CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Peter Smith
Hearing date:	29 and 30 October 2019
Date of findings:	11 December 2019
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in 1971 – inquest dispensed with – inquest ordered - were original cause and manner of death correctly identified?
File number:	2017/351826
Representation:	Counsel Assisting the inquest: K Edwards of Counsel i/b NSW Crown Solicitor's Office C Boulougouris: M Spartalis of Counsel i/b Sparke Helmore Lawyers The Smith family: L Barnes of Counsel i/b Legal Aid Commission.

Findings:	**Identity** The person who died is Peter Smith. **Date of death**: Peter Smith died on 22 October 1971. **Place of death**: Peter Smith died at Sydney Hospital, Macquarie Street Sydney 2000. **Cause of death:** The cause of Peter Smith's death is a massive basal subarachnoid haemorrhage caused by a blow to the head. **Manner of death:** Peter Smith died when he was struck to the head by a person whose identity cannot be established.

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held, the Coroner must record findings in writing as to the date and place of the death, and its cause and manner. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

These are the findings of an inquest into the death of Peter Colin Smith.

Introduction

1. Peter Smith was twenty years old when he died on the night of 22 October 1971. He had been taken to Sydney Hospital late that night after he was found collapsed on the footpath outside a milk bar in Pitt Street Sydney. At the hospital he was pronounced deceased. An autopsy examination recorded the cause of Peter's death as *'Subarachnoid haemorrhage due to ruptured cerebral artery (anterior communicating).'* The police report of Peter's death recorded there were no suspicious circumstances, and an inquest was dispensed with.

2. Forty-five years later Peter's sisters Judy Smith and Belinda Stapleton wrote to the NSW State Coroner asking for an inquest to be conducted. They submitted that the information placed before the Coroner in 1971 was not comprehensive, and that a recent neuropathological opinion had concluded it was unlikely his death was the result of a spontaneous rupture.

3. Peter's sisters provided supporting documents that were not in existence in 1971 when the decision was made to dispense with an inquest. In light of this, Judge Henson Chief Magistrate of the Local Court provided consent for the State Coroner to direct that an inquest be held into Mr Smith's death, pursuant to section 29(3) of the Act. The inquest was held on 29 and 30 October 2019.

Peter Smith's life

4. Peter Smith was born on 17 October 1951, the second child of his parents Colin and Jean Smith. He had an older sister Pamela and two younger sisters, Judith and Belinda. Colin and Jean raised their children in North Ryde, Sydney. Colin Smith was a returned serviceman who had served in the Australian Navy in World War Two. His daughters believe he suffered from post traumatic stress disorder after the war.

5. At the time of his death Peter was living with his parents and two younger sisters in the family home. He had completed the Higher School Certificate and was working in the Sydney CBD for the agency now known as Australia Post. His sisters described him as a smart and sociable person who had many friends and excelled at a number of sports. His best friend was Gary Hall, who was with Peter when he died and has remained a staunch friend to his sisters.

6. Peter's sudden death was a terrible blow to his family. Peter's mother died in 1978 and his father died in 1985. They had told their daughters that Peter died from a ruptured aneurism and made it clear they did not want the tragedy to be discussed. However the three sisters gradually came to the view that there was more to Peter's death than they had been led to believe. With the assistance of the Legal Aid Commission they set about gathering information and obtaining various expert reports.

7. In November 2017 the NSW Police Force commenced a reinvestigation of the circumstances of Peter's death. The investigation was led by Detective Sergeant Phil Hallinan, who proceeded to conduct a careful and comprehensive investigation. He searched for contemporaneous records and interviewed everyone who might be able to shed light on what had happened that night.

8. The inquest into Peter's death was attended by many members of his family, including his sisters Pamela, Judith and Belinda and their children. Gary Hall also attended. At the close of the evidence the sisters prepared written tributes to Peter which their children read to the Court. They spoke of the deep love they had for their brother and the profound and abiding sadness his early death brought to their parents and themselves. It was clear that he was deeply loved as a son, brother and friend.

