CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Peter Allen
Hearing dates:	30 November 2020 to 2 December 2020
Date of findings:	24 December 2020
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, time of death, conduct of postmortem examinations in fire-related deaths, carboxyhaemoglobin concentration, Forensic Pathology Code of Practice, National Fire Protection Association *921 Guide for Fire and Explosions Investigations*
File numbers:	2000/68703
Representation:	Ms J Single SC, Counsel Assisting, instructed by Mr P Armstrong, Crown Solicitor's Office Mr J Morris SC for Detective Sergeant M Smith, instructed by Cardillo Gray Partners Ms K Edwards for New South Wales Fire & Rescue, instructed by Governance and Legal Office, New South Wales Fire & Rescue Ms R Mathur for New South Wales Commissioner of Police, instructed by Hicksons Lawyers
Findings:	Peter Allen died on or about 26 November 2000 at Lismore NSW 2480 after being found inside his home following a residential fire. Due to limitations associated with the postmortem examination and investigation into the circumstances of the fire, the available evidence does not allow for any finding to be made as to the cause or manner of Peter's death.

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Introduction

1. In the early hours of the morning on 26 November 2000 the home of Peter Allen was observed to be on fire. After emergency services extinguished the fire, Peter was tragically found inside his home, deceased. After an initial investigation it was thought that the fire was an accident, and that Peter had died as a result of the effects of the fire. However, in the years that followed, further information became available to the police which raised questions as to the cause of Peter's death and the circumstances in which it was believed that he had died.

Why was an inquest held?

2. A Coroner's function and the purpose of an inquest are provided for by law as set out in the *Coroners Act 2009* (**the Act**). One of the primary functions of a Coroner is to investigate the circumstances surrounding a reportable death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it.

3. Section 6(1)(a) of the Act defines a reportable death to be one which occurs in circumstances where a person died a violent or unnatural death. As Peter died in the setting of a house fire it was initially considered that his death may have been a result of the fire and, therefore, unnatural. Later investigations raise the possibility that Peter's death may have occurred in suspicious circumstances. Therefore, as the cause and manner of Peter's death were not sufficiently disclosed it became necessary to hold an inquest into his death.

4. In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

5. It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated. It should be recognised that in this particular case, due to a number of unexpected events and procedural steps were required to be followed, the inquest into Peter's death took an unusually extended period of time.

Peter's life

6. Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on their family and those closest to that person only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Peter's life in a brief, but hopefully meaningful, way.

7. Peter was born on 23 December 1956. He attended Tempe Primary School and, later, Fort Street High. Peter completed Years 7 to 10 and performed well in his School Certificate. However he later decided to leave school early and initially found employment with the Roads and Traffic Authority (as it then was) doing clerical work.

8. Following this Peter and his best friend travelled to Perth, where they remained for a couple of years before returning to Sydney. Upon his return, Peter moved to Enmore and found work with State Rail, eventually working as an Assistant Stationmaster at various stations around Sydney. During this time Peter met his future wife, Julie-Ann. After dating for a few years Peter and Julie-Anne married in 1998 in a simple wedding ceremony held in the backyard of Peter's parents' house, with close family and friends in attendance.

9. Peter and Julie-Anne later moved to the Lismore area and settled in Tuntable Creek, about 90 minutes drive from Lismore. Peter and Julie-Anne enjoyed a bucolic lifestyle, living in a rustic home with a creek nearby and plenty of grassland to grow plants and vegetables.

10. After selling their home Peter and Julie-Anne moved to a house in Avon Street, South Lismore. Whilst there both Peter and Julie-Anne enrolled in a nursing course at Southern Cross University, although these studies were not pursued.

11. In August 1989 Peter and Julie-Anne's daughter, Kathryn (Kat) was born. Peter had a fondness and skill for woodworking and lovingly built a rocking horse and some other items for Kathryn. It was clear to all that Peter loved being a father.

12. When Kathryn was about 18 months old Julie-Ann developed a medical condition which required treatment at a hospital in Sydney. From this point, Peter and Julie-Ann lived apart; Peter in Lismore, and Julie-Ann and Kathryn in Sydney. However, Peter would often travel to Sydney to visit Kathryn, staying with his mother, Gwen. Similarly, Gwen travelled to Lismore once or twice a year to stay with Peter.

13. Peter was a true nature lover and keen gardener. He enjoyed growing mangoes and his favourite native plants, and often sent mangoes to family members in Sydney. Peter also enjoyed visiting a national park near Lismore, and spent much time there taking photographs of native flowers and other fauna.

14. It is evident Peter enjoyed a loving relationship with his family members and that, 20 years after his passing, he is still greatly missed. It is distressing to know that Peter's loss came at a time when he was looking forward to watching Kathryn grow into adulthood and being a part of her life. Peter's untimely and tragic death has meant that his family have lost a beloved son, brother and father with many positive qualities, and more life to give to those closest to him.

Background to the events of 26 November 2000[1]

Peter's personal history

15. Peter was known to be a heavy smoker. He smoked inside his house and was known to often fall asleep whilst sitting on his lounge. Julie-Anne Allen previously expressed a concern that Peter would fall asleep whilst smoking, and that a dropped cigarette might start a fire.

16. Peter was also known to rarely wear clothes to bed during the warmer months. He kept a pair of track pants or shorts near the bed in case he needed to get up during the night. Julie-Ann also recalled that Peter would walk around the house unclothed at times.

History of alcohol use

17. Peter was also known to be a heavy drinker and had a long history of alcohol abuse. As at November 2000 he had struggled with alcohol addiction for seven to nine years. During this period Peter took steps to address his addiction through abstinence, counselling, medication and attending Alcoholics Anonymous. These steps were successful in part and Peter reportedly had "*fairly prolonged periods of sobriety*".

18. In the two years preceding his death Peter was making consistent attempts to stop drinking. His efforts were particularly diligent from September 2000. Records from an outreach drug and alcohol program in Lismore reveal that Peter attended group counselling sessions regularly and with increasing frequency right up until his death.

19. As a consequence of his attempts to address his drinking Peter was admitted to Lismore Hospital on a number of occasions for symptoms of alcohol withdrawal such as agitation, tremors and seizures, with increasing frequency towards the end of 2000. Peter had one such occasion of seizure activity on 9 November 2000 during a drug and alcohol outreach program meeting. Peter subsequently attended hospital where it was noted that he had not had alcohol that day. Medical records noted "*alcohol withdrawal fits*" in relation to Peter's presentation.

Mental health history

20. Between February and May 1990 Peter was voluntarily admitted to hospital on three occasions for psychiatric treatment with two admissions lasting around two to three weeks each. Following this, Peter had two further admissions to hospital:

[1] The factual background have been drawn from the helpful opening and closing submissions of Counsel Assisting.

(a) On 20 April 1998 Peter attended Lismore Hospital "*requesting to be locked up as he feels suicidal*";

(b) On 11 November 1998 Peter again attended Lismore Hospital complaining of agitation and reporting that he had been drinking heavily for the preceding four weeks being a bottle of spirits each day.

21. Notwithstanding the reference to suicidal ideation on 20 April 1998, it is suspected that both of the above admissions are more closely linked to Peter's struggles with alcohol.

22. Variously throughout his hospital records there are references to Peter having a depressed mood or flat affect. Peter had been prescribed an antidepressant (Zoloft) in 1998 and appears to have been given a benzodiazepine used to treat anxiety and alcohol withdrawal (Diazepam) on admission following presentation of symptoms of alcohol withdrawal on some occasions. The available records also indicate that Peter was prescribed or recommended anti-seizure medication (Dilantin or Phenytoin) in the months before his death. However it had been noted that Peter's compliance with his medication regime had been poor.

23. During an admission on 9 November 2000 Peter was advised to stay on anti-convulsant medication until alcohol detoxification had been completed. However, it is not known if Peter was taking this medication in the period prior to his death.

The events of 26 November 2000

24. At about 4:50 am on Sunday, 26 November 2000 officers from NSW Fire and Rescue (**NSWFR**) and the NSW Police Force (**Police**) attended Peter's house at 20 Avondale Avenue, Lismore and found the premises alight. NSWFR units from Lismore and Goonellabah extinguished the fire and conducted a search of the premises.

