CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of AX
Hearing dates:	20 to 24 March 2023; 27 to 31 March 2023
Date of Findings:	26 April 2023
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, hypertensive heart disease, coronary artery disease, euthanasia, potential homicide, forensic investigation, Crime Scene Services Branch, toxicology, external examination, taking of blood sample
File number:	2017/00239528
Representation:	Ms S Callan SC & Ms E Sullivan, Counsel Assisting, instructed by Ms B Holliday-O'Brien & Ms A McShane, Department of Communities & Justice, Legal Ms G Bashir SC & Ms R McMahon for BX, instructed by Armstrong Felton Mr S Beckett SC for Dr LC, instructed by Avant Ms K Burke for New South Wales Commissioner of Police, instructed by New South Wales Police Force Office of General Counsel Mr G Doherty for Inspector M Chidgey & Sergeant K Gittoes, instructed by Walter Madden Jenkins Ms G Huxley for FV, instructed by Maria Walz Legal

Findings:	AX died on 5 or 6 August 2017 at Ashfield NSW 2131. The available evidence does not allow for a finding to be made, on the balance of probabilities, as to the cause of AX's death. As a finding cannot be made as to the cause of AX's death, the available evidence also does not allow for a finding to be made, on the balance of probabilities, as to the manner of AX's death.
Non-Disclosure/Non-Publication Orders	See Annexures A and B.

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1. Introduction

1.1 On the morning of 6 August 2017, AX was found in her bed at home with no signs of life. A wine glass was lying on top of her right hand and she was found sitting upright in bed. Emergency services were contacted but AX was later pronounced deceased at the scene. As AX's death was sudden and unexpected, and the cause of her death was not immediately apparent, it was reported to the Coroner.

1.2 The Duty Coroner considered the information gathered by the New South Wales Police Force (**NSWPF**) regarding the circumstances leading up to and surrounding AX's death and had regard to a recommendation made by the Duty Pathologist. A decision was made that no post-mortem examination was required and that a Coroner's Certificate could issue, recording the cause of AX's death as hypertensive heart disease. AX was later cremated.

1.3 On 10 October 2017, AX's former husband made a report to the NSWPF raising suspicions that AX did not die of natural causes, and that she may have been administered a lethal drug. The NSWPF established a Strike Force to investigate these suspicions.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 The suspicions held by AX's former husband raised the question of whether AX died, or might have died, as a result of homicide. That is, a question arose as to whether AX died of natural causes, or whether there was some non-natural contribution to, or cause of (such as the administration of a lethal drug), her death.

2.3 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.

2.4 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.

3. AX's personal background

3.1 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 those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 AX was born in 1947 and was 70 years old at the time of her death. She married her husband, HX[1], in 1970. They had two children together, BX and CX.

3.3 In the early 1980s, AX, HX and their children moved to a home in the Inner West of Sydney (**AX's house**). AX was a fourth generation teacher who began her career in a remote First Nations community in Enngonia. CX describes her mother as dedicating her life and giving wholeheartedly to providing opportunities for all. In her later career, AX took up a position at the NSW Roads and Transport Authority, producing creative road safety educational material for students which are still used today. AX was known to have a strong work ethic and was described as being very intelligent and sharp.

3.4 AX and HX separated in the early 1990s and divorced several years later. AX never remarried and remained living in the Inner West.

3.5 In 2000, CX married ZY. They have two children together.

3.6 In 2004, BX married FV. They have two children together.

3.7 CX describes her mother as a splendid woman, whose quiet and calm exterior was her trademark, who shared her gentle spirit with anyone and everyone. AX had an exceptional intellect and broad interests, including opera, ballet, orchestral and instrumental music, poetry, literature, history, current affairs and natural beauty. Following her retirement, AX regularly met up with friends to socialise. She also enjoyed going for walks.

3.8 AX was a doting grandmother and was actively involved in the lives of her grandchildren. She regularly babysat them and attended their different activities. AX was also proud of both her children and was known to be a kind and generous person.

3.9 There is no doubt that AX was a remarkable woman. According to CX, AX was one of those rare women who only grew more beautiful with age, and who was an icon of love and growth. Although AX's passing is still deeply felt by those who love and miss her the most, at the end of the inquest, CX graciously shared these words when speaking about her mother:

> You will never be gone and we will carry you into forever with us.

[1] This matter is subject to a Non Disclosure Order which has necessitated names not be used to ensure anonymity is preserved.

4. AX's medical history[2]

4.1 AX had a history of hypertension, osteoporosis and osteoarthritis. She did not smoke and was known to only drink wine occasionally. Between 2005 and March 2017, AX attended Multicare Family Medical Centre (**Multicare**) in Ashfield for various health issues. As AX attended Multicare irregularly she did not always see the same general practitioner (**GP**). Two of the GPs that AX saw were Dr Gerry Markezinis and Dr Kevin Cheng.

4.2 In April and May 2014, AX consulted with a rheumatologist who noted that she had elevated blood pressure. It was recommended that AX resume celecoxib (nonsteroidal anti-inflammatory medication) and that her blood pressure be monitored closely.

4.3 On 19 March 2015, a chest x-ray showed AX's heart to be of normal size with "*no evidence of cardiopulmonary or pleural abnormality*".

4.4 By 2015, BX and CX became concerned about AX's mental state and the potential onset of dementia. On 22 August 2015, BX took AX to see his then general practitioner, Dr Lachlan Soper. AX was subsequently referred to a neurologist, Dr Ronald Joffe.

4.5 On 27 August 2015, Dr Joffe reviewed AX. It was noted that AX "*performed extremely well*" on tasks testing her cognitive ability and that she was "*substantially better than the average healthy adult*". AX was referred for magnetic resonance imaging (**MRI**)/magnetic resonance angiograph (**MRA**) which was later performed on 31 August 2015.

4.6 Dr Joffe saw AX again on 3 September 2015. The results of the MRI/MRA were reviewed and it was noted that they showed "*some mild, age-related changes*" which were not significant.

4.7 Dr Joffe reviewed AX again on 22 February 2016 and 22 August 2016. On both occasions, it was noted that AX performed very well overall in tasks testing her cognitive ability. However, it was noted that AX was *"suffering from a very mild cognitive impairment*" which did not seem to be progressing particularly quickly. Dr Joffe noted that no further investigations were required although he did offer to review AX in a year.

4.8 On 14 December 2016, AX obtained a prescription for blood pressure medication from Dr Markezenis.

4.9 On 11 March 2017, AX attended Multicare complaining of a headache and was seen by Dr Cheng. It was noted that AX's blood pressure was slightly, but not significantly, raised and that she was non-compliant with her blood pressure medication. No other significant or concerning features were noted at this consultation.

4.10 On 19 March 2017, AX purchased a quantity (30 tablets) of candesartan (an angiotensin receptor blocker used mainly for the treatment of high blood pressure). This was apparently the last time she obtained her blood pressure medication.

[2] The following summary has been drawn from the helpful opening submissions of Counsel Assisting.

5. AX's financial affairs

5.1 AX retired in 2014 at age 67. She had nearly $900,000 in savings, mostly in superannuation. She was also the sole owner of a two-story townhouse in the Inner West.

5.2 During the 2014/2015 financial year a number of arrangements were made regarding AX's financial affairs:

(a) BX arranged for AX's superannuation to be invested in Macquarie and Credit Suisse investment accounts;

(b) Arrangements were made for a monthly pension of just over $5000 for day-to-day expenses to be paid from a Macquarie account into AX's credit union account;

(c) The AX Trust (**the Trust**) was established with [REDACTED] as the trustee. This company was owned and controlled by BX and FV. The initial balance of the Trust was approximately $150,000 held in a Credit Suisse investment account.

(d) The balance of AX's superannuation was invested in Macquarie investment accounts.

5.3 As at 30 June 2015, the total value in the Credit Suisse and Macquarie investment accounts was $859,725.

Enduring Power of Attorney & Enduring Guardian

5.4 On 19 August 2015, AX signed an Enduring Power of Attorney which appointed BX as the Attorney pursuant to the *Powers of Attorney Act 2003*. This empowered BX to make financial and legal decisions on AX's behalf, including signing legal documents, operating bank accounts, paying bills and managing investments.

5.5 On 22 August 2015, AX signed a document jointly appointing BX and FV as Enduring Guardians.

Execution of new will

5.6 On 29 October 1996, AX executed a will appointing BX and CX as joint executors and trustees. The will indicated that AX's estate was to be divided equally between them.

5.7 On 3 February 2016, AX executed another will (**the 2016 Will**) appointing BX and FV as joint executors and trustees. Again, relevantly, the will indicated that AX's estate was to be divided equally between BX and CX.

AX's access to her finances

5.8 As at 30 June 2016, the total value of AX's superannuation investments in the Credit Suisse and Macquarie investment accounts was $892,808.

5.9 In August 2016, AX's monthly pension of just over $5000 ceased to be deposited into her credit union account. Instead, these payments were transferred into a National Australia Bank (**NAB**) account in BX's name. Irregular transfers were made from this account to AX's credit union account.