Issues

9. On the night of his death Peter had been out with Gary Hall at a city hotel, and then at a milk bar. What happened at the milk bar, and the events that preceded Peter's collapse onto the footpath outside it, is the subject of this inquest. The issues examined were:

    - Was Peter Smith's cause of death correctly recorded in the autopsy report and death certificate that were prepared in 1971?

    - Was the original police investigation into Peter Smith's death adequate?

The original coronial file

10. The original coronial file in relation to Peter's death is sparse, consisting only of the three documents described below. No other official records are known to exist.

    <u>The Police P79a document</u>

11. This document dated 23 October 1971 is a brief report to the Coroner, prepared by NSW Police officer Constable John Egan who was called to the scene on the night of Peter's death. It set out the circumstances of Peter's death as follows:
    On the 22nd October 1971 the deceased and a friend Gary Michael Hall had been drinking at the Carlton Rex Hotel. They left the hotel and went to a milk bar in Pitt Street, Sydney. At the milk bar they were behaving in an offensive

manner and were abusing the proprietor. Both men were under the influence of intoxicating liquor. The proprietor Mr Boulougouris asked both men to leave. Hall stayed and argued with Mr Boulougouris and the deceased left the shop. A short while later the deceased was found on the footpath by Mr Ross McFadyen in a collapsed condition. Central District Ambulance was called and the deceased was conveyed to Sydney Hospital where life was pronounced extinct by Doctors Sunderland and Henning. He was then conveyed to City Morgue.

12. Constable Egan's report concluded that there '*appears to be no suspicious circumstances'.*

13. What is remarkable, certainly by contemporary standards, is that there is no other investigatory account of the incident whether by way of police notes, interviews with witnesses, or witness statements. A search for such records has not uncovered any. It appears that if further documents were created they have since been destroyed.

The autopsy report

14. A post mortem examination was performed on 23 October 1971 by Dr Edward La'Brooy at the Sydney Morgue. He recorded the cause of death as follows: *'Subarachnoid haemorrhage due to ruptured cerebral artery (anterior communicating)'.* The anterior communicating artery is one of the vessels which supply oxygenated blood to the brain.

15. In his report Dr La'Brooy noted a small bruise measuring one inch by half an inch over '*the upper middle of the right side of the chest behind'.* There were no other external injuries, and no injuries inside the mouth. Peter's brain showed a very large subarachnoid haemorrhage over the base and extending upwards *'over the Sylvian fissures and over the sulci on the parietal lobes laterally'*. There was a small one mm rupture on the anterior communicating artery which had perforated the entire vessel. Dr La'Brooy found no aneurysmal dilatation anywhere in the cerebral arteries. The other organs showed no gross evidence of disease or injury.

16. The autopsy report does not attach any photographs, diagrams or other reports, apart from a notation that Peter's post mortem blood was sent for analysis of alcohol content. The results showed a high concentration of alcohol, at 0.185mg per 100ml of blood.

The death certificate

17. A death certificate was issued with the cause of death given in identical terms to that in Dr La'Brooy's post mortem report. Also appearing on the death certificate is the handwritten notation: *'Inquest dispensed with at Sydney on 22nd December 1971'*. The cause of death is said to have been certified by '*K Schirmer Delegate of the City Coroner'.* No other documents have been located regarding the decision to dispense with an inquest, or explaining the reasons for the decision.

The inquest

18. At the inquest the above documents were tendered, together with the evidence gathered by Detective Sergeant Hallinan in the new investigation. The inquest heard oral evidence from former Constable Egan, from an expert neuropathologist Dr Michael Buckland, and from the only two surviving witnesses known to have been at the scene when Peter died. These are Gary Hall and Mr Con Boulourgouris.

