CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Dyllan Kettule
Hearing dates:	18 February 2021
Date of findings:	18 February 2021
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, unsolved homicide
File numbers:	2014/26272
Representation:	Ms K Mackay, Coronial Advocate Assisting the Coroner Mr A Taleb for the Kettule family
Findings:	I find that Dyllan Kettule died on 26 January 2014 at Canley Vale NSW 2166. The cause of Dyllan's death was gunshot wounds to the trunk. These gunshot wounds were inflicted when Dyllan was shot by a person unknown. The manner of Dyllan's death is therefore homicide.
Recommendation:	I recommend that the death of Dyllan Kettule be referred to the Unsolved Homicide Unit of the NSW Police Homicide Squad for further investigation in accordance with the protocols and procedures of that Unit.
Non-publication orders:	See Annexure A

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Introduction

1. In the early hours of the morning on 26 January 2014 Dyllan Kettule, a 19-year-old young man, was fatally shot by an unknown male person in a residential street outside the home of Dyllan's girlfriend. The offender later fled from the scene in a vehicle, in the company of other unknown persons who are also believed to have been involved in the incident.

2. Despite an extensive police investigation conducted over a number of years no persons involved in the incident have been identified, and no criminal proceedings have yet been commenced.

Why was an inquest held?

3. 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.

4. 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 Dyllan died from injuries sustained from a number of gunshot wounds his death is clearly regarded as being both violent and unnatural, making it a reportable death. Further, section 27(1)(a) of the Act provides that an inquest is mandatory if it appears to a coroner that a person died or might have died as a result of homicide. In this case, the evidence establishes that the gunshot wounds were inflicted by another person or persons, meaning that Dyllan died as a result of homicide. It is therefore mandatory to hold an inquest into Dyllan's death.

5. 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 wish to attempt to cope with the consequences of such a traumatic event in private. The loss experienced by family members does not diminish significantly over time. Therefore, it should be acknowledged that both the coronial process and an inquest by their very nature unfortunately compel a family to re-live distressing memories and to do so in a public forum.

Dyllan's life

6. Understanding the impact that the death of a person has had on their family 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 Dyllan's life in a brief, but hopefully meaningful, way.

7. Dyllan was born on 18 July 1994 in Hamilton, New Zealand, after his family immigrated from Iraq earlier that year. Dyllan was one of eight children to Najah and Najeeba Kettule, with all of his siblings having been born in Iraq.

8. In December 2000 the Kettule family immigrated to Australia and lived in various suburban locations in the south west of Sydney. Dyllan initially attended Fairfield Heights Public School and, later, Fairvale High School. By all accounts, Dyllan had a large group of friends and was well liked amongst them. Dyllan was also known as a talented rugby league player and was later contracted to play for the Sydney Roosters development squad when he was 16 years old.

9. Dyllan left high school in year 10, but later returned to complete part of year 11 before leaving school again. He subsequently found work with a fencing company before undertaking work as a removalist, and then a packer.

10. At the conclusion of the evidence in the inquest, some heartfelt and moving words were shared with the Court by a family friend on behalf of his Dyllan's family. It is distressing to hear of the pain and grief that Dyllan's family have had to endure for the past seven years, and to know that this pain and grief will continue well beyond the end of the inquest.

11. Shortly before the inquest one of Dyllan's brothers also lost his life in tragic and violent circumstances. It is therefore even more distressing to know of the immeasurable sorrow that Dyllan's family have experienced in losing two young members of the family to sudden acts of violence.

12. There is no doubt that Dyllan is greatly missed and loved by his family and his many friends. The sudden and violent circumstances in which Dylan's life ended are both extremely tragic and distressing. It is equally upsetting to know that Dyllan lost his life at such a young age, with his future, dreams and aspirations all ahead of him.

The events of 21 January 2014

13. On the evening of 21 January 2014 Dyllan and his girlfriend went to a public reserve in Canley Heights in order to meet with some friends and socialise. They arrived at around 11:30pm, and some members of the group consumed a quantity of cannabis, which had been acquired earlier that evening.

14. Shortly before 12:30am on 22 January 2014 a vehicle was observed by a member of the public to be driving towards the public reserve. At around this time, two unidentified male persons approached Dyllan and his group of friends. One of the male persons produced a firearm, pointed it towards Dyllan and attempted to discharge it but the firearm misfired.