5.10 AX's credit union account became overdrawn on several occasions, attracting dishonour fees. In December 2016 and January 2017, correspondence was sent to AX indicating that her council rates and Teachers Health Fund were in arrears and that she had an overdue phone bill (as at the date of the correspondence).

5.11 Between November 2016 and July 2017, CX and ZY formed the view that AX was often without any money, and that this was causing her considerable distress. CX and ZY raised this with BX on multiple occasions, expressing concerns that the financial arrangements for AX were not working. In summary:

(a) In mid-February 2017, CX and ZY helped AX to set up a NAB account for her day-to-day expenses. However, other than some initial transfers no other funds were deposited into this account.

(b) CX and ZY expressed concern that regular monthly deposits were not being made into AX's bank account for her day-to-day living expenses, and that she was not being provided with any regular statements regarding the status of her investments.

(c) BX and FV arranged for AX to have access to another NAB account in FV's name with a pink bank card (**the Pink Card Account**). However, this appeared to cause AX further confusion and distress as she believed that she was spending FV's money and was reluctant to do so.

(d) On 13 June 2017, ZY sent an email to BX describing AX as being "*incandescent*" regarding her financial arrangements as she could not understand where her income was coming from. ZY indicated that he needed information from BX because he wanted to create a chart for AX which could be placed on her fridge, explaining the amount and frequency of money that she was receiving.

(e) On 6 July 2017, correspondence between ZY and FV referred to AX losing the card for the Pink Card Account and being tearful and crying about being destitute.

5.12 Between March and June 2017, almost $300,000 was withdrawn from AX's Macquarie investment account and deposited into BX's personal accounts. This money appears to have been used by BX and FV for renovations to their properties, travel and other personal uses.

6. The events of 4 to 6 August 2017

Friday, 4 August 2017

6.1 On the morning of 4 August 2017, LY, AX's cleaner, attended AX's home to clean. When LY arrived, she saw BX and AX standing at the kitchen bench top, having a cup of tea. LY noted that there was a paper gift bag on the bench top near them. After BX left a short time later, AX reportedly told LY that he "*had brought something over for her to sign*".

6.2 At 7:27pm, BX sent AX the following text message: "*Hi mum. Can you pls come to our place tomorrow (sat) 5pm for dinner?*". AX replied, "*Of course! How lovely!*".

Saturday, 5 August 2017

6.3 At 2:55pm on 5 August 2017, BX sent AX the following text message: "*So see you at 5 at our place*". AX replied, "*See you at 5pm!!!!!*".

6.4 AX's Opal card records indicate that she left her local train station at around 4:17pm and arrived at Milsons Point station at around 4:47pm. AX's mobile phone records indicate that she was in the vicinity of BX's apartment in Kirribilli at 5:26pm.

6.5 At 5:28pm, BX's vehicle passed the Sydney Harbour Bridge toll point travelling in a southerly direction.

6.6 FV's phone records indicate that her mobile phone was in the vicinity of Potts Point at 5:39pm. The phone records also indicate that on the afternoon of 5 August 2017, two calls were made from FV's phone to Yama Gardens, a Japanese restaurant located on Liverpool Street, Darlinghurst. It is believed that AX had dinner with BX and FV and her grandchildren at this restaurant.

6.7 At 7:56pm, BX's vehicle passed the Sydney Harbour Bridge toll point travelling in a southerly direction for a second time. BX's mobile phone records indicate that his phone was in the vicinity of Kirribilli that evening.

Sunday, 6 August 2017

6.8 At 6:56am, BX sent AX the following message: "*Running a bit late. Leaving in 15. Sorry*". At 8:02am, BX's vehicle passed the Sydney Harbour Bridge toll point travelling in a southerly direction.

6.9 At 8:25am, BX called CX's mobile phone but she did not answer. Two minutes later at 8:27am, BX called the landline for CX and ZY, followed by CX's mobile number again. Neither of these calls were answered.

6.10 Between 8:28am and 8:30am, BX called ZY's mobile number and called the landline for CX and ZY again. These calls were similarly not answered.

6.11 At 8:34am, BX called AX's mobile number which also was not answered.

6.12 BX, FV and their children walked approximately five minutes to the home of ZY and CX to ask for a key to AX's home. ZY gave them a key and called CX after they left. During the phone call, CX told ZY that she could see BX and his family whilst on her way home, and was stopping to speak with them.

6.13 Shortly before 8:50am, CX and BX entered AX's home. They made their way to the upstairs bedroom and found AX sitting upright in bed, unresponsive and showing no signs of life.

6.14 One of AX's neighbours, JP, heard a scream from the direction of AX's house. She went to investigate and saw FV and her children standing outside AX's house. FV told JP that AX had passed away. JP called Triple Zero at 8:51am.

6.15 NSW Ambulance paramedics Nathan O'Donohue and Brenda Evans arrived at AX's house at 8:57am. They were shown upstairs and found AX sitting up on the right hand side of her bed, half covered by a blanket which was positioned diagonally across her legs and waist. AX was noted to have a wine glass lying on top of her right hand. Following an examination, the paramedics confirmed that AX was deceased.

7. Transfer to Department of Forensic Medicine

7.1 AX was later taken to the Department of Forensic Medicine (**DOFM**), which at the time was located in Glebe. On arrival, a post-mortem computed tomography (**CT**) scan of the head and neck was conducted and later reported on by a radiologist.

7.2 Dr Lorraine Du Toit-Prinsloo, forensic pathologist, was the rostered Duty Pathologist for the week. On 7 August 2017, Dr Du Toit-Prinsloo viewed AX's body and reviewed the information contained in the NSWPF P79A Report of Death to the Coroner (**the P79A**) prepared by Leading Senior Constable (as he then was) Matthew Spooner, the initial police officer-in-charge, regarding AX's death.

7.3 On 8 August 2017, Dr Du Toit-Prinsloo recommended that no post-mortem examination be conducted and that instead a Coroner's Certificate be issued recording hypertensive heart disease as the cause of AX's death. This recommendation was accepted by Deputy State Coroner Elizabeth Ryan who was the rostered Duty Coroner at the time.

8. Subsequent procedural history

8.1 Following the issuing of the Coroner's Certificate, AX was released from the care of the DOFM. Arrangements were made for a funeral and AX was cremated.

8.2 On 10 October 2017, HX went to Mudgee police station and spoke with a police officer to convey his suspicions about BX being involved in his mother's death. These suspicions were based primarily on two matters:

(a) First, HX met CX and ZY on 10 May 2017. During that meeting, CX and ZY told HX about a meeting they had with BX earlier that month when BX had spoken about euthanising AX, indicating that he could access drugs in Sydney or overseas.

(b) Second, HX had seen messages on AX's phone and some of her bank statements which related to withdrawals of substantial amounts of money, which caused him to become concerned about the management of AX's financial affairs.

8.3 On 11 December 2017, Detective Senior Constable Merryn Prout from Burwood Detectives Office was made the officer-in-charge of the further investigation into AX's death arising from the suspicions raised by HX. Following some initial investigation, Strike Force Conway was established, headed by Detective Senior Constable Prout.

8.4 On 10 May 2018, Detective Senior Constable Prout contacted the Office of the State Coroner, raising concerns regarding the circumstances of AX's death and that it may not have been due to natural causes, and requesting that further investigation into AX's death be conducted.

8.5 Detective Senior Constable Prout was subsequently requested by the Office of the State Coroner to prepare a brief of evidence. After this brief of evidence was submitted and reviewed, a view was formed that AX might have died as a result of homicide (section 27(1)(a) of the Act) or, at the least, the cause and manner of her death had not been sufficiently disclosed (section 27(1)(d) of the Act). Further investigation was conducted and additional evidence gathered in an attempt to address both of these matters. However, as both questions remained open, it became mandatory to hold an inquest.

9. What issues did the inquest examine?

9.1 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 issues to be considered. That list identified the following issues for consideration:

(1) Whether hypertensive heart disease was the cause of AX's death?

(2) What was the manner or circumstances of AX's death?

(3) Related to (1) and (2) above, was AX's death a homicide?

(4) Noting (3), if yes - whether there is sufficient evidence to satisfy the elements of section 78 of the Act to refer a known person(s) to the Director of Public Prosecutions for potential prosecution?

(5) Whether the police investigation into AX's death was adequate, including whether any further investigations ought to have been carried out at the scene?

(6) Whether any recommendations are necessary or desirable in connection with AX's death?

9.2 In order to assist with consideration of some of the above issues, opinion was sought from the following independent experts as part of the coronial investigation:

(a) Associate Professor Mark Adams, consultant cardiologist;

(b) John Farrar, consultant forensic pharmacologist;

(c) Associate Professor Michael Kennedy, consultant physician and clinical pharmacologist;

(d) Associate Professor Darren Roberts, consultant clinical pharmacologist and toxicologist; and

(e) Dr Trevor Watkins, forensic radiologist.