25. NSWFR Officer Mark Huxley found Peter lying on his back on the floor of the lounge room area, amongst plaster and building materials. Peter's body was severely fire damaged making visual identification impossible. It was not until 28 November 2000 that Peter's identify was confirmed by a forensic odontologist who performed a dental records comparison.

26. Detective Senior Constable Michael Smith (as he then was) and Crime Scene Investigator Detective Senior Constable Whayne Day arrived at the scene at approximately 6am. Detective Senior Constable Day subsequently conducted a forensic examination of the scene.

27. At 12:00pm Inspector Garry Malpass, from the NSWFR Fire Investigation Unit, arrived at the scene from Sydney and conducted an investigation as to the cause and origin of the fire. Detective Senior Constable Day and Inspector Malpass could not identify the direct ignition source but attributed the origin and cause of the fire to an electrical fault.

Postmortem examination

Autopsy

28. Peter was later taken to Lismore Base Hospital where an initial examination was performed by Dr Shaun Stevens on 26 November 2000. Following this, a Report of Death to Coroner which was prepared and forwarded to the Coroner at Lismore.

29. On 27 November 2000 Dr Geoffrey Cawley performed a three cavity (head, chest, abdomen) autopsy. Dr Cawley noted the following pathological findings:

    (a) Heavily charred body with heavy charring of both hands and feet;

    (b) No signs of brain abnormality or haemorrhage or head injury;

    (c) Oedematous smoke affected lungs;

    (d) Fatty liver;

    (e) No signs of neglect or violence

30. Dr Cawley noted that because of heat changes the organs were inspected but not removed or weighed.

31. Dr Cawley completed a medical report in relation to the postmortem examination he conducted. The report was two pages in length, written in hand, and completed on the same day as the postmortem examination itself. Ultimately, Dr Cawley recorded that in his opinion the direct cause of death was "*incineration*" due to "*alleged house fire*" and identified "*smoke inhalation*" as a significant condition contributing to the death.

32. A number of forensic specimens were submitted for further analysis with Dr Cawley noting that there was a history suspicious for drug abuse or addiction, and that drugs or poisons were possibly related to death. Dr Cawley further made a notation indicating that the death was considered to be accidental (and not self-inflicted, or as a result of homicide).

33. Further, Dr Cawley expressed the opinion that death occurred about 30 hours prior to postmortem examination which would have been at approximately 5:00 am on 26 November 2000. However, from the records kept by Dr Cawley, the basis for this estimate as to time of death is unclear.

Toxicology

34. Toxicology testing of postmortem blood samples, which were produced in a report dated 19 December 2000 (**the Toxicology Report**) identified a blood alcohol level of 0.144g/100ml and a carbon monoxide saturation of 8%.

35. The Toxicology Report noted that carbon monoxide saturation of up to 10% was considered to be in the normal range; saturation of between 20-30% was considered to be in the toxic range; and saturation of more than 30% was considered to be in the reported fatal range.

Re-investigation of the circumstances of Peter's death

36. Following the Report of Death to the Coroner a brief of evidence was prepared and submitted. On 14 June 2002 the Lismore Coroner dispensed with holding an inquest and listed the cause of death as incineration with an antecedent cause of smoke inhalation.

37. In 2006 police received intelligence reports suggesting that Peter's death may have been the result of homicide, and that the fire had been deliberately lit. On 5 July 2006 the Police officer in charge of the investigation, Detective Senior Constable David Mackie (as he then was), received information that a person named Matthew Walker was in custody awaiting sentence in relation to unrelated matters, and wished to provide information in order to receive assistance in relation to his sentencing proceedings.

38. On 11 July 2006 Mr Walker participated in a recorded interview and provided the following information in relation to the fire on 26 November 2000:

    (a) A fellow inmate named Andrew Benn had made admissions to being involved in the incident;

    (b) Mr Benn stayed with Mr Walker in Corindi sometime after 2000 and brought a television with him claiming that "*he got it from a drunk that he'd killed*";

    (c) Mr Benn said that he was "*doing a house over*" a couple of blocks from his own house in Lismore, with a friend, Jamie Vidler, and that he disturbed the occupant who he described as *"a drunk*";

    (d) Mr Benn claimed that at around 8:00pm he entered the house by kicking the door which was a "*joke*" because the door was unlocked and unlatched;

    (e) Mr Benn said that he knocked the male occupant of the house down to the ground and "*kicked his head into a door jamb a few times*" and "*when he stopped he said he heard silence*". Mr Benn said that there was some "*crunching … 'cause he was putting his heel in*".

    (f) Mr Benn repeated that "*the guy was asleep on the lounge apparently, woke up disturbed by them, lent forward, he was knocked down and had his head kicked in, in the middle of the doorway, oh, in the door jamb of the hallway*";

    (g) Following this, Mr Vidler entered the house and together they ransacked the house looking for valuables which they took back to a caravan at the rear of Mr Benn's father's house – the items included some cash, jewellery, possibly a ring, a TV, and a Suzuki four stroke lawnmower;

    (h) Mr Benn and Mr Vidler checked on the man that Mr Benn had assaulted and found that he was deceased;

(i) Mr Benn and Mr Vidler decided to set fire to the house in order to conceal evidence of the crime;

(j) Mr Benn said that he distributed flammable material around the house and then ignited fuel which had been obtained from the underside of the house;

(k) Mr Benn said that "*he tipped over some furniture, a lounge, made as if the guy had fallen. Knocked over a coffee table with an ashtray, some bottles. Picked up some flammable items from around the place but tried to make it as natural as, so it could ignite a trail. So he must have known, known the fuel was downstairs otherwise he wouldn't have done that*".

(l) Mr Benn said that although Mr Vidler wanted the lawnmower he later gave it to a person he referred to as "Pete the taxi driver";

(m) Mr Walker later told Mr Benn to leave, and Mr Benn gave the television to Leesa Brading, a 17 year old girl who lived next door to Mr Walker;

(n) Mr Benn threatened that he would kill Mr Walker if he repeated to anyone what he had been told; and

(o) Mr Walker described Mr Benn as being "*real cocky*" about the incident as the Police considered it to be an accidental fire and death.

39. Mr Walker later received a 30% reduction in his sentence for his cooperation in the investigation into Mr Allen's death and his undertaking to give evidence against Mr Benn.

40. As a result of the disclosures made by Mr Walker, a Police Strike Force was subsequently established on 12 July 2006 to re-investigate the circumstances of Peter's death. Numerous enquiries were made to either corroborate or dispel the information provided by Mr Walker, which revealed the following:

(a) Mr Walker stated Mr Benn lived in a caravan at premises in Post Office Lane, Corindi. Enquiries showed that on 29 January 2002 this was the addresses provided by Mr Benn to Police in relation to a ticket which had been issued.

(b) Mr Benn was confirmed to be in Lismore at the time of the fire. Mr Benn reported to Lismore Police on 24 and 27 November 2000. He also made bank withdrawals in Lismore on 23 November 2000 and 30 November 2000.

(c) Mr Vidler was also in Lismore at the time of the fire, having used an ATM in Lismore on 28 November 2000.

(d) Mr Walker stated that around the time of the alleged admissions made by Mr Benn he provided a statement to police in relation to an armed robbery offence to which he and Mr

Benn were witnesses. Enquiries confirmed that Mr Walker made a statement dated 29 November 2001 in relation to this incident.

41. As part of the reinvestigation the Strike Force examined a number of features of the initial investigation in order to confirm or refute the alleged admissions made by Mr Benn.

Peter's television

42. Julie-Ann bought Peter a black Samsung television from a store in Lismore on 19 September 2000. Peter set up the television in the lounge room and connected a recently purchased TEAC brand video player to it. However the television was not functioning correctly and was subsequently replaced by the store where it had been purchased.

43. Julie-Ann spoke to Peter a few days prior to 26 November 2000. At this time Peter made no mention of any of his property having been stolen. As Peter was known to be fond of watching movies Julie-Ann expected that Peter would have mentioned the television if it had in fact been stolen by this time.