The statutory declaration and statement of Gary Hall

19. Gary Hall was with Peter on the night of his death. He was a very close friend and a classmate of Peter's, and they played a lot of sport together. They completed the Higher School Certificate together and the following year both took jobs in Sydney's CBD. Despite his presence at the scene it does not appear Gary Hall was ever interviewed by police. However on 28 April 2016 he prepared a statutory declaration setting out his account of what happened that night. He also provided a statement dated 22 January 2018 to the current Officer in Charge.

20. According to Gary, he and Peter were in the habit of meeting up in the Wynyard area on Friday evenings after work. They did this a couple of times a month. On the night of 22 October 1971 they were drinking at the Carlton Rex Hotel where they each had a meal and drank seven to eight beers. After that they walked towards another hotel which was close to the bus stop they used to get home. Gary said they were both affected by the alcohol but were '*not drunk'*. Peter, he said, was a bit noisy but not aggressive.

21. On the way they stopped at the Blue Sky Milk Bar on Pitt Street to buy a snack. Gary said he'd never been to that milk bar previously. At that time the milk bar was owned and operated by brothers Con and Jim Boulougouris, who had migrated to Australia from Greece in 1965. The milk bar faced onto Pitt Street opposite to the Post Office, and was a take away operation selling drinks, milkshakes, cigarettes and sandwiches. The brothers sold the business in 1990 and it no longer stands, having been replaced by another building.

22. On the night of 22 October 1971, while standing at the front counter of the milk bar Peter accidentally knocked over a stand with packets of chips or similar. According to Gary a male attendant behind the counter said he wouldn't serve them. Peter moved into the store and started to argue with the attendant, despite Gary urging him to come away. Gary himself remained on the footpath. He described the attendant as around 40-45 years of age, with short dark hair, clean shaven and just slighter taller than Peter who was 5 foot 8 inches. He spoke with an accent and was wearing black pants and a short-sleeved top.

23. The attendant went to the back of the store and came around to the customer area where Peter was, telling him to get out. Peter was continuing to demand

service. They pushed each other a little. At that point a second attendant appeared from the back of the store. He was younger than the first man, a bit broader and stockier and perhaps a bit taller, also clean-shaven and with short hair. He wore similar clothes to the first man. He came up alongside the first man and punched Peter to the top right side of his head.

24. Gary saw Peter stumble backwards two to three steps, then fall and hit the ground near the gutter. Gary ran to Peter telling him to get up, but Peter made no response. He lay still, not breathing, with his eyes closed. Gary said he felt certain he was dead. Some passersby gathered around, including a man who ran across the road to a public phone and called an ambulance. The man was of medium slim build, early 30's, sandy hair, and was wearing office clothes.

25. Gary says he was shouting out '*You've killed him'*. When the ambulance arrived the paramedics lifted Peter in, and he wanted to accompany Peter but they refused to let him. Then two or three young men whom Gary thought were connected with the café confronted Gary. Fearing he would be assaulted Gary ran to George Street. He took a taxi straight to the Smith family home in North Ryde to tell them the terrible news of Peter's death.

26. At the Smith home Peter spoke to Colin, Jean and Judy who was then aged thirteen years. Gary told them that Peter was dead and that he had been in a confrontation at a milk bar. The family was shocked and distraught. In his statutory declaration Gary said he had probably not given the family a detailed account of what happened, as they were so upset. Colin told Gary he would contact Harry Still (now deceased), who was married to Colin's sister. Gary understood him to be a senior police officer at Chatswood Police Station.

27. The next day was Saturday. Gary had a pre-arranged trip to Singleton army base, where he and a school friend Phillip Williamson were to visit another friend, Peter Lumb. Despite the shocking events of the previous night Gary decided to proceed with the trip, wanting to tell Peter Lumb, who is himself now deceased, that Peter had died.

28. Gary says the only police officer who made contact with him about Peter's death was Harry Still. He thinks this happened in a telephone call on the Sunday night or Monday morning. In the phone call Gary told Harry Still that Peter had been '*punched or propelled'* to the ground. However Harry told him that Peter's father did not want charges to be laid and therefore there was no need for Gary to be interviewed or to provide a statement. He said he himself would take charge of the matter, and it would be treated as a death from a cerebral haemorrhage. Gary accepted this, thinking it right to respect the wishes of the Smith family. According to Gary it was only in about 2000, after Peter's parents had died, that Peter's sisters Judy and Belinda started to ask him questions about what had happened to him.