9.3 In addition, the legal representatives for BX engaged Emeritus Professor Stephen Cordner, forensic pathologist.

9.4 Each of the above experts provided reports which were tendered as part of the brief of evidence during the inquest. Some of the experts also gave oral evidence during the inquest.

9.5 For convenience, the issues considered by the inquest are set out below in chronological order.

10. Adequacy of the police investigation into AX's death

10.1 Consideration of this issue involves examination of several aspects regarding the attendance of NSWPF officers at AX's house on 6 August 2017. Each of these aspects is dealt with in turn below.

10.2 Leading Senior Constable Spooner, together with Constable Bruce Smart, acknowledged the initial broadcast over NSWPF radio in relation to AX being found deceased on the morning of 6 August 2017. Leading Senior Constable Spooner was one of the first NSWPF officers to arrive at the scene and was the initial officer-in-charge of the investigation into AX's death. He was later joined at AX's house by Detective Inspector Melanie Chidgey, the Duty Officer for Ashfield Local Area Command, and Sergeant Katie Gittoes, the Supervisor at Ashfield Police Station.

Attendance of Crime Scene Services Branch

10.3 On or about 23 April 2001, the then NSWPF Deputy Commissioner, Specialist Operations issued Police Services Notices (**PSN**) 01/20 which relevantly provided the following:

> In circumstances where death is not known to be from natural causes, and a death certificate… Has not been issued by a medical practitioner, it is a **standing direction** that local detectives and Forensic Services investigators be called to attend. [original emphasis]
> […]
> Detectives should always be notified of the death and should attend the scene where appropriate. Crime Scene investigators will attend death scenes in accordance with Forensic Services Group callout guidelines.

10.4 PSN 01/20 was also referred to and reproduced in part in the version of the NSWPF Handbook which was in force as at 6 August 2017. Therefore, on 6 August 2017, as a matter of NSWPF policy and procedure, a detective should have been notified of AX's death and forensic services, or crime scene, investigators should have been called to attend the house. As to the first matter, no call to a detective was required as Detective Inspector Chidgey was already on the scene. As to the second matter, Superintendent Roger Best, Commander of the current Crime Scene Services Branch (**CSSB**), gave evidence confirming that it was his expectation that CSSB would have been contacted on 6 August 2017. Superintendent Best also said that if such contact was made, he expected that officers from the CSSB would attend the scene.

10.5 In her statement dated 22 May 2018, Sergeant Gittoes describes having a conversation with Detective Inspector Chidgey, Leading Senior Constable Spooner and Constable Smart at AX's house on 6 August 2017:

> It was discussed that there were no signs of forced entry, no signs of a struggle, no signs of a robbery, no immediate signs of injuries on the deceased, nothing seemed out of place and the daughter and son of the deceased had mentioned she suffered from some medical conditions including headaches and high blood pressure. As a result of this discussion the death was deemed not suspicious and crime scene would be notified but not needed [sic] to attend. I phoned crime scene and inform [sic] them of the incident. The crime scene officer stated they would note the incident but did not see the need to attend.

10.6 In her statement dated 20 August 2018, Detective Inspector Chidgey describes her recollection of the above conversation:

> Whilst in the main bedroom, I had a conversation with Sergeant Gittoes and Leading Senior Constable Spooner. From our combined observations, there was no sign of forced entry, no signs of any struggle, no sign of anything being ransacked or moved and no obvious sign of injury to the deceased. I asked Sergeant Gittoes to contact Crime Scene as I was confident that on a Sunday a doctors [sic] certificate would not be forthcoming, considering that the deceased children had indicated that the deceased was not suffering from any ongoing medical conditions and had no regular doctor. I saw Sergeant Gittoes make a phone call. At the end of the phone call she informed me that Crime Scene wouldn't be attending.

10.7 After leaving AX's house, Leading Senior Constable Spooner returned to Ashfield Police Station and entered the following details on the NSWPF Computerised Operating Policing System (**COPS**) regarding the attendance of police at the residence:

> Police have taken photos of the scene as Crime Scene were not contacted due to the nature of the death and that it wasn't suspicious.

10.8 The differing accounts described above raise obvious questions regarding whether on 6 August 2017 contact was made with the CSSB and if so, whether they were requested to attend the residence and why they did not do so.

10.9 On 6 August 2017, Detective Sergeant Dane Kremers was the Forensic Coordinator for the NSWPF Forensic Services Group (**FSG**) (as it was then known)[3]. His duties included receiving enquiries and requests from NSWPF officers at various crime scenes around the state. Upon receiving a request, Detective Sergeant Kremers would determine whether crime scene services were required to attend a scene and, if so, what forensic resources were to be despatched. In this regard, Detective Sergeant Kremers stated:

> When assessing a forensic response to a deceased person, the general rule was that Crime Scene would attend all death scenes, unless a medical certificate was to be issued. This again would be reliant on information given from officers at the scene.

10.10 After reviewing a daily running sheet, mailbox and Computer Aided Despatch (**CAD**) entry for 6 August 2017, Detective Sergeant Kremers could not identify any evidence that any call had been received requesting that CCSB attend AX's house, or seeking advice regarding the attendance of the CSSB.

10.11 In a subsequent statement dated 6 November 2022, Sergeant Gittoes explained that, after making certain enquiries, she learned that on 6 August 2017 she did not in fact contact the CSSB. Sergeant Gittoes stated that she had instead called Ashfield Police Station.

10.12 Sergeant Gittoes gave evidence that as at 6 August 2017, she was aware of the requirement to contact the CSSB if a death appeared to be not due to natural causes. Sergeant Gittoes also

[3] For convenience, FSG will be referred to as CSSB given that is the current title of that NSWPF unit.

acknowledged that Detective Inspector Chidgey had asked her to do so and that this was an important request. Sergeant Gittoes also said that she would typically comply with the request of a senior officer and denied that she had forgotten to comply with Detective Inspector Chidgey's request to contact CSSB.

10.13 Instead, Sergeant Gittoes gave evidence that at the time of making her 2018 statement, she recalled making a phone call whilst at AX's house on 6 August 2017 and speaking about AX. Sergeant Gittoes gave evidence that she believed (as at 2018) that this call was to CSSB as she would typically only call either CSSB or the detectives' office whilst at a death scene. As detectives were already present at AX's house, this led Sergeant Gittoes to believe that the call she made was to CSSB.

10.14 Sergeant Gittoes gave evidence that it was only when she was asked to make her 2022 statement that she learned that the call she made whilst at AX's house was not in fact to CSSB. In preparing to make that statement, Sergeant Gittoes obtained the call log for her mobile phone which showed that she had instead called Ashfield Police Station on 6 August 2017. Sergeant Gittoes surmised that she had made this call in order to arrange for government contractors to attend the scene to transfer AX to the DOFM.

10.15 Sergeant Gittoes theorised that following the conversation described in her statement, she and Detective Inspector Chidgey may have had a further discussion during which it was discussed that because AX's death appeared to be due to natural causes, and no sign of forced entry was evident, that it was decided that there was no need for the Crime Scene Unit to attend. Detective Inspector Chidgey makes no mention of this purported further conversation in her statement and was unavailable to give evidence at the inquest.

10.16 **Conclusions:** On 6 August 2017, the NSWPF standing direction which was in force at the time, and consistent with the provisions of the NSWPF Handbook, required attending police at AX's house to contact CSSB. However, no such contact was made despite Detective Inspector Chidgey instructing Sergeant Gittoes to do so. Sergeant Gittoes suggests that this instruction was superseded by a subsequent conversation between herself and Detective Inspector Chidgey in which a decision was reached that CSSB was not required to attend. This is because the circumstances of AX's death were considered not to be suspicious, with no sign of any third party involvement.

10.17 Sergeant Gittoes' explanation for not contacting CSSB could not be comprehensively tested at inquest because Detective Inspector Chidgey was unavailable to give evidence. However, it is noted that Sergeant Gittoes did make a phone call on 6 August 2017 whilst at AX's house to Ashfield police station. Her evidence that this call was likely made to arrange for government contractors to attend, is consistent with usual procedures that would be followed when NSWPF police officers attended a death scene. Further, there is no evidence that Sergeant Gittoes deliberately ignored Detective Inspector Chidgey's instructions or that she fabricated a version of events in an attempt to conceal her omission. In evidence, Sergeant Gittoes explicitly denied doing so.

10.18 The question that arises from the above is how the attendance of a CCSB investigator at AX's house on 6 August 2017 might have assisted with the investigation into AX's death. In this regard, Detective Sergeant Kremers gave evidence that:

(a) all coronial scenes are unique;

(b) a coronial scene should be approached as if there is only one opportunity to preserve available evidence;

(c) evidence obtained from a coronial scene can play a pivotal role in resolution of the cause and manner of a person's death;

(d) careful investigation is necessary to preserve evidence so that it may yield reliable information;

(e) it is prudent for forensic investigators to have a high index of suspicion; and

(f) it is even more difficult for general duties police officers than it is for a CSSB investigator to determine whether the death of a person was due to natural causes or not.