15. The two male persons subsequently fled the scene, chased by Dyllan and some of his friends. As this pursuit occurred one of the male persons discharged a number of rounds in Dyllan's direction. The male persons eventually fled, and Dyllan and his friends subsequently drove around the area to look for the male persons, without success. The incident was subsequently reported to police by a member of the public who heard the sound of gunshots.

The events of 26 January 2014

16. On the evening of 25 January 2014 Dyllan was at his girlfriend's home in Canley Vale with a number of other friends. At around 2:43am on 26 January 2014 Dyllan's girlfriends went out to take Dyllan's dog for a walk, whilst Dyllan said goodbye to a number of other friends who were leaving. As Dyllan started walking to join his girlfriend and remaining friends he was confronted by an unknown male person. It is believed that this person had emerged from a vehicle which had been parked nearby. It is also believed that there was at least one other person in the vehicle and that the occupants had been conducting surveillance in the area sometime earlier in the evening.

17. The unknown male person produced a firearm and fired at Dyllan, with two projectiles striking Dyllan in the chest region. The unknown male person fled the scene and is believed that he was joined by at least two other unknown male persons. The group of male persons entered a second vehicle which was located nearby, and which was subsequently driven away from the scene.

18. Emergency services were called but Dyllan could not be revived and was later pronounced deceased at the scene.

What was the cause and manner of Dyllan's death?

19. Dyllan was later taken to the Department of Forensic Medicine where an autopsy was performed on 28 January 2014 by Professor Johan Duflou, forensic pathologist. The autopsy identified two gunshot wounds to the trunk consisting of:

    (a) a bullet passing from the left shoulder through the left side of the chest and ending in the back of the right chest wall after passing through the left lung; and

    (b) a bullet passing from the back of the chest on the left, through the left lung and the heart, and passing out through the front of the chest on the left.

20. Extensive associated blood loss was also identified. In his autopsy report dated 11 June 2014, Professor Duflou opined that the cause of Dyllan's death was gunshot wounds to trunk. Having regard to the events of 26 January 2014 is clear that Dyllan died as a result of the actions taken by a group of unknown persons as part of alleged criminal activity. The manner of Dylan's death is, therefore, homicide.

What investigation was conducted into Dyllan's death?

21. Dyllan's death was investigated over a number of years by experienced and senior investigators from the NSW Police State Crime Command Homicide Squad. The brief of evidence tendered in the coronial proceedings contains a large number of witness statements, forensic reports and other documentary and electronic material gathered over the course of the investigation.

22. As the investigation involves consideration of a variety of sensitive information, and because the persons involved in the 26 January 2014 incident have not been apprehended, it is not proposed in these findings to recount in detail every aspect of the police investigation. Rather, the summary

below provided. In doing so it should be emphasised that the relative brevity of the inquest and these findings in no way reflects the extent of the investigation that has taken place in an attempt to identify and apprehend those persons responsible for Dyllan's death, or the immense loss which has been, and continues to be, felt by Dyllan's family and friends.

23. The initial stages of the investigation included the following:

(a) A review of CCTV cameras and Roads and Maritime Service cameras positioned near the scene of the shooting, together with data captured by police highway patrol vehicles near the scene which were fitted with in car video and mobile automatic number plate recognition. None of this electronic data was able to identify the persons or vehicles involved in the incident.

(b) Forensic examination of the scene itself, including exhibits seized from the scene. However, this examination did not produce any evidence that assisted in identifying the persons involved in the incident.

(c) A ballistics examination was also conducted which was able to identify the calibre of projectiles fired at the scene. However, distance between the muzzle of the firearm used to where Dyllan was shot, and any other identifying information of the persons involved could not be established.

24. Over the course of the remaining investigation, police undertook a number of other investigative steps:

(a) Following the initial stages of the investigation police spent several months building rapport with a number of Dylan's friends and associates in order to understand the circumstances and background which led to the fatal incident.