29. It may have been at an earlier point than this however. In her statement Belinda says that when she was about 16 years old (which would have been in 1983 or 1984) Gary and her sister Judy told her that Peter had been hit by

someone working in a city milk bar and had died immediately. Belinda was shocked to hear this as her mother had always told her he'd died of a pre-existing aneurism. Over the years she and Judy became increasingly concerned by the possibility their brother had died as a result of a violent act.

30. At the inquest Gary gave evidence which was generally in accordance with his statutory declaration and statement. Certain features of his oral evidence impact upon his reliability as a witness, and these are discussed below.

The evidence of Con Boulougouris

31. Mr Con Boulougouris also gave oral evidence at the inquest, with the assistance of an interpreter in the Greek language. He was interviewed twice by police following the decision to reopen this investigation. The second interview, on 24 May 2018, took place with the assistance of an interpreter. Mr Boulougouris gave the interviews voluntarily and has co-operated throughout the process of the investigation and the inquest.

32. In his interviews Mr Boulougouris told police he recalled a young man who was drunk on the footpath outside the milk bar. The young man had not been inside the milk bar at any stage, nor had there been any physical or verbal confrontation inside the milk bar. No one had been asked to leave. Mr Boulougouris saw the young man out on the pavement falling down, grabbing a pole and not being able to get up. There may have been shouting and swearing outside the milk bar. The police were called, perhaps by his brother Jim Boulougouris. After the young man was taken away in an ambulance, police in uniform came to the milk bar and took the names of Con and Jim but didn't ask them what happened; nor did Con provide them any details.

33. In his interviews Mr Boulougouris also said that other men might have been working at the milk bar that night but he couldn't recall their names. He and Jim didn't keep a record of their employees' names and details. He said the milk bar was always busy on Friday nights and would normally stay open until 11pm or 11.30pm. He thought he had been working at the counter of the milk bar, and his brother at the back.

34. In significant areas Mr Boulougouris' evidence at the inquest was consistent with what he told police in his interviews, namely that on the night of 22 January 1971 there had not been any argument with a customer and no one had been punched. However it cannot be denied there were points at which his responses to questions contradicted answers he had given minutes previously. An example is his confirmation, early in his evidence, that there was an open space at the rear of the milk bar around which staff could move from the counter area into the customer area, and which made the entire area of the milk bar visible to customers. Shortly afterwards however he denied there was any such open space and stated there was instead a full length timber door which was kept shut during service hours. This had some relevance to Gary Hall's evidence, as if the latter description was correct it would have contradicted Gary's recollection of the milk bar's layout.

35. It must be borne in mind that Mr Boulougouris is now aged 80 years and has suffered strokes in recent years which he said had impacted on his memory. These factors combine with the length of time that has passed since the night Peter Smith died, and the communication difficulties that are to be expected when evidence is given in a different language. Taking these matters into account there is no basis to conclude that Mr Boulougouris was not giving truthful evidence about what he saw and recollected about the night's events. They are matters however which bear upon the court's assessment of the reliability of his recollection, a matter which is discussed below.

The status of the original finding as to cause of death

36. I have noted above that in 1971 the cause of Peter's death was registered as *'Subarachnoid haemorrhage due to ruptured cerebral artery (anterior communicating).'* Evidence was presented at the inquest which called into question the correctness of this finding. As will be seen, the expert evidence at the inquest was that although the cause of death was a subarachnoid haemorrhage, the haemorrhage was unlikely to have been caused by a ruptured cerebral artery or by any other natural means.