44. After reviewing the crime scene photographs Detective Sergeant Mackie could find no evidence of any fire damaged remains of a television inside the premises.

45. Police enquires revealed that Ms Brading was living at Post Office Lane, Corindi at the time of the fire. Ms Brading subsequently told police that when she was about 18 years old a person named "Andrew" moved into a caravan at the back of Mr Walker's house.

46. On 15 November 2006 Detective Sergeant Mackie spoke to Ms Brading at her home. She provided the following information:

    (a) "Andrew" came to her house with a television and asked her if she wanted it;

    (b) As she did not have her own TV at the time she accepted the TV, together with a remote;

    (c) The TV was relatively new with few scratches;

    (d) "Andrew" gave her the TV as he was moving out and could not take everything with him because he did not have a car; and

    (e) "Andrew" moved out of the caravan after staying for approximately six months and Ms Brading never saw him again.

47. Ms Brading showed Detective Sergeant Mackie a Samsung television which was kept in the spare room of her home. It was noted that the serial number and model number sticker appeared to have been removed from the back of the television.

Peter's lawnmower

48. Julie-Anne recalled that Peter bought a red coloured lawnmower sometime in 1987.

49. Peter Carn lived in Ewing Street Lismore near Mr Benn. At some stage Mr Carn told Mr Benn that his lawnmower was playing up. Mr Benn informed Mr Carn that he could have one of his spare lawnmowers. As Mr Carn was aware that there were numerous old lawnmowers at the Benn residence he did not consider Mr Benn's offer to be unusual and accepted it. Mr Benn later gave Mr Carn a red coloured lawnmower which might have been a two-stroke Rover. Mr Carn later returned the lawnmower to Mr Benn.

50. Gary Vidler told police that in about 2002 Mr Benn lent him a lawnmower which had a red base, some chrome parts and a Suzuki motor. Mr Benn reportedly told Mr Vidler that the lawnmower came from "*up the hill*". Mr Vidler used the lawn mower for a month before returning it to Mr Benn in Lismore, as he became concerned about the origin of the lawnmower.

51. Lucille Benn, Mr Benn's mother, told police that she had seen a lawnmower, which was in a new condition and was cream and red/orange in colour, underneath their house. When she asked Mr Benn about the lawnmower he told her, "*I found it*", which Mrs Benn understood to mean that Mr Benn had stolen it.

52. Karran Keaton, a close friend of Mr Benn, told police that sometime in 2007 Mr Benn told her that he had stolen the lawn mower.

53. Kay Johnson, Mr Benn's former probation and parole officer, told police of a conversation she had with Mr Benn in February 2007. During that conversation Mr Benn reportedly said that some six years earlier he had taken a lawnmower a week before 27 November 2000. According to Ms Johnson, Mr Benn was "*adamant in this conversation that he had nothing to do with the fire or with the man.*"

54. Police subsequently executed a search warrant at Mr Benn's home on 24 January 2007, during which a red Rover Suzuki lawn mower was found, together with a number of other push lawnmowers.

Alleged admissions

55. During the re-investigation it was identified that Mr Benn made a number of admissions to the following people:

    (a) Darren Marsden is Mr Benn's cousin. Mr Marsden told Police that he had conversation with Mr Benn in 2000 during which Mr Benn said that he had been "*casing a place*" in Lismore and wanted to steal the television from the house. Mr Benn reportedly described climbing through a window into the house, believing no one was home. Mr Benn encountered the male occupant of the house and a struggle ensued, during which Mr Benn got the man on the floor and began to kick him in the head. Mr Benn reportedly said that he kicked the man towards the wall and when his head was against the wall he kept kicking him. Mr Benn said that he felt the man's head cave in but he kept kicking him. Mr Benn said that he then burnt the house down, and was laughing at how stupid the police were as they thought the house fire was just an accident. Mr Benn then showed Mr Marsden his pair of blood-spattered white joggers that he had worn on the night of the assault. Mr Benn said that he had intended to burn the shoes

at a farm, as they were the only piece of evidence that Police could get, but had not done so. Mr Marsden told police that he had been present on other occasions when Mr Benn had told the same story to other people.

(b) Peter Marsden recalls being at a farm with Mr Benn who wanted to burn the shoes that he was wearing.

(c) Alwyn Marsden told Police that Mr Benn stayed with him for about 12 months from late 2002. During this time Mr Benn was "*always talking about killing people, he was on the telephone to his friend Jamie Vidler, always about killing people.*" Mr Marsden said that he was aware of a story of Mr Benn killing a man in a house at Lismore and then setting fire to the house, but could not recall where he heard it from. However, Mr Marsden said that the story was common knowledge within his household.

(d) Sometime in 2002 Mr Benn told Patrick Hartley (whose daughter was in a relationship with Darren Marsden) that he had "*bashed a bloke and burnt his home in Lismore*".

(e) Craig Connell said that in about 2006-2007 Mr Benn told him about a friend named "Jamie" who was being investigated for a murder. Mr Benn expressed concern that "Jamie" would talk, as he and "Jamie" had been involved in a break and enter in Lismore. Mr Benn also reportedly spoke about the murder of the "*bloke in the house fire near his place*" and said that he did it.

(f) In December 2007 Mr Benn was involved in an ongoing disagreement with his neighbour, Melanie Butcher. On 11 December 2007 Mr Benn reportedly yelled at Ms Butcher, "*You better be looking for real estate or I'll burn your fucken house down like I did to old mate*". Mr Butcher told police that a photocopy of a photo of a burnt house had been left on her patio by a person, or persons, unknown.

(g) On 29 November 2007 Christopher Churchill reportedly heard Mr Been threatened to burn down the office where he worked, stating "*I have killed before and it will be fun to do it again*".

Revised cause of death

56. As part of the re-investigation Associate Professor Timothy Lyons (as he then was), forensic pathologist at the Department of Forensic Medicine in Newcastle, was asked in November 2006 to provide an opinion regarding the original postmortem examination and the cause of Peter's death.

57. In a report dated 2 November 2006, Associate Professor Lyons noted the following:

(a) The postmortem blood alcohol concentration of 0.144g/100ml was "*consistent with a very heavy drinking session and at this blood level there would have been significant central nervous system depression from a decrease in reflexes and reduced co-ordination*";

(b) A carbon monoxide level of 8% falls just slightly above blood carbon monoxide averages obtained in a spectrum of urban non-smokers and smokers (with a carbon monoxide range of 1-6% provided). However, Associate Professor Lyons noted that a level of 8% was well below

that which has been routinely reported for post mortem carbon monoxide concentration for victims of smoke inhalation and fires, being a range of 25% to 85%. Associate Professor Lyons expressed the view that the carbon monoxide level suggested that Peter did not experience smoke inhalation, and that he was already deceased prior to the commencement of the fire.

58. As to the original postmortem examination Associate Professor Lyons described Dr Cawley's autopsy report as "*extraordinarily brief*", and noted the following:

(a) It is not possible to make comments on injury patterns from crime scene photographs;

(b) The autopsy report is "*brief in the extreme*" and provides no detailed descriptions of the body on internal and external examination;

(c) No post mortem photographs appear to have been taken;

(d) Associate Professor Lyons indicated that he was unable to discern how Dr Cawley had described the lungs as oedematous and smoke affected. Associate Professor Lyons noted that it is possible that the lungs were oedematous because they had been affected by heat. However, as no histological examination was undertaken it is not possible to obtain further information regarding this issue.

(e) No radiological examination of the body was undertaken, and such examination is considered to be a pre-requisite in the investigation of a fire death;

(f) In any forensic setting the information in the postmortem report and subsequent investigations were insufficient to provide information for retrospective assessment of this case; and

(g) The case should have been transferred to a forensic facility for appropriate investigation and radiological and histological examination, which were both pre-requisites for such an investigation.

Forensic Toxicology

59. A report was also obtained from A/Deputy Director Tatiana Prolov, forensic toxicologist, dated 27 July 2006. Ms Prolov noted that the carbon monoxide level of 8% is considered to be in the normal range which a heavy smoker may have in their blood.