(b) Various sources provided information that there had been a history of conflict between Dyllan and his friends/associates and at least two groups involved in alleged criminal activity. A number of sources provided information to police which led to the identification of several persons of interest to the investigation. Investigating police comprehensively followed all lines of enquiry in relation to these persons but did not identify sufficient evidence to allow for any person to be arrested and charged in relation to the incident.

(c) Police also conducted investigations in an attempt to identify the vehicles used during the incident. However these investigations were unable to positively identify the vehicles.

(d) Mobile phone records of persons known to Dyllan were also obtained and examined. However this examination did not produce any evidence that assisted police in identifying any person involved in the incident.

(e) Police received intelligence reports from a variety of sources. These reports were subsequently investigated, using a variety of covert and overt strategies. However these lines of enquiry also did not positively identify any person associated with the incident.

25. In summary, the investigation involved the following:

(a) 36 detectives were assigned to the investigation at different stages, together with input from specialist forensic and ballistic units, and operational support from general duties police officers;

(b) The creation of approximately 1950 individual records/documents;

(c) The taking of over 180 individual statements;

(d) Approximately 500 individual requests were made to telecommunications companies for information which was then analysed;

(e) Review of CCTV footage from approximately 30 locations;

(f) Canvassing of over 500 residences;

(g) Review of seven other police investigations each themselves consisting of thousands of individual records.

26. Despite an extensive police investigation, employing a variety of investigative strategies, the persons present on 26 January 2014 who were involved in Dyllan's death have not been identified. Whilst the police investigation has considered that there are a number of persons of interest, criminal proceedings have not yet been commenced against any person.

Should any recommendation pursuant to section 82 of the *Coroners Act 2009* be made?

27. Section 82 of the Act allows a Coroner to make recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Such recommendations are often made with view to hopefully improving public health and safety.

28. The discharging of a firearm multiple times in a public location resulting in the death of a person is unquestionably a matter of utmost seriousness which impacts upon the safety of members of the community. There is obviously considerable public interest in having the person, or persons, responsible for such a criminal act being brought to justice.

29. Accordingly, the following recommendation is both necessary and desirable: ***I recommend that the death of Dyllan Kettule be referred to the Unsolved Homicide Unit of the NSW Police Homicide Squad for further investigation in accordance with the protocols and procedures of that Unit.***

Findings

30. Before turning to the findings that I am required to make, I would like to thank Ms Karissa Mackay for her assistance during both the preparation for the inquest, and the inquest itself. I also thank

Detective Senior Constable Daniel Palmer, the officer-in-charge of the police investigation, for conducting a comprehensive investigation and compiling the extensive brief of evidence.

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

Identity
The person who died was Dyllan Kettule.

Date of death
Dyllan died on 26 January 2014.

Place of death
Dyllan died at Canley Vale 2166.

Cause of death
The cause of Dyllan's death was gunshot wounds to the trunk.

Manner of death
These gunshot wounds were inflicted when Dyllan was shot by a person unknown. The manner of Dyllan's death is therefore homicide.

Epilogue

32. On behalf of the Coroners Court of NSW I extend my sincere and respectful condolences to Dyllan's family and many friends for their painful and tragic loss. It is hoped that those criminally involved in Dyllan's death will eventually be brought to justice.

33. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
18 February 2021
Coroners Court of New South Wales

Inquest into the death of Dyllan Kettule

Annexure A: Non-publication orders

1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (**the Act**) the following information contained in the brief of evidence tendered in the proceedings is not be published:

    a. All material contained within Tabs:

1.5	1.6	2.1, 2.2	6.2	9	9.1	9.2	9.3	9.4	9.5
9.6	9.7	9.8	9.9	9.10	10	10.1	10.2	10.3	10.4
11	11.1	11.2	11.3	12	12.1	13	13.1	13.2	13.3
13.4	14	14.1	14.2	14.3	15	15.1	15.2	15.3	16
16.1	16.2	17	17.1	17.2	18	18.1	-	-	-

    b. The names, contact details and place of employment of all non-police witnesses.

2. Pursuant to section 65(4) of the Act, a notation is to be placed on the Court file that if an application is made under section 65(2) of the Act for access to the documents on the Court file, that material shall not be provided until the NSW Police Force has had an opportunity to make submissions in respect of that application.

Magistrate Derek Lee
Deputy State Coroner
18 February 2021
Coroners Court of New South Wales