37. Before considering the above evidence, I will address a submission regarding the status of the original finding as to cause of death. The submission was made on behalf of Mr Con Boulougouris by his Counsel Mr Spartalis. On behalf of Mr Boulougouris it was submitted that the doctrine known as the presumption of regularity applied in this inquest, creating an evidentiary presumption that those police officers and medical practitioners who performed public duties in the original investigation of Peter Smith's death did so in compliance with their respective statutory duties. The application of the doctrine was said to favour the conclusions of the original autopsy report. It was further submitted that those who asserted that the cause of death found in the autopsy report was incorrect were required to rebut that presumption.

38. I do not accept the proposition underlying the above submission, that the presumption of regularity operates to create an evidential presumption that the original pathologist's conclusions must be accepted as correct by the Coroner after hearing all the evidence.

39. First, I respectfully endorse the submission in reply of Counsel Assisting, that such an application of the doctrine misconstrues its scope. The presumption of regularity is a doctrine which applies to the underlying validity of a public act or an act by a public official and not to the act itself, as explained by his Honour Justice McHugh in *Minister for Natural Resources v New South Wales Aboriginal Land Council* (1987) 9 NSW LR 154:
'Where a public official or authority purports to exercise a power or to do an act in the course of his or its duties, a presumption arises that all conditions necessary to the exercise of that power or the doing of that act have been fulfilled.' (at 164).

40. Thus the doctrine may operate to create a presumption that the police officers and pathologist in this case had valid authority to exercise their powers. It

does not extend to create a presumption that their conclusions must be accepted as correct by the Coroner.

41. Secondly the submission on behalf of Mr Boulougouris misapprehends the statutory role of the Coroner. That is to make public findings as to the manner and cause of death based on evidence, as enunciated by his Honour Justice O'Keefe in *X v Deputy State Coroner of New South Wales* [2001] NSWSC 46. The Coroner ought not to commence with any assumption of the correctness of a public official's conclusions but rather, must make findings on the basis of the evidence received at the inquest. This is the approach which I have taken.

The neuropathological evidence

42. I now turn to consider the medical evidence concerning cause of death which was heard at the inquest.

43. With the assistance of the Legal Aid Commission, in October 2016 the Smith family sought a report from consultant forensic neuropathologist Dr Michael Rodriguez. Dr Rodriguez is forensic pathologist of many years' standing, who also teaches neuropathology at undergraduate and post graduate levels. He was supplied with the three coronial documents described above and asked to provide his opinion on the following question:
'Concerning the death of Peter Colin Smith what is the significance of the observation that no aneurysmal dilatation was identified at post mortem and whether this supports or contradicts the conclusion that this was a natural/spontaneous death as opposed to the possible result of trauma caused by the punch or the strike to the pavement'.

44. At the inquest the Court heard expert evidence from Dr Michael Buckland, head of Neuropathology at Royal Prince Alfred Hospital. His evidence focused upon the conclusions drawn by Dr Rodriguez in his report. He commenced by explaining those conclusions.

45. In his report Dr Rodriguez confirmed that the cause of death was a subarachnoid haemorrhage. A subarachnoid haemorrhage describes bleeding on the surface of the brain below the arachnoid, which results in restricted blood flow to the brain. As to what had caused the subarachnopid haemorrhage, Dr Rodriguez commented that the absence of photographs or diagrams documenting either the haemorrhage or the ruptured cerebral artery made it difficult to be conclusive. In his opinion however it was unlikely that the source of the haemorrhage was the one mm rupture of the cerebral artery, which Dr La'Brooy appeared to have assumed was a rupture of a pre-existing aneurysm. This was because:

    - the autopsy would be expected to have identified an aneurysm or a remnant of it, although Dr Rodriguez acknowledged there are cases where this does not happen

- It could not be excluded that the rupture was instead the result of a laceration of a previously normal vessel due to trauma, whether occurring ante mortem or as a result of the post mortem examination itself.