10.19 Detective Sergeant Kremers gave evidence that he would treat the circumstances of AX's death as suspicious, until proven otherwise, because no cause of death was immediately apparent. As a result, if he had been contacted on 6 August 2017 he would have arranged for crime scene investigators to be despatched.

10.20 In addition, Detective Sergeant Kremers gave evidence that in general, forensic investigators are cognisant of the possibility of a staged homicide (that is, a homicide made to look like a death from natural causes) when attending a death scene. Leading Senior Constable Spooner gave evidence that his approach when attending the scene of a death is to "*start off with homicide and work backwards*". These approaches are entirely consistent with the provisions of PSN 01/20 which relevantly provided:

> Natural causes should **never** be presumed, with each death to be treated as a potential homicide until clear evidence to the contrary is obtained. [original emphasis]

10.21 Detective Sergeant Kremers gave evidence that:

(a) the wine glass, mug and wine bottle at AX's house would have been seized by a CSSB investigator;

(b) swabs would have been taken of all these items;

(c) analysis would have been conducted of any fluid remaining in the mug;

(d) whilst the quality of the photos taken by NSWPF officers at the scene was acceptable, he would have liked to have seen some more detailed and macroscopic photos of, for example, both sides of AX's hands and of her eyes; and

(e) whilst it was "*fair*" that none of the photos taken from the scene showed obvious signs of poisoning, he would have looked for injection marks at less obvious sites such as between the toes and fingers, and around the neck and armpits.

10.22 As to the quality of photos taken at AX's house on 6 August 2017, Superintendent Best gave evidence that the cameras used by investigators from the CSSB would have been "*better*", and noted the following:

> Had crime scene officers attended they would have conducted a very thorough physical examination of the deceased to ensure no signs of trauma were present. I note that the attending police conducted a thorough examination of the deceased with associated photographs, including examining the eyes for petechial haemorrhaging, the hands and nails for defensive wounds/abrasions, the neck/throat for evidence of choking, the lividity and rigor mortis of the body for consistency with positioning, and back and front of the body for wounds/abrasions/bruising. The examination of the deceased was in line with what a crime scene investigator would have undertaken, although I cannot comment on the expertise of the officers in assessing lividity/rigor mortis. By nature of our training and SOPs, had a forensic investigator attended, there would have been a more thorough and detailed recording of the scene with comprehensive notes and sketches, and higher quality photographs. Given the facts in this case, none of this would have changed the outcome.

10.23 Superintendent Best explained that in January 2020, PSN 01/20 was revoked and replaced with an update in the version of the NSWPF Handbook in force at the time, which provided for detectives to always be notified of a death and to attend the death scene where appropriate, and for forensic investigators to attend death scenes where a death is not due to natural causes, upon request through the CSSB Crime Scene Coordinator.

10.24 **Conclusions:** If the CSSB had been contacted on 6 August 2017, it is most likely that a CCSB investigator would have attended AX's house to examine the scene. Although the examination of the scene that was instead conducted by general duties police officers was consistent with the type of investigation that a specialist forensic investigator would have conducted, the evidence establishes that such an investigator would have brought an additional degree of expertise to such an examination.

10.25 In particular, physical items from the scene would have been seized and subjected to forensic analysis, and more detailed and better quality photographs would have been taken. Such evidence gathering would have been directed towards the ultimate task of reliably eliminating the possibility that AX's death was a homicide and establishing a basis to conclude that it was most likely due to natural causes. As a CSSB investigator did not attend AX's house on 6 August 2017, for the reasons explained above, it could not be said that the NSWPF investigation was entirely adequate in this regard.

Contemporaneous note-taking

10.26 In his statement signed on 17 October 2018, Leading Senior Constable Spooner stated that after examining the scene, he spoke to BX "*in an attempt to establish the events leading up to [AX] passing away*". Leading Senior Constable Spooner recorded in his statement the following version of events provided by BX:

> We went out last night to Japanese in Potts Point for dinner. Mum caught a train to Milson's Point where I picked up. She was still able to use the trains fine. We had an early dinner and then I drove mum home. I went inside with mum and she asked me to open the bottle of Muscat and then I left. It was just after 8pm and she seemed fine.
>
> On Sundays we usually come over and pick mum up and go out for breakfast. I was running late this morning and sent her a text. I got here and she wasn't out the front and I went to the front door but it was locked and she didn't answer. It wasn't like her because [s]he always opens the front door. I went around my [sic] sisters place to get a spare key. I went upstairs and found her in bed still holding the wine glass. I then called 000.

10.27 The version of events described above is significant because it is the only documented version of events provided by BX to investigating police regarding the events of 5 and 6 August 2017.

10.28 Leading Senior Constable Spooner completed an entry in his NSWPF Notebook regarding his attendance at AX's house on 6 August 2017. The entry consists of approximately 2½ pages of handwritten notes, most of which relates to the personal details of AX, BX and CX. Leading Senior Constable Spooner recorded the following note which appears to represent the entirety of his conversation with BX at AX's house on 6 August 2017:

> 8pm 5/8/17 dropped off. At 7am 6/8/17 called for breakfast. Son BX.

10.29 Upon returning to Ashfield police station, Leading Senior Constable Spooner entered the following in the COPS narrative regarding his attendance at AX's house:

> On the evening of Saturday the 5th of August 2017, the Deceased travelled by train to Milsons Point Train Station where she was met by her son, BX. The Deceased's [sic] and her family went to Potts Point and had Japanese for dinner. Dinner was early, approximately starting between 5pm - 5.30pm. At the conclusion of dinner, the Deceased's son drove her home, to AX's house. The Deceased and her son went into the house, where they [sic] had a short conversation with his mother, opened a bottle of 2013 Chapoutier Muscat des Beamunes de Venise, a 375ml "half bottle" at the request of his mother and then left her alone. At the time he left, it would have been no later then [sic] approximately 8.10pm.
>
> Some time during the night the Deceased has passed away. The Deceased is usually awake early in the mornings, about 7am. The Deceased's son has breakfast with his mother every Sunday morning, and as such, has arrived at his mothers house just after 8am on Sunday the 6th of August 2017. The Deceased's son was running late, and has sent his mother a text message. Upon arrival at AX's house, the Deceased's son has seen that the front door was still locked and he was unable the [sic] raise his mother. This was uncharacteristic of her as the from [sic] door is usually open. The Deceased's son has driven to his sister's house, CX and obtained the house keys in order to gain entry.

10.30 Leading Senior Constable Spooner gave evidence:

(a) agreeing that the function of a NSWPF Notebook is to take contemporaneous notes;

(b) that he had not taken any such notes on 6 August 2017;

(c) that the observations of a person who last saw a deceased person alive is significant and could prove critical to an investigation;

(d) that any observations of a death scene should be recorded in a NSWPF Notebook;

(e) accepting that it would have been best practice to contemporaneously record in his NSWPF Notebook any conversations with critical witnesses and any significant observations that he had made of the scene at AX's house on 6 August 2017; and

(f) that the version recorded in his notebook of his conversation with BX bore little resemblance to the version recorded in his statement made some 14 months later.

10.31 Leading Senior Constable Spooner gave evidence that, despite having been made some hours later, his COPS entry was the most contemporaneous account of his attendance at AX's house. Whilst Leading Senior Constable Spooner did not agree that the COPS entry differed from his notebook entry and his statement, he agreed that the different accounts were not identical, although the information was "*the same*". Notwithstanding, Leading Senior Constable Spooner accepted that there were some material differences between the accounts (for example, whether BX had arrived at AX's house at 8:00am as recorded in the COPS entry, or whether he arrived at 7:00am, which the Notebook entry seems to suggest).

10.32 Leading Senior Constable Spooner accepted that if a contemporaneous note had been made whilst he was at AX's house there would be no issue about which version is now correct. Leading Senior Constable Spooner also accepted that the notebook entry was unclear in its terms, and that more detail should have been taken from BX, as the last person who saw AX alive. Leading Senior Constable Spooner acknowledged that important details were missing from the version of events which he took from BX, such as how AX appeared at dinner on 5 August 2017, whether AX usually drank in bed, and whether she usually drank dessert wine.

10.33 **Conclusions:** When obtaining a version of events from BX on 6 August 2017, it was apparent to Leading Senior Constable Spooner that BX was the last person to have seen AX alive and was therefore a critical witness. Despite this, Leading Senior Constable Spooner did not make a sufficiently comprehensive and detailed contemporaneous record of his conversation in his NSWPF handbook. Instead, the notebook entry of this conversation consisted of approximately 11 words.

10.34 The records of this conversation which Leading Senior Constable Spooner subsequently made in the COPS narrative and in his statement (some 14 months later) contained significantly greater detail. Leading Senior Constable Spooner frankly acknowledged in evidence that recording a sufficiently comprehensive and detailed contemporaneous record of his conversation with BX would have represented best policing practice. Further, such best practice would have eliminated any doubt, in the context of a potential homicide investigation, as to which account of the conversation was reliable and correct. It therefore cannot be said that the police investigation was entirely adequate in this regard.