Debris

60. It was noted that Peter was found naked, which is consistent with information provided by Julie-Ann that he had a preference for sleeping unclothed. As Peter's back was not burnt, unlike the rest of his body, this raised the question of whether there was a layer of debris found underneath his body. Such a finding would indicate that Peter had collapsed onto debris caused by the collapse of the house structure, after the fire had started.

Criminal proceedings

61. On 13 February 2007 Mr Benn was arrested and charged with the following offences:

    (a) Murder , pursuant to s 18(1)(a) *Crimes Act 1900 NSW* (**Crimes Act**);

    (b) Malicious damage to property with intent to endanger life, pursuant to s 198 Crimes Act;

    (c) Break and enter a building and commit a serious indictable offence, pursuant to s 112 Crimes Act; and

    (d) Larceny, pursuant to s 117 Crimes Act.

62. A committal hearing was conducted on 7 and 8 October 2008 during which Mr Walker, Daniel Marsden, Peter Marsden and Associate Professor Lyons all gave evidence.

63. Mr Walker gave evidence which was generally consistent with his initial interview with Police. In cross examination he stated the following:

    (a) A couple of days after the first discussion about the incident Mr Benn disclosed to him that Mr Vidler and Mr Benn both kicked the male occupant during the robbery (a matter which Mr Walker did not refer to in his initial interview);

    (b) Mr Benn said that Mr Vidler was kicking the male occupant to the body and the head, fast and repeatedly;

    (c) Mr Benn did not state the exact location where the fire was ignited; and

    (d) Although they had had some drinks Mr Benn was not drunk at the time he disclosed the incident.

64. Associate Professor Lyons gave evidence in which he noted the following:

    (a) He had not been briefed with Peter's medical history prior to completing his report in November 2006;

    (b) In light of Peter's history of seizure, Associate Professor Lyons could not exclude the possibility that the carbon monoxide level of 8% was a result of Peter experiencing a seizure and being unconscious on the floor at the time the fire started. Associate Professor Lyons explained: *"… given that I now know that [Peter] is an epileptic and in conjunction with a high blood alcohol I could not – I couldn't completely exclude the possibility that [he] was possibly unconscious at the commencement of the fire and simply because he's unconscious hasn't breathed very much in terms of smoke inhalation*".

    (c) Associate Professor Lyons noted that deposition of soot in the airways (a common finding in cases of smoke inhalation) was not documented, described or histologically examined;

(d) Associate Professor Lyons agreed that radiological examination would be part of routine examination for a victim of a house fire, which was not done in this case, but agreed that "*Dr Cawley has made the specific observation that he didn't believe there was a head injury*";

(e) Associate Professor Lyons noted that whilst "*soft tissue injury can be very substantially concealed in fire victims*" he "*would have expected any significant fractures or bony injuries to have been picked up at post mortem*". Associate Professor Lyons noted that Dr Cawley "*doesn't appear to have observed any significant injuries and he does appear to have looked for them*".

(f) Associate Professor Lyons was critical of the autopsy report and noted the following: "*A forensic pathologist is supposed to write a report that another pathologist can pick up, read and place himself in exactly the same situation and I'm sorry I'm not able to do that with the report that I've been tendered*".

65. Mr Benn was later committed to stand trial for Peter's murder. However, on 27 April 2009 the Director of Public Prosecutions (NSW) withdrew all of the charges against Mr Benn with the exception of the larceny charge.

66. On 10 November 2009 Mr Benn pleaded guilty to stealing the lawnmower. The agreed set of facts tendered during the sentence proceedings noted that the offence occurred "*days or weeks before the fire*". Mr Benn was sentenced to three months imprisonment.

67. On 6 January 2017 Detective Sergeant Mackie requested that the matter be referred back to the Coroner. On 12 February 2019 the then Acting State Coroner made a direction pursuant to section 29(1) of the Act that an inquest be held. Pursuant to section 29(3) of the Act the Chief Magistrate provided consent for the inquest to be held.

What issues did the inquest examine?

68. Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the matters that the inquest would examine and consider. NSWFR, the Police and Detective Sergeant Smith, Detective Senior Constable Day and Inspector Malpass were all identified as sufficiently interested parties. The list of issues identified the following:

(1) The time of death:

(a) Whether there is sufficient evidence to determine Peter's time of death.

(b) If there is sufficient evidence, whether Peter died before or during the fire that destroyed his home on 26 November 2000.

(2) The cause of death:

(a) Whether there is sufficient evidence to determine the cause of Peter's death.

(b) If there is sufficient evidence, whether Peter died as a result of the fire or from some other cause.

(3) If the time and cause of Peter's can be determined, the manner of death, including:

(a) Whether any other person was involved in Peter's death.

(4) The adequacy of the postmortem conducted by Dr Cawley:

(a) Whether the postmortem was conducted in accordance with the professional standards for the examination of fire affected bodies in place at the time;

(b) Whether there were deficiencies in the professional standards for the examination of fire affected bodies in place at the time; and

(c) Whether any deficiencies in the professional standards for the examination of fire affected bodies in place at the time have subsequently been rectified.

(5) The adequacy of the initial investigation into the cause of the fire by the NSW Police Force and the Fire Investigators:

(a) Whether the fire investigation was conducted in accordance with the policies, procedures and professional standards in place at the time; and

(b) Whether there are any current systemic deficiencies with the policies, procedures and professional standards of FRNSW, in relation to any matter connected with the death, that warrant recommendations by the Deputy State Coroner.

69. Each of these issues is discussed in further detail below.

Was the postmortem examination adequate?

70. The coronial investigation identified a number of deficiencies associated with the postmortem examination conducted by Dr Cawley, namely:

(a) No photographs were taken of the examination;

(b) Radiological and other imaging investigations were not performed;

(c) Although the three bodily cavities were examined, none of the organs were removed and weighed, and no investigation was conducted for the presence of soot;

(d) Whilst samples of blood, bile and urine were taken for toxicological testing, no record was noted as to where the blood sample was taken from; and

(e) The duration of the postmortem examination is unclear. Whilst records indicate that the examination commenced at 11:00am, there is no record as to when it concluded. Detective Senior Constable Day's Duty Book indicates that he left the police station at about 10:45 to attend the postmortem examination and returned at 11:30am. Detective Senior Constable Day gave evidence that he could not recall whether he was present for the entire postmortem examination but noted that it appears he took forensic samples back with him to the police station at 11:30am.

71. As part of the reinvestigation in 2006, Detective Sergeant Mackie contacted Dr Cawley on 3 November 2006. Dr Cawley stated he could find no records relating to Peter and had no independent recollection of the matter. Dr Cawley reviewed the autopsy report and confirmed that he did not remove the organs, and that there was no finding of head trauma. Dr Cawley acknowledged that whilst the lungs were smoke affected, he could not determine whether this finding was due the fire or Peter's past smoking history. It should be noted that Dr Cawley later passed away on 27 July 2019.

72. Further expert opinion was sought from Dr Linda Iles, Head of Forensic Pathology Services at the Victorian Institute of Forensic Medicine. In a report dated 16 July 2019 Dr Iles noted that, in general, the purpose of an autopsy examination in the case of a death in the setting of a fire is to:

(a) Assess the contribution of injury, if present, to death;

(b) Determine whether death occurred as a consequence of the fire, or has occurred prior to the fire taking hold and

(c) Determine the presence of any natural disease and its contribution to death.

73. As to the specific autopsy examination conducted in Peter's case, Dr Iles considered it to be inadequate in terms of determining:

(a) definitively whether death occurred prior to the fire taking hold;

(b) whether trauma had caused or contributed to death;

(c) whether natural disease had caused or contributed to death; and

(d) the cause of death.

74. In particular, Dr Iles noted that the failure to remove and weigh the organs means that the examination of the brain was inadequate to exclude acute or remote traumatic brain injury or natural disease. Further, the failure to remove the lungs means the observation that the lungs were "*oedematous*" has no factual basis and should be disregarded. Finally, the observations that the lungs were "*smoke affected*" is of no evidential value as any "assessment of the lungs being acutely

affected by smoke required examination of the airways", which was not done. Ultimately, Dr Iles concluded that "*the medical examination in this case, given its very significant limitations, is uninformative as to the cause or manner of [Peter's] death*".