46. In Dr Rodriguez's opinion, where a person died of a basal subarachnoid haemorrhage, and if an aneurysm or other source of bleeding had not been identified at post mortem, it was less likely that the cause of death was spontaneous or natural. He concluded at par 41 of his report: *'A possible traumatic aetiology caused by a punch or a fall striking the pavement should be considered'*.

47. At the inquest Dr Buckland agreed with Dr Rodriguez that the cause of Peter's death was a massive basal subarachnoid haemorrhage. He conceded, as had Dr Rodriguez, that the possibility of a natural and spontaneous rupture of an aneurysm could not be excluded as the cause for Peter's haemorrhage. However it was his unambiguous evidence that this was an unlikely cause, for the following reasons:

    - Dr La'Brooy had found no evidence of aneurysmal dilatation, which refers to swelling around the site of the rupture. In Dr Buckland's opinion it was possible but unusual for an aneurysm to rupture without such evidence

    - the rupture to the anterior communicating artery identified at autopsy was unlikely to have been an aneurysm, as the chances of such a small aneurysm spontaneously rupturing were very low. As conjectured by Dr Rodriguez, the rupture had possibly occurred during the post mortem examination

    - a spontaneously ruptured aneurysm in a healthy young man with no known symptoms or family history of aneurysm was possible, but was so unlikely that it ought to be concluded only where other possibilities had been excluded.

48. Regarding the proposition that Peter's haemorrhage was caused by a spontaneous rupture of a pre-existing aneurysm, it is important to note the concurrence of opinion of both neuropathologists that although this possibility could not be excluded, it was unlikely.

49. Dr Buckland then considered whether the subarachnoid haemorrhage could have been caused by a significant vascular malformation. In his view were this the case such a feature would have been identified at the autopsy examination. Hypertension was another cause of subarachnoid haemorrhage but this too was unlikely in the case of a healthy twenty year old.

50. Having assessed as unlikely the possibility of various natural causes for the subarachnoid haemorrhage, Dr Buckland considered whether the more likely cause was a traumatic event. He endorsed Dr Rodriguez's opinion that it was. He noted that traumatic injury was the primary cause of fatal massive subarachnoid haemorrhage in young men, with the most common injury being traumatic vertebral artery dissection. This is usually caused by a blow to the

head which causes it to swivel or rotate, rupturing the vertebral arteries at the base of the brain. A blow to the side of the head was more likely to cause the rotating action which dissects the vertebral artery. Dr Buckland stated further that it was common for a blow which was sufficient to cause internal vertebral artery dissection not to create a visible external injury.

51. In submissions on behalf of Mr Boulougouris, it was proposed that Dr Buckland's conclusion that a spontaneously occurring rupture was unlikely had been affected by him *assuming* Peter had been punched. However at the inquest Dr Buckland was specifically asked if the more likely cause of Peter's injury was a punch, or the result of falling and striking his head on the pavement. There was some circumstantial evidence to support the latter scenario, being the evidence Peter had been intoxicated and so may have lost his balance and fallen.

52. It was evident from his response however that Dr Buckland had considered the possibility that Peter's collapse had *not* been precipitated by a blow. He gave cogent reasons why he thought this was a less likely mechanism for Peter's injury than a punch to the head. He explained that when a person fell and hit the back of his or her head the impact jolted the brain, causing bruising to its undersurface. In that event basal bruises would be visible at the postmortem examination. None was recorded by Dr La'Brooy. Furthermore, a fall causing massive basal subarachnoid haemorrhage was likely to leave visible injury on the scalp or skull. For these reasons he considered it more likely than not that Peter had fallen as a result of receiving a punch to his head.

53. Dr La'Brooy's specialist expertise in the area of neuropathology is unknown. Dr Rodriguez and Dr Buckland on the other hand are highly experienced neuropathologists and it must follow that the court would accord significant weight to their opinions as to the cause of Peter's subarachnoid haemorrhage. Their evidence provides a sound evidentiary basis to find on the balance of probabilities that the subarachnoid haemorrhage which Peter suffered had a traumatic and not a natural cause, most likely a blow to the head.