11. AX's admission to Department of Forensic Medicine

11.1 There are several matters relating to the processes which followed AX's admission to the DOFM which are ultimately relevant to consideration of the issue as to the cause and manner of AX's death. These processes are discussed below.

Preliminary examination

11.2 As noted already, the only preliminary examination performed on AX at the DOFM was a post-mortem CT scan (**the PMCT**). This was done in accordance with standing arrangements at the time between the DOFM and the Office of the State Coroner. On 8 August 2017, a radiographer reported the following relevant impressions from the PMCT.

> CHEST:
> No evidence of sternal or rib fractures seen. Heart looked unremarkable. Minor focal vascular (incl both CA's) calcification seen. The lungs looked unremarkable. No evidence of PTX or later seen. Soft tissues of head and torso did not identify any injury on slightly hypersthenic patient.

11.3 No photographs were taken of AX upon her admission to the DOFM. Instead, a head-to-toe filming of AX was performed in accordance with standard procedures which existed at the time.

11.4 Section 88A of the Act provides the following:

> (1) A pathologist may carry out (or arrange for another person to carry out) a preliminary examination in relation to the remains of a deceased person even if a post mortem investigation direction has not been given authorising the examination.
>
> (2) A preliminary examination in relation to the remains of a deceased person may only involve any one or more of the following—
>
> (a) a visual examination of the remains (including a dental examination),
> (b) the collection and review of information, including personal and health information relating to the deceased person or the death of the person,
> (c) the taking of samples of bodily fluid, including blood, urine, saliva, vitreous humour and mucus samples from the remains (which may require an incision to be made) and the testing of those samples,
> (d) the imaging of the remains, including the use of computed tomography (CT scan), magnetic resonance imaging (MRI scan), x-rays, ultrasound and photography,
> (e) the taking of samples from the surface of the remains (including swabs from wounds and inner cheek, hair samples and samples from under fingernails and from the skin) and the testing of those samples,
> (f) the fingerprinting of the remains,
> (g) any other procedure that is not a dissection, the removal of tissue or invasive in any other way.

11.5 However, section 88A was only inserted in January 2020 following an amendment to the Act. This means that as at August 2017, Dr Du Toit-Prinsloo did not have the authority to, relevantly, take a

sample of bodily fluid or take samples from the surface of AX's body, for subsequent analysis. Such preliminary examination in August 2017 would have required authorisation from a Coroner.

Obtaining AX's healthcare summary

11.6 Following AX's admission to the DOFM, Dr Du Toit-Prinsloo undertook a number of enquiries to inform her eventual recommendation to the Duty Coroner as to whether any post-mortem examination ought to be conducted and if so, what type of examination. The Progress Notes in the DOFM file for AX relevantly record the following notes authored by Dr Du Toit-Prinsloo:

09h30 7/8/17	*Dr Cheng phoned – will fac HCS* *CT HCS ?CC*
8/8/17 *09h00*	*Phone @ 9h30*
11h10	*Phoned GP* *CT scan no acute COD* *no #*

11.7 Dr Du Toit-Prinsloo gave evidence that she called Dr Cheng to discuss whether a Medical Certificate of Cause of Death (**MCCD**) would be provided and if not, to request a copy of AX's healthcare summary (**HCS**). The purpose of requesting the HCS was to confirm that the medical history provided by police in the P79A, namely AX's history of hypertension, and to provide the basis for proposing that a Coroner's Certificate be issued.

11.8 The P79A noted the following in relation to AX's medical history:

> Police searched the kitchen, bathroom and bedroom for any medication that the Deceased may have been taking, however there was no prescription medication located. Police had a conversation with both of the children of the Deceased, to which they both stated that the Deceased did not have a regular doctor and didn't regularly see one. The deceased suffered from both dementia and alzheimers [sic], as well as suffering from high blood pressure, although it appears that she was not currently taking any regular medication for any of her health issues. Police were able to determine that the deceased visited Dr Kevin CHENG from the Multicare Family Medical Centre on Liverpool Road, Ashfield on 11th of March 2017. Police were not able to obtain the reason for this last visit, however her children stated that she only went to the medical centre and didn't have a regular treating doctor.
>
> The Deceased's son and daughter also stated that the majority of the time, the Deceased's cognitive ability and memory was not overly impaired by her illness, however there would be random days when she would totally forget days and weeks of previous events. The Deceased had complained over the three years of having terrible headaches, however never saw a doctor about this as she would commonly say that it was the first headache she had had, as it was apparent that she simply did not remember the previous ones, but her children would remind her that she was having them regularly and that she should see a doctor.

11.9 Dr Cheng gave evidence that he did not recall speaking to Dr Du Toit-Prinsloo on either 7 or 8 August 2017 but that this was not unusual as his day-to-day practice was typically busy. Dr Cheng also said that if he received a call directly it would sometimes be redirected back to the front desk of his general practice, meaning that whilst he had no recollection of speaking with Dr Du Toit-Prinsloo, someone else at Multicare may have.

11.10 However, Dr Cheng gave evidence that if AX's HCS had been provided to the DOFM, the software used at his general practice would have automatically generated an entry in AX's medical record. In addition, Dr Cheng gave evidence that if he had spoken to Dr Du Toit-Prinsloo, it would have been his usual practice to document this conversation in AX's medical record. The medical record itself contains no such record by Dr Cheng, nor a software-generated entry indicating that AX's HCS had been provided to the DOFM.

11.11 Dr Du Toit-Prinsloo gave evidence that she phoned Ashfield Multicare on 8 August 2017 but did not document the call. This indicated to Dr Du Toit-Prinsloo that she did not receive the material requested the previous day, namely AX's HCS.

11.12 The available evidence therefore establishes that Dr Du Toit-Prinsloo did not have AX's HCS available to her when formulating an opinion as to whether any post-mortem examination of AX ought to be recommended to the Duty Coroner. Dr Du Toit-Prinsloo stated that whilst a Duty Pathologist will attempt to obtain clinical information, to corroborate medical information that might be recorded in a P79A, when such clinical information is not forthcoming then a recommendation regarding post-mortem examination will be made based on available information.

11.13 Whilst the evidence indicates that Dr Du Toit-Prinsloo attempted to obtain AX's HCS, it is not entirely clear why it eventually could not be obtained, despite being apparently available. One matter raised by Dr Du Toit-Prinsloo is that in around August 2017, DOFM had introduced a Clinical Nurse Consultant (**CNC**) position to assist with the post-mortem triage process. Dr Du Toit-Prinsloo explained that the role of the CNC includes obtaining and reviewing medical information to assist a Duty Pathologist in making recommendations to a Duty Coroner about post-mortem examinations.

11.14 Notwithstanding, Dr Du Toit-Prinsloo gave evidence that even if AX's HCS had been available to her on or about 8 August 2017, it would not have affected her opinion as to the cause of AX's death. This is because, Dr Du Toit-Prinsloo stated, there was no indication from the P79A (which recorded no suspicious circumstances and AX's medical history of hypertension) that AX's death was due to anything other than natural causes.

Formulation of recommendation for Coroner's Certificate to be issued

11.15 Ultimately, Dr Du Toit-Prinsloo gave evidence that in proposing the cause of AX's death as hypertensive heart disease she based her opinion on the following factors:

(a) the P79A indicated that AX had known hypertension;

(b) AX had last visited her GP on 11 March 2017; and

(c) the absence of any acute cause of death from the PMCT.

11.16 As to the "*minor focal vascular calcification*" reported by the radiographer, Dr Du Toit-Prinsloo gave evidence that at times the extent of calcification can be variable and that the calcification seen on the PMCT did not indicate to her how patent or occluded the coronary vessels were. Dr Du Toit-Prinsloo acknowledged that in hindsight she did not think that it would be wrong to consider coronary artery disease as the cause of AX's death. However, in August 2017, Dr Du Toit-Prinsloo considered it more likely that hypertensive heart disease was the cause of AX's death. Dr Du Toit-Prinsloo also acknowledged that it would have equally been open to describe the cause of AX's death as being due to unascertained natural causes.

11.17 Dr Du Toit-Prinsloo acknowledged that one option available to her was to recommend to the Duty Coroner that some type of post-mortem examination be conducted. However, Dr Du Toit-Prinsloo gave evidence that she did not consider that such a recommendation was warranted given the following factors:

(a) AX's age;

(b) AX had an underlying medical history of hypertension;

(c) the police did not consider the death to be suspicious;

(d) there was no indication that the death was due to anything other than underlying natural disease process;

(e) no further medical investigation was indicated; and

(f) the issuing of a Coroner's Certificate with the most probable cause of death being hypertensive heart disease would be in keeping with the least invasive means to determine the cause of death.

11.18 The last of these matters is entirely consistent with the provisions of section 88 of the Act which provides the following:

> (1) When a post mortem examination or other examination or test is conducted on the remains of a deceased person under this Part, regard is to be had to the dignity of the deceased person.
>
> (2) If more than one procedure is available to a person conducting a post mortem examination to establish the cause and manner of a deceased person's death, the person conducting the examination is to endeavour to use the least invasive procedures that are appropriate in the circumstances.

