand side and Mr Wise's injuries are more prominent on the right hand side of his body. He expresses the opinion that "there is a real doubt as to the position of Mr Wise at the point of impact" and that the evidence does not support a finding that Mr Wise "was in the middle of the south bound lane full face to oncoming vehicle when he was struck". Professor Thomas seems to have assumed that the effect of Senior Constable Cordwell's opinion was that the point of impact was "in the middle "of the south bound lane. I am not convinced that Senior Constable Cordwell stated the position of Mr Wise in the south bound lane with that degree of certainty, but in any event there is probably little importance in this discrepancy. Professor Thomas also expresses the opinion that "Mr Wise was more likely to be positioned in the vicinity of the gravel verge of the road and was turning towards his left at a 45 degree angle to the oncoming vehicle of Ms Oates" at the

point of impact. He relies on "the predominance of right sided injuries to his body together with the passenger corner and left sided damage to the car".

Discussion

23 The only argument advanced on behalf of the applicant as to why I should be satisfied that it is necessary and desirable in the interests of justice for the coroner to hold an inquest is that the hearing will provide an opportunity for the testing by cross-examination of evidence already obtained in the investigation. Although not actually stated, I assume that the applicant believes that an inquest will also provide her with an opportunity to cross-examine Ms Oates. It was not seriously suggested on behalf of the applicant that an inquest will have any real prospect of eliciting further evidence concerning the causation of death, apart from that already obtained in the police investigation. Notwithstanding the general assertions about further evidence in the applicant's affidavit, there was no attempt by the applicant to provide the identity of another witness or any other particulars of such evidence.

24 I accept that the police investigation has not resolved with certainty the factual question as to whether Mr Wise moved in front of Ms Oates' vehicle immediately before the collision. Clearly, this was the view of the Director, and I agree with it. I accept also that it is appropriately within the ambit of the coronial investigation to make a finding about this question, if such a finding is possible. Under s 28(1), the coroner must find, if possible, how death occurred and the cause of death. The question of whether Mr Wise moved in front of the vehicle at the last minute is clearly directly related to, and hence falls within the ambit of, those two mandated findings.

25 I do not understand either party to argue to the contrary. However, during submissions, there was discussion concerning the relationship between any potential finding by the coroner about this question and the completed criminal proceedings. Section 25(4) provides that where a person has been charged on indictment, the inquest, "must not contain any finding which is inconsistent with the determination of the matter by the result of those proceedings". I accept the submission of counsel for the Attorney-General that this provision is not applicable to this case. Section 25 requires a coroner to adjourn an inquest if, before making a finding, a coroner is informed that a person has been charged with certain specified offences. The section also provides for the resumption of the adjourned inquest after the conclusion of the criminal proceedings. Section 25(4) relates specifically to findings which may be made after an inquest which has been so resumed. The section, therefore, can only apply to an inquest which has been commenced and then so adjourned. That is clearly not the situation in this case.

26 However, there are other provisions which regulate the relationship between a coronial investigation and findings as to criminal responsibility. The primary position is that a coroner is not permitted to include in a finding or comment as a result of an investigation, any statement that a person is or may be guilty of an offence, see s 28(4). However, if the coroner believes that an indictable offence has been committed in connection with a death, the coroner is obliged to report that belief to the Attorney-General, see s 30(3).

27 In my view, these provisions do not affect the obligation of the coroner to make a finding as to the events immediately preceding the collision, if it is possible to do so. For example, even a finding that Ms Oates had seen Mr Wise and had deliberately driven at, or even into him, would not, in my view, offend the prohibition contained in s 28(4). In this respect, it is important to distinguish between findings of fact, which are within the jurisdiction of the coroner, and determination of criminal responsibility, which is not. The determination of criminal responsibility invariably requires a finding that involves the application of an objective or subjective standard to a set of facts and/or the identification of a state of mind. An example of this arose in the case of *Perre v Chivell* [2000] SASC 279; (2000) 77 SASR 282. In that case Nyland J, was concerned with an application to set aside

coronial findings concerning the identification of a person who had sent a bomb to premises which exploded and killed a police officer. His Honour was concerned with a prohibition arising under the coronial legislation in that State which prohibited a "finding, or suggestion of criminal or civil liability". His Honour concluded that the finding in question did not breach the provision because it was limited to a finding of fact, that is, that the applicant had, in fact, sent the bomb to the premises. His Honour distinguished this from a finding which suggested that on that evidence, the person may be guilty of a crime, for example murder, which would have breached the prohibition. His Honour made this point:

> "Even though some acts may not seem to be legally justifiable, they may often turn out to be just that. For example a shooting or stabbing will, in some circumstances, be justified as lawful self-defence. As I have stated, criminal or civil liability can only be determined through the application of the relevant law to the facts, and it is only the legal conclusions as to liability flowing from this process which are prohibited by s 26(3)."