54. In Dr Buckland's opinion, a death from a massive subarachnoid haemorrhage would be quick and relatively painless. I do hope that this evidence provided a little comfort to Peter's family.

The credibility and reliability of Gary Hall's evidence

55. If it is accepted, Gary Hall's evidence about Peter's collapse and death being preceded by a punch to the head also raises significant doubt as to whether the cause and manner of his death have been correctly recorded.

56. It was submitted on behalf of Mr Boulougouris that the court would not find Gary Hall to be a reliable witness. This was due to the passage of time since the incident and the likelihood, it was asserted, that Gary was highly intoxicated on the relevant night and would not have been able to accurately recall events. However there is no objective evidence of the degree of Gary's

intoxication that night. To the court he described his own condition as intoxicated, but not '*staggering or obviously drunk'*. It cannot be concluded from this description that his recollection of Peter being punched to the head ought not to be believed.

57. Submissions for Mr Boulougouris were also that Gary's evidence contained errors further evidencing his unreliability as a witness. These included details as to the layout of the milk bar and whether the shop served hot food. In addition it was submitted that Gary had likely reconstructed some of his memories of the night after having read the contents of the brief of evidence. For example in his oral evidence Gary provided the information that the man who rang the ambulance was named '*Ross*' and that he had checked Peter's pulse; and that later at the family home while Gary was there Colin Smith made a phone call to Harry Still, then informed Gary that he didn't want Peter's death to be investigated or anyone to be charged. These matters were not referred to in Gary's statutory declaration or statement.

58. It is accepted that Gary Hall's evidence contained minor errors and that it is likely he reconstructed some details from sources other than his own memory of the night. The question is the degree to which these features affect the assessment of his evidence as to the core events: that is, that Peter was punched to the head that night after an argument with one of the milk bar attendants.

59. It is important to note that in the time following Peter's death Gary Hall told a number of people that his death was the result of him being punched at the milk bar that night. These accounts were given a number of years before he provided his statutory declaration and statement. They are as follows.

- In her statement Judy Smith says that on the night of Peter's death Gary Hall came to the family home '*white as a ghost and shaking'*. He appeared to be frightened. She recalls being told at some stage about an altercation, Peter knocking over a chip stand, an argument and Peter being hit.

- Gary's and Peter's friend Phillip Williamson provided a statement in 2018, in which he recalled collecting Gary on the morning after Peter died. Gary had seemed '*stunned*' and *'shaken'* and had told him Peter had died after having been involved in an argument in a milk bar the night before about a packet of Twisties. Gary had told Phillip that one of the shop owners had punched Peter and he had immediately died.

- In her statement Peter's youngest sister Belinda Stapleton said that over the years she had spoken often with Gary about Peter's death. Specifically when she was about sixteen years old Gary Hall and her sister Judy told her that Peter had been hit by a blow to the head from someone working at a city milk bar, and had died immediately.

60. There is no evidence that these people were not telling the truth about what Gary told them. Furthermore, Gary's eye witness account of Peter receiving a

punch to the head is consistent with the evidence of the two neuropathologists, Dr Rodriguez and Dr Buckland, that it is more likely that his fatal haemorrhage was caused by a traumatic injury than by a natural event.

61. In my view the evidence presented at the inquest represents a substantial body of evidence that the original autopsy finding as to cause of death was incorrect. I do not accept the submission on behalf of Mr Boulougouris that the evidence presented does not amount to '*a reputable body of evidence'* to that effect. I have found the medical evidence of Dr Buckland and Dr Rodriguez that Peter's haemorrhage most likely had a traumatic cause to be both reputable and persuasive. For the above reasons, I further find that Gary Hall's evidence that Peter was struck to the side of his head that night is reliable and credible.

62. As a result of the above conclusion there is a need for me to make a fresh determination as to the cause of Peter's death. I find that Peter Smith died from a massive basal subarachnoid haemorrhage caused by a blow to the head.