Changes made to postmortem examinations since 2000

75. Information was sought from Dr Issabella Brouwer, Chief Forensic Pathologist at the Department of Forensic Medicine, as to any relevant changes made to the conduct of postmortem examinations since November 2000. Dr Brouwer identified the following:

    (a) The Policy Directive Forensic Pathology Code of Practice, first published on 3 September 2012, provides that all fire-related deaths are referred to one of the three Forensic Medicine facilities in NSW where examinations are performed by qualified specialist Forensic Pathologists. The previous practice of engaging itinerant Coronial Medical Officers to perform autopsy examinations is no longer considered to be acceptable.

    (b) The Forensic Medicine Clinical Standard on Autopsy Definitions, developed in 2017, provides clear guidelines to the extent with which an examination should be performed and has assisted with standardising examination practice in NSW.

    (c) Full body postmortem CT imaging is performed on admission to a Forensic Medicine facility.

    (d) Routine digital photography of the body at examination is routinely performed by all forensic pathologists.

    (e) Forensic toxicology analysis is performed for a wide range of commonly used drugs (approximately 300 drugs), as well as testing for alcohol and carbon monoxide. In particular, carbon monoxide levels can be tested for and results made available within 24 hours in fire-related deaths.

    (f) A peer review process has been implemented whereby all suspicious/homicide deaths, as well as deaths where the cause of death is undetermined, are peer reviewed.

76. It should be noted that Dr Brouwer was unable to locate any autopsy standards (or any policy directive equivalent to the Forensic Pathology Code of Practice) prior to September 2012 in the NSW Health policy directive archives.

Conclusions

77. The coronial investigation has been unable to identify whether any autopsy standards or NSW Health policy directives in relation to the conduct of postmortem examinations applied as at November 2000. Therefore, it is not possible to reach a conclusion as to whether the postmortem examination conducted by Dr Cawley was consistent with any overarching policies in force at the time.

78. However, the opinions expressed by both Associate Professor Lyons and Dr Iles establish that the postmortem examination was not conducted in accordance with the professional standards for the examination of fire-related deaths at the time. Critically, as identified above, routine examinations expected to be performed in the context of a fire-related death were not, in fact, performed. This resulted in the postmortem examination being unable to assist with determining the extent to which (if any) trauma or natural disease process contributed to Peter's death, whether he died before the commencement of the fire, and the cause of his death.

79. Further, it is apparent that Detective Sergeant Smith relied heavily on the results of the postmortem examination and the opinions expressed by Dr Cawley as to the cause of Peter's death. This had the unintended consequence of reducing the likelihood that aspects of the postmortem examination (such as the Toxicological Report) and other potential lines of enquiry would be considered more closely.

80. Relevantly, and importantly, a number of significant improvements have been made since November 2000 in relation to the conduct of postmortem examinations, both generally and in particular, in relation to fire-related deaths. Current procedures and guidelines now provide a more robust and comprehensive system for the postmortem examination of such deaths.

Was the investigation into the cause of the fire adequate?

Initial examination and investigation

81. Detective Senior Constable Day examined the scene on two occasions on 26 November 2000: the first, by himself, at 5:30am; and the second, with Inspector Malpass, later during the afternoon. Photographs were taken by both Detective Senior Constable Day and Inspector Malpass, and drawings were made of the scene and the layout of the house. Detective Sergeant Smith was also on the scene from around 6:00am.

82. From his examination of the scene, Detective Senior Constable Day identified the following matters of significance:

    (a) The premises was severely fire damaged with the main area of consumption being the interior, particularly on the rear half of the dwelling, and including partial roof collapse.

    (b) Detective Senior Constable Day formed the opinion that the premises was probably not heavily furnished but did consist of enough available combustibles to assist with acceleration and travel of the fire.

    (c) The fire damage to the exterior of premises was not consistent with an accelerant except where the chainsaw was stored at the top of the rear steps.

    (d) No evidence was located of a liquid accelerant or a build-up of combustible material which may have been foreign to the front steps and landing at the top of the stairs.

    (e) A severe area of burning of the roof and ceiling materials in the lounge room was located over the area established as the point of origin of the fire at the base of the southern wall.

(f) At the base of the southern wall there were the remains of an electrical extension lead that passed down under the wall through to the veranda, with sections of the lead totally consumed by the fire.

(g) On the floor in front of the middle of three studs in the southern wall were the remains of a number of electrical items and melted plastic. These included the remains of a power point, a radio aerial, a melted 3 plug power board, a melted radio speaker, a melted video cassette tape and a bundled co-axial cable. A two wire aerial lead was found travelling along and through the floor in the north eastern corner of the lounge room.

(h) Peter was found lying in a supine position with his legs generally stretched out amongst the debris on the floor. The debris included fire damaged timber, ashen debris from timber and available combustibles with the premises and the remains of collapsed gyprock from the walls and ceiling. The debris was approximately 50mm to 75mm in depth around Peter.

(i) There were no suspicions injuries other than the severe burns and Peter's back was in good condition in comparison to the front of his body. No obvious serious burning to the skin on the back was identified.

83. Ultimately, Detective Senior Constable Day expressed the following view: "*The undamaged condition of [Peter's] skin on his back and the variation in the location and height of the fire debris indicated [Peter] had fallen into his current position during the earlier stages of the fire and prior to collapse of the ceiling and roof…I am of the opinion that the direct cause of the death was related to the well established fire and the resulting layer of thick, hot and poisonous smoke and associated gases. It appears [Peter] has collapsed very quickly after exposure to the extreme heat and dangerous gases…It appears [Peter] has most likely been sleeping in bedroom one and has awoken during the fire and walked out of his bedroom and become disoriented as a result of the dark environment and breathed the hot poisonous gases associated with the fire. [Peter] had fallen quickly in the located he was found*".

84. As to the cause of the fire, Detective Senior Constable Day expressed this view: "*My opinion based on the available physical evidence at the scene indicates the cause of the fire was an electrical fault which has resulted in fire at the base of the southern wall. The fire has initially involved a slow build up of heat and fire but once established in a good fuel load provided both within the wall in the form of dust and debris and the ply board linings it has quickly spread both up the wall and breached the walls on both sides and spread through available combustibles. Once in the ceiling the fire has again spread across the premises. I have not been able to identify the direct ignition source. I did not locate any evidence to indicate suspicion and the involvement of arson as a factor in this fire*".

85. As part of his examination, Inspector Malpass noted the following:

(a) The lounge room had sustained the greatest damage. The rear northern stud wall of the lounge room was more fire affected than the other walls. The centre of this wall showed greater charring with the centre stud burnt away and the wall plate in this area was also burnt

away showing a hole in the floor. Studs and noggins progressively lessened in charring on both sides moving away from the centre in a "V" shaped fire pattern. This area was determined to be the point of origin for the fire.

(b) Directly in the area of most fire damage the remains of a general power outlet was found that had an extension lead wired into the back of it by just twisting the wire together. No junction box or BB connecters were evident. The extension lead went to a power board with a stereo and lamp plugged in.

(c) Very little personal items and furnishings were found. It was noted that there was no television within the lounge room although there was coaxial cable.

86. Detective Sergeant Smith expressed a similar view to Detective Senior Constable Day: "*As a result of the investigation I agree with DSC Day's opinion that the cause of the fire was an electrical fault which has resulted in fire at the base of the Southern wall. I am of the opinion that [Peter] woke after the fire had ignited and possibly due to his level of intoxication (0.144 grams per 100 ml of blood) was unable to escape from the premises. I can find no evidence of any person or persons involvement in the death of Peter Allen*".

Re-investigation after 2006

87. In 2007 Detective Sergeant Chin, a crime scene investigation expert, reviewed the circumstances of Peter's death and noted the following:

(a) He agreed with Detective Senior Constable Day and Inspector Malpass as to the area of origin of the fire being the lounge room, with the point of origin being the centre of the north wall of the lounge room.