28 Earlier in his judgment his Honour had provided another example, particularly apposite to the circumstances of this case:

> "For example, in an inquest concerned with the death of a pedestrian struck by a motor vehicle, such matters as the identity of the driver of the car, his/her level of intoxication by reason of alcohol or drugs, and the position of the car on the road, would all be relevant matters upon which the coroner could make findings of fact. A finding by the coroner that the driver of a car was affected by alcohol or drugs, or his/her motor vehicle was on the wrong side of the road, might lead to a subsequent determination of criminal or civil liability, but that consequence does not preclude the coroner from making the particular finding of fact."

29 I agree with this analysis. In this case, there would in my view, be a clear distinction between a finding, if it was possible, as to where and how Mr Wise came to be on the road and whether he was visible to Ms Oates and, if so, for how long, prior to the impact, and an assessment of criminal responsibility associated with those facts. Of course, if the coroner has as a result of finding those facts, formed a belief that Ms Oates had committed an indictable offence, then he would be obliged to report that matter to the Attorney-General pursuant to s 30(3).

30 The question of Ms Oates' criminal responsibility has now been determined as a matter of record by the resolution of the criminal charges against her. For example, if any attempt were made to charge her with any further crime which relied upon an allegation that she had caused Mr Wise's death, then she would be entitled to meet those charges with a plea in bar. However, that does not preclude the coroner making findings of fact which might be inconsistent with the resolution of those criminal proceedings, although the coroner would be so precluded if s 25(4) was applicable. Because it is not, then it seems to me that the mandatory requirements of s 28(1)(b) and (c) require the coroner to make those findings, if possible, irrespective of any such inconsistency.

31 The real question, of course, is whether an inquest would add anything to the police investigation and, in particular, increase the chances that it will be possible to make findings as to whether or not Mr Wise moved into the path of the vehicle. In my view, the police investigation was extremely thorough. It appears from the Director's opinion that the investigation was initially directed at the possibility that Ms Oates was directly responsible for Mr Wise's death, but as the investigation unfolded, it became clear that the evidence did not support charges based on that factual hypothesis. The thoroughness of the investigation is consistent with that history. It is a reasonable assumption that the police were actively focussing on and looking for evidence of wrongdoing by Ms Oates. Nothing has been suggested by the applicant, apart from the limited and very general matters already discussed, which would or could take the investigation further. I am not satisfied that, even if witnesses were available who could support the vague allegations of threats and prior family violence described in the applicant's affidavit, that that in itself will assist the coroner to make any findings

which are not possible on the basis of the evidence already collected in the investigation. Further, I do not think that the opportunity for cross-examination of the witnesses who have provided statements will amount to any more than an unproductive fishing expedition. There is nothing suggested in the applicant's evidence or submissions which supports the proposition that there is any forensic benefit or point to such cross-examination.

32 I have the same view in relation to the potential evidence of Ms Oates, assuming that she can be compelled to testify at an inquest. Unless cross-examination extracted a clear admission of wrong doing, which is extremely unlikely, her version is unlikely to vary from that already stated to other witnesses. There has been nothing put forward by or on behalf of the applicant which would suggest that there are obvious inconsistencies or further information that would underpin the utility of such cross-examination. Even if the coroner formed an adverse view about Ms Oates' credibility after hearing her give evidence, that in itself, in the absence of further evidence concerning the events immediately before the collision, will do little to advance the possibility of further findings about what happened in those moments.

33 Finally, I make comment in respect of Professor Thomas evidence. In my view, his evidence while it can and should be taken into account by the coroner, it is not likely to significantly affect the possibility of making further findings other than those which are currently available. The location of debris and markings at the scene is thoroughly documented in the investigation, in particular in Senior Constable Cordwell's report, and the location and nature of damage to the vehicle and the injuries on Mr Wise are also clearly established. All of this is available for the coroner's analysis and assessment, and it does not seem to me that an inquest will provide any significant advantage in respect of that analysis. The coroner can, of course, seek further information or opinion of an expert nature, including from Professor Thomas, if that is thought to be useful.

34 Because I am of the view that an inquest will not place the coroner in any better position to make the findings in question, than that which arises from the police investigation, I am not satisfied that an inquest is necessary or desirable in the interests of justice. Accordingly, the application is refused.