63. I accept the submissions of Counsel Assisting, and those on behalf of Mr Boulougouris and Peter's family, that the evidence does not enable me to identify the person who inflicted the blow.

The adequacy of the original police investigation

64. Submissions made on behalf of Peter's family were that the 1971 police investigation into Peter's death was inadequate, even by the standards that likely prevailed in 1971. In particular the submissions were critical of the likelihood that then Constable Egan did not take a statement from Gary Hall or others at the scene, and that Mr Still appeared to have intervened in the investigation to avoid further distress for Peter's parents.

65. The court heard evidence from the current Officer in Charge, Detective Sergeant Hallinan, about the investigative steps that would be taken if Peter's death occurred in 2019. In circumstances where a young man died after having been found collapsed on the footpath following an altercation, statements would have been taken from all people at the scene together with a crime scene examination and photographs. There would have been a canvass of the area for other possible witnesses, and an examination of relevant CCTV footage (which of course would not have been available in 1971). Detective Sergeant Hallinan's search of police records did not find any such material in relation to Peter's death. As regards the involvement of Mr Harry Still in the investigation of the matter, Detective Sergeant Hallinan said there was no doubt that applying current standards, a close relative would not be permitted to take any role other than identification. Detective Sergeant Hallinan was unaware if any such policy existed in 1971.

66. The former officer in charge Mr John Egan gave evidence at the inquest. He was a constable at the time of the death, and is no longer a NSW police officer. Unfortunately but perhaps not surprisingly he had almost no

recollection of the event. He was unable to recall to whom he had spoken at the café and what he had been told. It was likely he had a police partner with him but he was unaware if that officer had spoken to people at the scene including Gary Hall and the Boulougouris brothers, and prepared notes and sketches. He thought it likely that Harry Still had spoken to him about the incident when they were at the morgue for the identification of Peter's body, but he could not remember any details.

67. As for his notation on the P79a that there were no suspicious circumstances, Mr Egan agreed that in hindsight this did not accurately describe the situation. Nevertheless if he had been told at the time by a senior officer at his station that the incident was not to be treated as suspicious, he said that is how he would have recorded it.

68. Submissions of Counsel Assisting and on behalf of Mr Boulougouris were that it would not be open to conclude that the original police investigation was deficient, in circumstances where it could not be known if other investigative steps had been taken, nor whether records in relation to them had since been destroyed. I accept that on the state of the evidence it cannot be concluded that the original documents before the court represent the entirety of the police investigation.

69. On this issue Counsel Assisting further submitted that Dr La'Brooy's finding was probably communicated to police as a conclusion that Peter had died as a result of a natural cause being a spontaneous aneurysm. I accept her submission that in these circumstances it may not have been unreasonable for the police to conduct no further investigations.

70. For the above reasons I find that it is not open on the balance of probabilities to conclude that the police investigation into Peter's death was inadequate.

Conclusion

71. Peter's sudden death left his family shocked and grieving. For many long years his sisters have been deeply concerned that something was not right about the official cause and manner of his death. With the help of Gary Hall, the Legal Aid Commission, and the Officer in Charge, they have succeeded in opening Peter's death up to an inquest. Because of their efforts and those who assisted with the inquest, answers have been found to some, but not all, of the questions that have haunted the family over the years. This will not bring Peter back to them, but I hope it gives some comfort.

72. I wish to thank Counsel Assisting and the NSW Crown Solicitor's Office for their outstanding assistance. I thank also those representing the Smith and Boulougouris families, and the Officer in Charge Detective Sergeant Hallinan.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I make the following findings.

Identity
The person who died is Peter Smith.

Date of death:
Peter Smith died on 22 October 1971.

Place of death:
Peter Smith died at Sydney Hospital, Macquarie Street Sydney 2000.

Cause of death:
The cause of Peter Smith's death is a massive basal subarachnoid haemorrhage caused by a blow to the head.

Manner of death:
Peter Smith died when he was struck to the head by a person whose identity cannot be established.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

Date 11 December 2019