11.19 Dr Du Toit-Prinsloo said that the following evidence gathered after August 2017, reinforced the view which she formed in August 2017 of hypertensive heart disease being the cause of AX's death:

(a) the finding of an enlarged heart by Dr Watkins (discussed further below);

(b) AX's history of hypertension; and

(c) AX's history of non-compliance with her heart medication preceding her last visit to a GP.

12. Categories of Non-Medical Evidence

12.1 In his report, Professor Cordner described the criteria that need to be satisfied for a forensic pathologist to arrive at an opinion regarding the cause of a person's death. Professor Cordner firstly explained that definitive causes of sudden unexpected natural deaths (such as pulmonary embolism and ruptured aortic aneurysm) "*are fewer than people think*". Professor Cordner went on to explain the following:

> What is more common is the conclusion that a chronic process (eg coronary artery disease) with which a patient has been living - whether knowing it or not - has suddenly manifested itself as sudden death. In concluding the cause of death, what in fact usually happens in coming to a conclusion is that **a** cause of death discovered in the medical history (or an external examination of the body, the CT scan or at autopsy), which accords with the circumstances of the death, is elevated to **the** cause of death. In general terms, the doctor or pathologist makes a decision that asserted condition or finding is capable of leading to death, and that as this fits with the supposed circumstances of death, and there is no other competing cause, it becomes *the* cause of death. Such a conclusion is retrospective and therefore generally cannot be tested. [original emphasis]

12.2 What is important to note from the above is the qualification that whilst a person's underlying medical condition (whether known or not) may accord with the circumstances in which a person is found to be deceased, and therefore explain the cause of their death, there must be no other competing cause of death. The question that relevantly arises in AX's case is whether there is a competing cause of death.

12.3 The evidence gathered during the coronial investigation identifies several matters which raise the possibility of a competing, non-natural cause of death. This evidence falls into the following categories (**the Non-Medical Evidence**):

(a) purported conversations involving BX regarding euthanasia;

(b) evidence regarding the "doctor in Taylor Square";

(c) the contents of BX's laptop;

(d) financial matters relating to AX and BX; and

(e) other circumstantial evidence.

12.4 In other words, was AX administered a substance and did the toxic effects of this substance cause her death? If so, then the cause and manner of her death would obviously not be due to natural causes as a result of natural disease process.

13. Purported conversations regarding euthanasia

13.1 It is proposed to deal with each category of evidence that raises the possibility of a competing cause of death, beginning with conversations regarding euthanasia. CX and ZY describe three meetings that they had with BX, together and separately, in 2017 during which the topic of euthanasia was allegedly raised by BX:

(a) at an Italian Restaurant in The Strand Arcade in February 2017;

(b) for coffee around Aurora Place in the Sydney CBD in February 2017; and

(c) for drinks at The White Rabbit pub on 8 May 2017.

The Strand Arcade Meeting

13.2 In her statement, CX described a meeting with ZY and BX at a restaurant in the Strand Arcade in February 2017 (**the Strand Meeting**). The purpose of the meeting was to discuss AX's financial issues and her physical care. CX indicated that by this time it had reached the point where AX's care could no longer be managed and that AX was becoming unhappy. According to AX, BX then said the following:

> You know my views about putting her into a home. I told her I would never do that. I promised that if it got to that point I would give her a handful of pills and that would be it.

13.3 CX indicated that AX had not reached that stage and that the focus should instead be on helping AX and maintaining the quality of her life. CX suggested using a gardener and someone to assist AX in her home to make things easier for her and to ensure that she could stay in her house for longer, which BX agreed with. However, according to CX, this plan was never actioned because BX did not make any funds available to pay for such assistance.

13.4 In his statement, ZY described BX as making the following "*explicit statements*" during an exchange with CX that he would not allow AX to enter a nursing home:

> BX: I made mum a promise never to put her in a nursing home. She used to have to go and see her mother every day to wipe her chin and all that.
>
> CX: Do you mean euthanasia?
>
> BX: I promised I would give her a pill.
>
> CX: She's nowhere near that stage, that's for people in agony or shitting themselves, who can't feed themselves, who have no quality of life.
>
> BX: I will not let it get to that point.
>
> CX: It is illegal and you will go to jail.

BX: I've spoken to my doctor about the dose, it has to be taken with anti-nausea medication. I can get what I need in Amsterdam.

13.5 According to ZY, BX expressed a fear of going to jail, and he described BX as drinking "*heavily and quickly, finishing a bottle of champagne and ordering more*".

13.6 In his oral evidence, ZY said that during the Strand Meeting:

(a) BX promised to give AX "*a pill*";

(b) BX referred to AX previously saying that she had to visit her mother in a nursing home and wipe her chin, and BX saying that he would not "*let it get to that stage*";

(c) BX's comments upset CX who indicated that AX was nowhere near the point where euthanasia should be considered and that this was for people who could not look after themselves;

(d) BX said that he had spoken to his doctor about the dose and that anti-nausea medication needed to be taken with it; and

(e) CX indicated to BX that this was illegal and that he could go to jail.

13.7 ZY gave evidence that during the meeting he had a glass of wine to drink but said that he did not think he had drank enough for it to affect his recollection. However, he agreed that his recollection was affected in other ways, namely:

(a) he had conflated the Strand Meeting and the two meetings with BX which followed (described below);

(b) he had difficulty distinguishing the conversations where BX had raised the topic of euthanasia during each meeting;

(c) he described the meetings being "*like a slideshow*" with "*different cut scenes*"; and

(d) he explained that because similar topics had been discussed at all three meetings that they had become "*less distinctive*" over time.

13.8 ZY gave evidence that on 8 February 2018 he supplied Detective Senior Constable Prout with a document that he had prepared, which he described as a timeline of events (**the Timeline**), as he wanted to provide her with context to assist her in forming a view about what matters were to be investigated. ZY described being "*very horrified*" at what was apparent to him and CX, and that he was looking to provide the police with as much information as he could to allow them to form a view regarding the circumstances surrounding AX's death.

13.9 ZY gave the following evidence about the Timeline:

(a) he included everything in it that he thought might be relevant to the police investigation;

(b) he was not suggesting that it was a complete or "*final settlement*" of everything that he understood to be relevant to the circumstances of AX's death;

(c) he accepted that it made no reference to any meeting at an Italian restaurant at the Strand Arcade;

(d) when preparing it he usually referred to a document or something that was tangible, and that because he did not think that he had any documentary evidence regarding the Strand Meeting, it was left out of the Timeline;

(e) he could not recall the precise date of the Strand Meeting and tried to keep the Timeline to "*tangible or provable things*"; and

(f) when Senior Counsel for BX asked why ZY had included a meeting at the White Rabbit pub (discussed further below) in the Timeline when he had no documents referable to it, ZY said that he was able to "*anchor*" the meeting to CX's birthday.

13.10 On 1 April 2018, ZY sent an email to Detective Senior Constable Prout attaching a draft statement which he described as having "*developed*". In the draft statement, ZY said the following:

(a) he, BX and CX met for lunch at an Italian restaurant in early 2017 "*to discuss AX's situation*";

(b) when the conversation at the meeting turned to AX's mental capacity, BX made explicit statements that he would not allow AX to enter a nursing home and said that he had promised AX to take action to prevent her from being in care;

(c) when CX asked BX if he was referring to euthanasia, BX said that he had promised to give AX a pill;

(d) when CX told BX that this was illegal and that he would go to jail, BX dismissed these statements, stating that "*he asked his personal doctor about dosages and that they had to be taken with anti-nausea medication and the [sic] he could access the right drugs in Amsterdam when the time came*".

13.11 ZY gave evidence that on 6 April 2018, he met Detective Senior Constable Prout and brought his laptop to the police station where he "downloaded bits and pieces". ZY gave evidence that he had worked on some documents the previous night in anticipation that Detective Senior Constable Prout would ask him to provide a statement. He said that Detective Senior Constable Prout typed the balance of the statement and provided some additional content. ZY described the draft statement as being more developed and evolved than he recalled.

Meeting for coffee

13.12 In his statement ZY said that sometime in February 2017, he made arrangements to meet BX to obtain AX's passport so that a bank account could be opened for her. They met for coffee near ZY's workplace in the Sydney CBD (**the Coffee Meeting**). According to ZY, during the meeting BX spoke about how he felt about nursing homes and that he would never allow AX to go to a nursing home or retirement village. ZY stated that BX expressed the following view:

> Nursing homes are robbers. I won't let it get to that stage. She won't go to a nursing home under any circumstances.

13.13 In his oral evidence, ZY said the following about the Coffee Meeting:

(a) It took place in the P&O building in the CBD and lasted no more than 30 minutes;

(b) mention was made of a retirement complex (the Cardinal Freeman retirement village in Ashfield) near his home which prompted BX to indicate that he was very opposed to nursing homes;

(c) BX said that nursing homes were "*robbers*" and that he would not put AX into a nursing home under any circumstances.