(b) The severe fire damage to the power board could be caused as a result of an electrical fault in the power board or as a result of the power board suffering severe fire damage because of its location in the area of origin. The power board cannot be excluded as the cause of the fire.

(c) No evidence was located to show that any other electrical item was involved in the cause of the fire, but a fault in an electrical item causing the fire cannot be excluded.

(d) As a heater was not located in the area of origin, a heater causing the fire has been excluded as the cause of the fire.

(e) No evidence was located to indicate that the fire may have been caused by a cigarette, oil burner or other burning object. The remains of an oil burner were not located and have been excluded as a cause of the fire. Any items such as candles or cigarettes could have been totally consumed by the fire and cannot be excluded as the cause of the fire.

(f) No evidence was located to indicate spontaneous combustion may have caused the fire, but this cannot be excluded.

(g) No evidence was located to indicate that the fire had been deliberately lit by the ignition of available materials by means of a match, cigarette lighter or other ignition source but this cannot be excluded.

(h) No evidence was located to indicate that the fire had been caused by the ignition of liquid accelerants. Any liquid accelerants may have been completely consumed during the course of the fire or during fire fighting activities. This cause cannot be excluded.

88. As noted above, Detective Senior Constable Day observed that there was a variation in the location and height of fire debris, indicating that Peter had fallen onto the position where he was found prior to the collapse of the ceiling and roof. As to this issue, Detective Sergeant Chin noted: "*The photographs also show areas of skin on the back of [Peter] that were in direct contact with the floor to be unaffected by fire and heat. When the body was moved, the photographs show the area under the body to be partially covered by burnt debris. I noted that there were three areas clear of burnt debris. I also noted that the photograph of the back of Peter Timothy Allen showed a large area unaffected by fire and heat. These areas were in contact with the floor with no debris underneath.*"

89. Detective Sergeant Chin ultimately concluded that the cause of the fire was undetermined. He further expressed a view in support of the conclusion reached by Associate Professor Lyons that Peter was likely to have been deceased prior to the commencement of the fire.

90. Inspector Malpass later revised his opinion following case review, and also expressed the view that the cause of the fire was undetermined. As part of a similar process, Detective Senior Constable Day also similarly revised his opinion, concluding that the cause of the fire was undetermined.

Review as part of the coronial investigation

91. John Gardner, an electrical engineer frequently engaged by NSWFR to assist in the investigation of electricity-related fires, also provided an opinion in a report dated 30 July 2019. Mr Gardner expressed an opinion regarding the following three relevant matters:

(a) There was no significant material or debris found under Peter after the fire. The lack of fire damage to his back and corresponding protection patterns on the floor, indicate that he was lying face up on the floor before the fire developed.

(b) The findings of the original investigation in that there was no evidence to indicate suspicion or arson, are unreliable. It appeared that the fire scene was not further investigated for evidence of accelerants such as petrol and/or multiple areas of fire origin, which can be indicators of a suspicious or non-accidental fire.

(c) The cause of the fire is undetermined. There are numerous possible causes, none of which are considered more likely than the other due to a lack of evidence.

92. As to the possible cause of the fire, Mr Gardner explained further: "*The hypotheses which are not supported by physical evidence are eliminated until one is left that is best supported by the evidence, leading to an opinion as to the probable cause. In the absence of physical evidence of a cause, the fire has to be classified as undetermined*".

93. As to the possibility of electrical fault being the cause of the fire Mr Gardner noted that the mere presence of burnt electrical wiring and components in a suspected area of fire origin is not sufficient evidence to establish an electrical fault as a cause of the fire. He explained that such wiring needs to be further examined. However, as the wiring and components were not further examined in this case, an electrical fault cannot be excluded as a possible cause of the fire nor can it be considered to be a probable cause of the fire.

94. Mr Gardner also reviewed the scene photographs and noted that there was no significant material underneath Peter and his back is clearly unburnt, with coinciding protection marks on the floor. Mr Gardner opined that the inconsistency between his review of the scene photographs and the observations made by Detective Senior Constable Day that Peter was lying on debris that appeared to have fallen from the roof prior to its collapse, was possibly due to the delay in developing the films and printing the photographs as was required in 2000. Mr Gardner ultimately expressed the view that Peter was lying on his back on the lounge room floor prior to, or at the time, the fire started and did not fall onto debris after the ceiling had collapsed. This is consistent with the view expressed by Detective Sergeant Chin regarding the positioning of Peter's body relative to any debris.

95. Superintendent Graham Kingsland is a NSWFR expert fire investigator. He prepared a statement dated 31 March 2020 in response to Mr Gardner's report. Superintendent Kingsland noted the following matters relevant to fire investigation:

(a) Between 2000 and 2019 the undetermined rate for all fires investigated by the NSWFR fire investigation unit increased from 14.75% to 41%. This increase was likely a result of "*an increase in the collective knowledge of the fire investigators leading to a higher awareness of various ignition scenarios. This, in turn, leads to more ignition hypotheses of 'possible' rather than 'probable'. The increased knowledge of possible causes can make it more difficult to identify one probable cause.*"

(b) Modern fires progress to 'flashover' – a term used when the whole room is on fire – in a shorter period of time due to the increased flammability of modern furnishings. Flashover makes determination of the cause of a fire more difficult due to the likelihood that physical evidence which may assist a fire investigation is destroyed.

(c) It is not known whether the current practice of NSWFR engaging electrical engineers (such as Mr Gardner) to examine electrical appliances/components suspected of being the cause of a fire existed in 2000.

(d) In 2003, the Accelerant Detection Canine capability was established. This involves the use of dogs which are capable of indicating the location of a possible liquid accelerant, which enables samples to be taken from the scene of a fire. Without canine capability and when a

room has suffered significant fire damage due to flashover (which can destroy identifiable physical fire patterns to indicate the presence of an ignitable liquid accelerant) such as occurred in this case it is difficult to determine from where samples should be taken.

96. Superintendent Kingsland ultimately agreed with the conclusion that the cause of fire is undetermined.

97. In a supplementary report, Mr Gardner expressed a revised opinion which was consistent with the matters noted by Superintendent Kingsland. In particular, Mr Gardner noted that the pattern of damage throughout the house was consistent with flashover, and that without canine capability for accelerant detection, there was no means in November 2000 to identify areas from which samples could be taken for analysis.

98. Mr Gardner also noted that he was first engaged by NSWFR in 2003 and is unaware of electrical engineers being engaged prior to 2003. Mr Gardner noted that in 2000 there did not appear to have been any formal process for examining the remains of electrical wiring or power outlets for evidence of electrical faults, as opposed to an appliance. Mr Gardner opined that there was a tendency to arrive at a determination that the fire was probably caused by an electrical fault if burnt wiring and components were found in the suspected area of fire origin.

99. Overall, Mr Gardner expressed the view that "*the original fire investigation was carried out in a* thorough and meticulous manner based on the applicable standards at the time".

General principles of fire investigation

100. In 2000 the principles of fire investigation were set out in the United States National Fire Protection Association *921 Guide for Fire and Explosions Investigations, 1998 Edition* (**the NFPA Guide**). This was adopted by NSWFR, but only introduced to the Police Crime Scene Services Branch at some stage in 2007. Prior to 2007 there was no reference to the NFPA Guide within the Police Forensic Evidence and Technical Services Command or Forensic Services Group.

101. In 2007 Police conducted a review of the Structural Fire course and the NFPA Guide was introduced as a reference text for use by the Crime Scene Operations Branch. From 2007 the Structural Fire course included presentations on the scientific method, methodology on origin and cause determination as well as an introduction to the NFPA Guide.

102. Clause 12-2.4 of the NFPA Guide relevantly provides:

"*Whenever the cause cannot be proven, the proper classification is undetermined. The fire might still be under investigations and the cause may be determined later. In the instance in which the investigator fails to identify all of the components of the cause of the fire, it need not always be classified as undetermined. If the physical evidence establishes one factor, such as the presence of an accelerant, that may be sufficient to establish the cause even where other factors such as ignition source cannot be determined. Those situations arc also encountered to a lesser degree in accidentally caused fires. Determinations under such situations are more subjective. Therefore, investigators should strive to keep an open unbiased thought process during an investigation*".

103. Clause 9-5.3 of the NFPA Guide also provided that properly trained and validated ignitable liquid detection canine/handler teams have proven their ability to improve fire investigations by assisting in the location and collection of samples for laboratory analysis for the presence of ignitable liquids.

104. Clause 11-6.1 of the NFPA Guide provided that the pre-fire conditions in the interior of the structure should be documented. During the re-investigation after 2006 further evidence was gathered as to the pre-existing condition of the house. A number of Peter's friends, and who had been inside his house, were spoken to. The evidence gathered revealed the following:

(a) In 1999 Peter, or another person, had knocked down an internal wall that divided the lounge room and an internal veranda that leads onto the bathroom. The foundation beams in the wall were left remaining and the wires that ran down into the power point were exposed. There were two sections to this wall, from about waist height down there were planks of wood but the top half was only the exposed beams. The power point was in the wall on the top part of the bottom half.

(b) Peter had knocked out a section of the lounge room wall which faced the rear of the house. Peter was going to put a window in that section to let some light in.

105. The NFPA Guide also provides guidance as to the possibility of missing or removed items of property in cases of deliberately lit fires. Clause 17-3.3.2 of the NFPA Guide relevantly provides:

"*Fire scenes or fire buildings that are devoid of the 'normal' contents reasonably expected (or identified through witness statements etc) as being in the structure prior to the fire should be investigated and explained. The items removed are generally valuable items (such as television sets, VCRs, stereo systems, computers, camera equipment, stock, equipment etc) or items that are difficult to replace (including files, business records etc). Other items that may be removed prior to a fire may be those incriminating to a fire setter".*

106. The fire investigation of the scene identified a melted video cassette tape and a bundled co-axial cable on the floor of the lounge room near the southern wall amongst the remains of electrical items. A two wire aerial lead travelling along and through the floor in the north eastern corner of the lounge room was also identified.

107. Inspector Malpass recorded the following note as part of his investigation: "*Could find no remains of a TV except for the aerial cable*". This is consistent with the provisions of the NFPA Guide as to an item which could reasonably be expected to be in the house prior to the fire.

108. Whilst Detective Senior Constable Day (in his 2001 statement) noted the remains of a VCR tape and a co-axial cable, no comment was made in his notes that these items may be related to a possible missing television. Detective Sergeant Smith similarly made no comment in his statement about a possible missing television.

Relevant policy considerations

109. As at November 2000 there was no protocol between NSW Police Force and NSW Fire and Rescue as to the management and direction of fire investigations. Once NSWFR had determined the fire scene was safe it was handed over to Police for investigation. The officer in charge of the investigation would then contact a crime scene examiner to attend the scene to determine the origin and cause of the fire.

110. In 2011, and again in 2018, a memorandum of understanding was signed between Police, NSWFR and NSW Rural Fire Service in terms of interagency fire investigation protocol. The intent is to ensure a cooperative approach in fire scene investigations. For fire scenes that are declared a crime scene for the purposes of criminal or coronial investigation, once the scene is declared safe the scene is handed over to Police for examination.

111. As at 2020 a Forensic Investigator within the Police Crime Scene Operations Branch of the Forensic Services Group would have responsibility for documenting fuel loads, electrical appliance or notes about electrical items not located within the fire scene. This is in fact consistent with what occurred in 2000. Detective Senior Constable Day and Inspector Malpass investigated the fire scene and Detective Sergeant Smith conducted the investigation.

112. As the officer in charge, it was the responsibility of Detective Sergeant Smith to follow-up any lines of enquiry and pursue further investigations. Detective Sergeant Smith gave evidence that he relied upon both Detective Senior Constable Day and Inspector Malpass to inform him of any matters of significance as a result of their examination of the scene. Detective Senior Constable Day also gave evidence that he could not recall whether he saw any notes made by either Detective Senior Constable Day or Inspector Malpass. The original investigation file has not been able to be located.

113. The 2006 investigation considered the possibility of whether there was a television in Peter's home at the time of the fire, and whether it had been stolen from the property. Detective Sergeant Mackie interrogated the Computerised Operational Policing System (**COPS**) database which indicated that that Peter had previously pawned some electronic items, including a Toshiba television. However, as this television was different to the Samsung television that Peter's mother had purchased in September 2000, the investigation did not identify any positive evidence that Peter had pawned the Samsung television. Detective Sergeant Mackie gave evidence that he was unaware if the database records which he cited in 2006 were the same records that would have been available in 2000. However, it can be inferred that the record would have been available in 2000 as it must have been created before Peter died in November of that year.

114. Detective Sergeant Smith made a statement in September 2007 in which he said that he recalled seeing a VCR tape on the floor at the scene, and having a conversation with Detective Senior Constable Day regarding the absence of a television and VCR player. Detective Sergeant Smith said that he believed Peter may have pawned these items, but could not recall whether he conducted any investigation to confirm this. During a review conducted in 2007 Detective Senior Constable Day also recalled discussing with Detective Sergeant Smith the possibility that Peter may have pawned these items.

Conclusions – Fire investigation

115. It is evident that the NSWFR and Police investigators originally reached the conclusion that the cause of the fire was due to an electrical fault. This is despite there being an absence of any physical evidence confirming that this was the case. In 2007, Inspector Malpass and Detective Senior Constables Day and Detective Sergeant Smith each appropriately revised their opinions as to the cause of the fire, indicating that the cause could not be determined.

116. It is acknowledged that these revised opinions are a result of a number of factors. First, it appears that there was a tendency for fire investigators to reach a conclusion that the cause of a fire was due to electrical fault if electrical components were identified in the area of origin, as occurred in Peter's case. Second, as at November 2000 fire investigators did not have available to them the assistance of experts such as electrical engineers in order to interpret the contribution, if any, of electrical fault to the cause of a fire. Third, fire investigators similarly did not have available to them until 2003 assistance in the form of canines used to detect the presence of accelerants, in order to determine whether the cause of a fire was due to accidental or deliberate ignition. Finally, due to increased knowledge in fire investigation it is now more likely that a fire investigator will reach a conclusion that the cause of a fire is unable to be determined.

117. Having regard to the differences in fire investigation techniques and practices in 2020 compared to 2000 this inquest has not identified any current systemic deficiencies associated with the policies, procedures and professional standards of FRNSW.

Conclusions – Police investigation

118. As noted above, it was the responsibility of Detective Sergeant Smith as officer in charge to investigate any lines of enquiry arising from both the fire investigation and postmortem examination.

119. Although the Toxicology Report identified that the Senior Forensic Toxicologist could be contacted regarding interpretation of the toxicology results, there is no evidence that this occurred. Detective Sergeant Smith gave evidence that he did not see a need to perform any follow-up. He explained that he would not second-guess Dr Cawley (and the contents of the autopsy report and Toxicology Report) given Dr Cawley's expertise and experience.

120. A number of inadequacies have been identified with the postmortem examination. To the extent that Detective Sergeant Smith relied upon the results of the postmortem examination as a basis to consider what further investigation ought to be conducted, it is understandable that he would defer to the expertise of Dr Cawley. That said, the Toxicological Report plainly contained information as to the carbon monoxide saturation that indicated the saturation level identified was not within either of the reported toxic or fatal ranges. There was therefore a missed opportunity to interrogate the contents of the Toxicological Report more closely in order to better understand the likelihood of Peter being alive before the commencement of the fire. Indeed, it should be noted that Detective Sergeant Mackie performed such an interrogation of the toxicology findings in 2006, although it is acknowledged that he was in possession of information from Mr Walker that was obviously not available to Police in November 2000.

121. It is not possible to determine whether further interrogation of the Toxicological Report in 2000 might have allowed for a more precise determination to be made as to the cause of Peter's death. This is because of the absence of a comprehensive and well-documented postmortem examination, the findings of which may have in turn assisted with interpretation of the Toxicological Report.