13.14 ZY also referred to the Coffee Meeting in the Timeline, noting that it occurred at Aurora Place in the CBD. He recorded that whilst the tone of the meeting could accurately be described as "*friendly and convivial*", there was tension about the issues relating to AX.

13.15 ZY gave the following evidence about the account of the Coffee Meeting contained in the Timeline:

(a) he agreed his statement signed on 6 August 2018 provided more detail than the Timeline regarding the Coffee Meeting;

(b) when asked whether the Timeline reflected the extent of his recollection at the time that the document was created, ZY said that he was trying to keep the Timeline "*fairly brief*";

(c) he explained that because Detective Senior Constable Prout already had knowledge of various things he was attempting with the Timeline to "*keep it tight*", and that it was not intended for "*an audience who were ignorant of matters*";

(d) when asked whether his memory had improved between writing the Timeline and when he signed his statement he said that he was "*probably thinking very hard about*" each of the meetings with BX when preparing his statement and so he was probably able to recall greater detail of the events.

The White Rabbit

13.16 On 8 May 2017, CX, ZY and BX met for drinks at the White Rabbit pub to celebrate CX's birthday but also to discuss AX's care (**the White Rabbit Meeting**). According to CX in her statement, by this stage AX was unable to manage daily tasks of living such as getting dressed and washing her hair. CX stated that she was desperate for BX's help to arrive at a solution for how to support AX, and that it was a struggle to keep the conversation focused on how to help AX. CX described the meeting as "*almost like we were having two different conversations that didn't intersect*". CX stated that, during a conversation BX said the following:

> I don't know your view on this. She is not going to, under any circumstances, go into a home. I know you don't want to talk about it, but the kindest thing for her is a handful of pills. I made a pact with her. I promised her she wasn't going to sit there like a drooling animal.

13.17 CX told BX that he could not do that, that he would go to jail and that euthanasia was for people at the end stage of their lives who were suffering and in pain. She said that AX was "*a long way off that*" and that their job as her children was to treat her with love and kindness. CX also told BX about a documentary that she had seen recently on Australian Story about a woman that had taken her own life, which had raised the suspicions of the police.

13.18 CX stated that BX said the following:

> I've spoken to my doctor in Taylor Square and he said they don't do autopsies on people over a certain age. And anyway the half-life of these drugs is gone by that stage. They can't find the drug anyway. The drugs are easy to get if you know where to get them from. I know I can get it in Amsterdam. You have to take it in the right way. You have to take it with anti-nausea medication. It's perfectly humane, they just fall asleep.

13.19 CX reiterated that AX was not yet at the stage where that should be considered and stated that she then had the following exchange with BX:

> CX: It's years and years and years before she will be in that state.
>
> BX: You want to do it before it gets to that stage. Otherwise it looks suspicious.
>
> CX: If you've been looking these things up it will be on your computer. Even if you're looking it up they'll find it.
>
> BX: I wouldn't be that stupid.
>
> CX: Even to be having a conversation about it, if you're really going to do it you shouldn't be talking about.

13.20 CX stated that she attempted to redirect the conversation to ideas of providing assistance to AX by, for example, having her meals delivered or having AX stay with BX and FV occasionally on weekends. However, CX described BX as being "*so single-minded that he would not even acknowledge what I was saying*". CX also describes the conversation lasting for about two hours, with BX having consumed a whole bottle of champagne during this time. CX stated that the following exchange then took place between herself and BX:

BX: I don't know how you feel. I wouldn't do anything unless you agree.

CX: Euthanasia, for me, is for when people are at the end of their life and they're suffering. We are not at that point.

13.21 CX stated that she formed the view that BX was speaking about the possibility of euthanasia "*sometime in the future*". She said that this made her angry, causing her to end the meeting and leave.

13.22 In her oral evidence, CX described the White Rabbit Meeting in the following way:

(a) there was a discussion regarding euthanasia and "*a handful of pills*" which "*went on and kept going on*";

(b) BX went into detail about how AX had said to him that "*if she ever got to that point, to give her a handful of pills*";

(c) she said that she realised "*that there was detail in all of this*" which started to make her feel angry that it was being brought up;

(d) she expressed the view that euthanasia was for people at the end of their lives and told BX that he would go to jail;

(e) the conversation went "*on and on*", the topic of euthanasia "*didn't get dropped*", and she did not know why BX kept talking about it; and

(f) she made reference to the Australian Story documentary and she kept attempting to redirect the conversation back to how they could support AX;

(g) BX spoke about being able to easily access what was needed, how he could source it, how he knew where to get it from, being able to administer it correctly, how it cleared the body and how it left the bloodstream;

(h) BX said that he looked up information online and CX told him that this would leave a trail, but BX responded by saying that he would not be stupid and that he had it "*sorted*";

(i) BX referred to "*the system*" being "*clogged up*", that autopsies were not performed on people over the age of 70, and that any drug that might be used would "*not show up anyway*";

(j) BX said that the source of his information was a doctor in Taylor Square who he had spoken with about euthanasia, that the doctor had a parent who had cancer and had suffered, that the doctor knew how hard it was to "*watch someone in that state*", and that he could "*get it*" from his doctor.

13.23 Later in her evidence, CX acknowledged that she had made a mistake in saying that BX had told her that he could "*get drugs*" from his doctor in Taylor Square. CX also acknowledged that in her

statement she made no mention about BX speaking about the parent of his doctor as she did not recall this at the time she made her statement.

13.24 CX gave evidence that she drank no more than two or three glasses of Chardonnay. She acknowledged that the alcohol could have affected her recollection but repeatedly said that she recalled being so shocked by the things that BX said and that he "*just kept carrying on*" and "*didn't stop*".

13.25 ZY also gave evidence about the White Rabbit Meeting and described it as follows:

(a) it "*tracked similarly*" to the Strand Meeting;

(b) when the conversation turned to AX, BX raised the topic of euthanasia and said that he would not let AX be put into a nursing home;

(c) BX also brought up the topic of autopsies and said that they were not performed for people over the age of 70. ZY replied that autopsies were performed for all sorts of unexplained deaths but BX said that he was not worried;

(d) BX mentioned that he had "*done his research*";

(e) CX indicated strenuous opposition to the idea of euthanasia, said that it was illegal, that AX was nowhere near that stage and that BX would go to jail;

(f) BX indicated that he was "*absolutely opposed*" to nursing home care, without going into specifics, and that he did not want to address any other options regarding AX's care; and

(g) BX indicated that he made a pact or a promise to give AX a pill, although ZY acknowledged that he was unsure whether this was mentioned at the White Rabbit Meeting or elsewhere.

13.26 In his oral evidence ZY agreed that he and CX had had multiple conversations regarding the Strand Meeting and White Rabbit Meeting, between each meeting and also after AX's death. ZY accepted that it was now not possible for him to "*unscramble*" his own recollection of each meeting compared to what he had discussed with CX. He again made reference to his memory being like a "*slideshow"* with "*scenes independent of each other*" and "*the fragments all there*" but "*not a continuous real-time event*". Overall, ZY accepted that his memory was affected by events subsequent to the meetings.

13.27 In oral evidence, ZY was asked whether he considered approaching the police. He said:

(a) before AX's death, he had never contemplated going to the police in relation to each of the three meetings with BX;

(b) the idea of going to the police had never come up in conversation with CX;

(c) however, following AX's death he did contemplate going to the police and discussed this with CX;

(d) he considered that there was a reasonable suspicion that AX's death had been caused by BX, having regard to what BX had expressed to them about his intention to administer "*a pill*";

(e) he eventually did not go to the police because he found BX to be "*a very intimidating individual*", and that "*he has a bad temper and gets very angry*"; and

(f) he was afraid for his family if he were to make any allegations against BX, and that he was fearful that BX would "*cause something to happen to our family*".

13.28 ZY also referred to the White Rabbit Meeting in the Timeline and relevantly described it in this way:

> Met for drinks at White Rabbit bar. Discussed difficulties with AX and management strategies BX reiterated his promise about a nursing home and talked about his thoughts on euthanasia. BX made reference to the Australian Story episode on Nikki Gemmell's mother who chose euthanasia due to chronic pain. CX talked about options like in-home care.

13.29 ZY was asked about the Timeline account in his oral evidence where he:

(a) acknowledged that the information contained in the Timeline was more abbreviated than what was contained in his statement;

(b) agreed that the Timeline only contained a reference to the conversation regarding euthanasia in general terms but explained that because Detective Senior Constable Prout already knew what had been discussed regarding this topic, it was unnecessary to repeat it;

(c) explained that because Detective Senior Constable Prout already had details from their initial meeting, he was only seeking to provide context and validation for what was discussed; and

(d) described the Timeline and his draft statement as "*summaries, almost annotations*".