122. As to the investigation of the possible removal of a television from Peter's home at the time of the fire, it is clear that Detective Sergeant Smith and Detective Senior Constable Day considered this possibility as at November 2000. However, neither made, or could recall making, any positive enquiry in order to confirm whether Peter had pawned the Samsung television at some stage prior to the fire. Instead, it appears that an assumption was made, based on general understanding and experience, that this is what is likely to have occurred. It is also possible that Detective Sergeant Smith and/or Senior Constable Day did review police records available to them at the time and confirmed that Peter had a pawned a television, and then mistakenly assumed that this was the television that was missing from his house. Unfortunately, the evidence does not allow for a more definitive finding on this issue as the investigation file, containing any notes made by investigators, is no longer available.

123. If Detective Sergeant Smith had conducted an enquiry on COPS in 2000 (similar to the enquiry conducted by Detective Sergeant Mackie in 2006) it would have become apparent that Peter had previously pawned a television. However, a further enquiry with Peter's mother would have been required in order to confirm whether this pawned television was the same one that she bought Peter in November 2000. Of course, it is not possible to definitively state whether such inquiries would have altered the complexion and extent of the overall investigation. However, it is clear that there was a missed opportunity to at least pursue, and investigate as far as possible, an open line of enquiry that arose from the physical examination of the fire scene.

124. Notwithstanding the above, it is evident that the adoption by Police of the NFPA Guide has led to more robust practices regarding fire investigation, and appropriate consideration being given to the possibility of items having been removed, in suspicious circumstances, from the scene of a fire.

What was the cause and manner of Peter's death? When did Peter die?

125. The available evidence raises a number of possibilities as to the cause of Peter's death. Each of these matters is discussed below.

Carbon monoxide

126. As noted above, the Toxicology Report indicated that the carbon monoxide level of 8% identified in Peter's case was within the normal range of carbon monoxide saturation up to 10%. This raises an obvious question as to whether Peter was already deceased before the fire commenced, and whether his death was associated with the effects of the fire (incineration and/or smoke inhalation).

127. Dr Iles noted that whilst a carboxyhaemoglobin (**COHb**) concentration of 8% may reflect the normal concentration in a heavy smoker in isolation it does not preclude death as a consequence of fire. In particular, Dr Iles explained: "*The presence of a raised COHb or soot within the airways is informative in terms of indicating that a deceased person was alive when the fire was burning. However the converse does not necessarily apply, ie a negative COHb and the absence of soot within the airways does not necessarily indicate that an individuals did not die as a consequence of fire*". Dr Iles therefore opined that whilst Associate Professor Lyons indicated in his report that a low COHb may indicate that Peter was deceased prior to the commencement of the fire "*this is not necessarily the case*".

128. Further opinion on this issue was sought from John Farrar, consultant forensic toxicologist. Mr Farrar noted the following: "*Victims of house fires wherein the fire is enclosed and produces higher levels of carbon monoxide generally have blood-carboxyhaemoglobin saturation levels greater than 25%. However, in some cases, i.e. where combustion is more complete and less carbon monoxide is produced, the level of saturation may be between 0 and 10%*". Mr Farrar considered it probable that Peter was deceased before the commencement of the fire. However, he explained that the possibility that Peter was still alive when the fire commenced, and died very shortly after from burner shock or oxygen deprivation, could not be excluded on the available information. Ultimately, Mr Farrar expressed the opinion that it is not possible to determine whether Peter died from natural causes prior to the fire, or whether he died by other means.

Seizure activity

129. Medical records indicate that between December 1998 and November 2000, Peter was admitted on seven occasions to Lismore Hospital for symptoms of alcohol withdrawal such as agitation, tremors and seizures. These admissions occurred with increasing frequency proximate to the time of Peter's death, with four admissions occurring between August and November 2000.

130. As noted above, during the committal hearing, Associate Professor Lyons gave evidence that the possibility that Peter had experienced a seizure and was therefore unconscious at the time of the commencement of the fire could not be excluded. In this scenario, Professor Lyons explained that Peter's depressed respiratory rate could have accounted for the low levels of carbon monoxide saturation.

131. In order to investigate this matter further an opinion was sought from Dr Armin Nikpour, Head of the Department of Neurology at Royal Prince Alfred Hospital. Dr Nikpour expressed the view that it is not possible to identify the cause of Peter's history of seizure activity due to the paucity of medical information. Dr Nikpour noted that, on the balance of probabilities, the most likely diagnosis is that Peter had seizures associated with alcohol withdrawal. However, Dr Nikpour also noted that the only evidence to suggest that Peter may have suffered a seizure related to alcohol withdrawal on 26 November 2000 is based on the conclusion reached by Professor Lyons that Peter was already deceased or unconscious by the time of the commencement of the fire.

Third party involvement

132. The disclosures made by Mr Walker and the evidence gathered as a result of the 2006 reinvestigation clearly raise the possibility of third party involvement in Peter's death. However, for the reasons mentioned above, it has not been possible to reconcile the findings from the original postmortem examination as to the evidence of any traumatic injuries with the alleged admissions made by Mr Benn.

Conclusions

133. The inadequacies associated with the postmortem examination, and the missed opportunities to fully investigate other lines of enquiry which might have assisted the overall investigation, means that the available evidence does not, regrettably, allow for any conclusion to be reached as to the cause of Peter's death. As Dr Iles noted, the limitations associated with the postmortem examination means that it is entirely uninformative as to the cause of Peter's death. The other investigations conducted also did not assist with determining the cause of Peter's death.

134. The possibility of seizure activity raises the possibility of natural causes as the manner of death. The possibility of death as a result of an accidental house fire raises the possibility of misadventure as the manner of death. The possibility of third party involvement raises the possibility of homicide as the manner of death. Regrettably, the limitations associated with the postmortem and subsequent investigations means that these possibilities have not been sufficiently excluded to allow for a conclusion to be reached as to the manner of Peter's death.

135. Although it is possible to conclude that Peter died on or about 26 November 2000, it is not possible to reach a more precise conclusion as to the time of his death. In other words, the available evidence does not establish whether Peter died prior to the commencement of the fire, or during it. It is evident that there is some inconsistency regarding the extent of any debris which might have been found underneath Peter, and the significance of this. What is clear, however, is that the extent of any debris does not accurately inform whether Peter died prior to the commencement of the fire. The evidence in this regard only establishes that Peter collapsed to the position where he was found prior to the total destruction of the ceiling and build-up of any significant debris on the floor. However, it does not establish the mechanism by which Peter collapsed, whether due to a medical event, the effects of the fire, or some third party involvement.

Findings

136. Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Jennifer Single SC, Counsel Assisting, and her instructing solicitor, Mr Paul Armstrong of the NSW Crown Solicitor's Office. Their assistance during both the preparation for inquest, and the inquest itself, has been invaluable. I also thank them for the sensitivity and empathy that they have shown in this matter.

137. I also thank Detective Sergeant Mackie for his role as the officer in charge of the investigation, and for compiling a comprehensive initial brief of evidence.

138. The findings I make under section 81(1) of the Act are:

Identity

The person who died was Peter Allen.

Date of death

Peter died on or about 26 November 2000.

Place of death

Peter died at Lismore NSW 2480 after being found inside his home following a residential fire.

Cause of death

Due to limitations associated with the postmortem examination and investigation into the circumstances of the fire, the available evidence does not allow for any finding to be made as to the cause of Peter's death.

Manner of death

Due to limitations associated with the postmortem examination and investigation into the circumstances of the fire, the available evidence also does not allow for any finding to be made as to the manner of Peter's death.

Epilogue

139. These findings are being delivered on the day after what would have been Peter's 64th birthday. It is distressing to know that 20 years after Peter's death his family still do not have a complete understanding of the circumstances in which he died. However, since 2000, significant improvements have been made to the medical examinations and investigative processes associated with fire-related deaths that hopefully now provide other families who have lost a loved one with greater clarity as to the circumstances in which their loved one died.

140. On behalf of the Coroners Court of NSW I extend my sincere and respectful condolences to Peter's family and friends for their painful and tragic loss.

141. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
24 December 2000
Coroners Court of New South Wales