13.30 Senior Counsel for BX suggested to ZY that his different accounts regarding what BX allegedly said about AX had evolved over time. ZY accepted that his memories had evolved and that as he had reflected on them they had crystallised and become clearer. When Senior Counsel for BX suggested that his memories had evolved in a manner that was more adverse to BX, ZY initially said that BX was "*adverse to himself*" by mentioning euthanasia and pills consistently over their three meetings. Later ZY gave evidence that the suggestion of whether his memory had evolved in a way that was adverse to BX was for "*others to interpret*". ZY maintained that what he had "*put forward*" was true and that he did not accept that his memories had evolved in a hostile way.

Assessment of the reliability of the purported conversations regarding euthanasia

13.31 It is clear from what is set out above that neither CX or ZY provide a consistent account of the Strand Meeting, the Coffee Meeting and the White Rabbit Meeting across their statements to the police, the Timeline (in ZY's case) and their oral evidence. Most significantly, in both his statement to the police and his oral evidence, ZY nominates the Strand Meeting as being the occasion when BX made mention of his doctor, anti-nausea medication and Amsterdam. Further, ZY conceded that he made

no mention of the Strand Meeting at all in the Timeline. In contrast, CX nominates the White Rabbit meeting as when these matters were mentioned by BX. In addition, CX conceded that in her oral evidence she provided further detail about these matters (such as the reference to the parents of BX's doctor) that were not contained in her statement. In assessing the reliability of these accounts, regard should be had to the following matters.

13.32 *First*, during each of the three meetings, there were topics discussed other than AX and the purported conversations regarding euthanasia. Both CX and ZY state that BX referred to his ongoing relationship issues with FV during these conversations, and that he was experiencing difficulties with his neighbours regarding some building alterations. The evidence establishes that there was a temporal connection between these other events in BX's life and the three meetings between February and May 2017. For example, BX's medical records indicate consultations that BX had with his general practitioner, Dr LC on 1 February 2017 and 11 May 2017 in which Dr LC recorded "*relationship problem, partner*", "*due to see relationship counsellor*" and "*ongoing relationship problems*".

13.33 *Second*, DN, one of CX's close friends, stated that sometime in late 2016 or early 2017, she met CX for coffee. CX said that BX had rang her regarding AX's health. In her statement to the police, DN describes her recollection of her conversation with CX in this way:

> [BX] said that he was going to go to Amsterdam and get something to "help" the [sic] mum. He told her no one would ever find it in her system. I didn't take it seriously, and I think CX thought he couldn't possibly have meant he would actually do it. I thought, "who would do that to their mum?!"

13.34 DN also stated that in the months before AX died, CX became increasingly concerned that BX would "*actually do something to AX*" and repeatedly raised this topic in conversation. DN stated that she attempted to reassure CX that BX would do no such thing to his own mother.

13.35 *Third*, SW, another one of CX's close friends, stated that some time prior to the end of 2016, she met CX for coffee. SW stated that CX told her that she "*had spoken to BX and he had mentioned that euthanasia was a possibility in relation to their mother*". Although SW is unable to recall exactly what CX told her, she describes her reaction to the thought of euthanasia being discussed in relation to AX as being "*shocking*". SW describes CX being distressed during this meeting. SW also stated that over the subsequent months, CX spoke to her over the phone several times and mentioned "*BX's euthanasia idea*".

13.36 *Fourth*, AK, also one of CX's close friends and a practising solicitor, stated that in the first half of 2017 she had a number of conversations with CX in person and over the phone. In her statement to the police, AK described one of these conversations in this way:

> […] CX said to me words to the effect: "BX has talked about euthanising Mum. He said he would get the necessary medication when he is overseas". I asked her whether she thought he was serious and she said words to the effect: "yes and I think he is capable of doing it". I asked her whether anyone else heard him say these things and she said words to the effect: "yes, ZY was there. He was talking openly about it". She was clearly shocked and disturbed that her brother would suggest this.

13.37 AK gave evidence that she was unsure whether she had more than one conversation with CX in which CX had referred to BX and the topic of euthanasia. AK referred to a draft of the statement which she provided to the police which referred to more than one conversation. She gave evidence that she believes that there was an initial conversation with CX (in which BX and the topic of euthanasia was raised, and that there were a number of subsequent conversations in which CX referred back to this initial conversation. AK explained that the conversations stuck in her mind "*because of their significance*".

13.38 AK gave evidence that she expressed her doubt to CX that BX would act in the way in which CX asserted because, as a lawyer, he "*would not be so reckless*". AK also gave evidence that her initial impression of what CX told her was that "people say all sorts of things" and that they "*don't have any intention*" to act on them. However, AK said that the conversation described by CX became concerning "*in light of subsequent events*". AK also gave evidence that upon hearing of AX's death, she knew that CX would have suspicions, "*rightly or wrongly*", regarding BX's involvement.

13.39 *Fifth*, on the evening of 17 August 2017, CX sent AK an email in which she wrote the following:

> Hi AK,
> I am having trouble with this latest piece of information that BX was at Mums [sic] house signing documents the day before she died.
> I know I should have insisted that an autopsy was held. There are so many things that are unusual surrounding her death.
> I am considering going to Ashfield police tomorrow and telling them about BXs [sic] talk of euthanasia.

13.40 CX sent AK a further email on 18 August 2017 in which she referred to requesting information from the Coroner's Court regarding the basis upon which the Coroner's Certificate in relation to AX was issued. CX went on to write:

> When gathering this information is it advisable to say that I was told by my brother that he promised my mother a "handful of pills" or just try and understand this for myself?

13.41 *Sixth*, CX gave evidence that after leaving AX's house on 6 August 2017, BX drove her back home. Whilst in the car, CX gave evidence that she thinks she asked BX, "*Have you had anything to do with this?*". According to CX, BX replied, "*I would never do anything without asking you*".

13.42 Although CX's statement to the police does not refer to this conversation, there is evidence corroborating its occurrence. During an intercepted phone call on 16 April 2019, BX was recorded as saying to the person he was speaking with the following:

> Ah… She deliberately, which I thought was odd…um, I drove her home, um, she started accusing me of it. Tell me it was you. Then we had the massive litigation over the will, which is terrible. Disgraceful… I mean I've never seen anyone this…

13.43 Further, on 17 May 2019, BX consulted with Dr John Hayman, his treating psychiatrist. Dr Hayman made notes of the consultation in which he recorded the following:

> sister CX

> accused me on the day of [mother's] death of killing her

13.44 *Seventh*, Dr Hayman's notes of the 17 May 2019 consultation also record the following:

> they will see on my gadgets that I have done google searches about potential means of euthanasia drugs that he had d/w [mother]
> says he wanted to know what she might be planning to take and how it might go wrong

13.45 On 18 April 2019, NSWPF investigators executed a search warrant at BX's home during which an iPad (purportedly used by BX's son) was seized. This iPad was later analysed with an Internet search history extracted from it. This history revealed that Google searches were made using the following search terms:

> does coroner keep samples in nsw
> how long to get toxicology report
> autopsy nsw

13.46 *Eighth*, Senior Counsel for BX submitted that the accounts provided by CX and, in particular, ZY, should be assessed against the nature of the relationship that BX enjoyed with his mother. In other words, BX loved his mother and would never contemplate harming her, let alone prematurely causing her death. Senior Counsel for BX made specific reference to BX taking AX on a holiday to Europe with his family at the end of 2015, and AX's expressions of her fond memories of the holiday upon their return. Equally, it is undisputed that BX saw his mother often, noting their regular Sunday breakfasts.

13.47 However, it is noted that the holiday described above occurred in late 2015, some considerable time prior to the events of 2017 when CX and ZY reported that AX had become increasingly distressed about her financial situation, and they had correspondingly become increasingly insistent on greater visibility regarding these matters. In addition, one view that may be taken of the comments attributed to BX regarding the topic euthanasia is that they were motivated by BX's love for his mother and a desire to maintain the quality of her life.

13.48 It should be noted that in their oral evidence both CX and ZY readily conceded the errors and inconsistencies in their accounts when they were drawn to their attention. Moreover, they also acknowledged that they had discussed each of the three meetings with BX amongst themselves on a number of occasions and that these discussions had affected their memory of each discrete meeting. Relevantly, ZY was quick to concede the likelihood that he had conflated all three meetings.

13.49 However, it was readily apparent from the tenor of the oral evidence of CX and ZY that the three meetings, individually and collectively, had both an immediate and lasting impact on them. Both CX and ZY were visibly affected when recounting the meetings, with CX in particular expressing distress that the topic of euthanasia was repeatedly raised by BX.

13.50 **Conclusions:** CX and ZY do not have a perfect and entirely consistent recollection of the Strand Meeting, the Coffee Meeting and the White Rabbit Meeting. However, these imperfections and

inconsistencies do not detract from the reliability of their memories. The imperfections and inconsistencies can be explained by the fallibility of human memory, the topic of euthanasia being repeatedly raised in circumstances which caused distress to both CX and ZY, and CX and ZY understandably discussing the matter between themselves due to their concerns regarding the topic itself and its potential implications for AX.

13.51 CX and ZY did not make any contemporaneous record of any of the three meetings. Further, the Timeline created by ZY omits one of the meetings entirely and contains significantly less detail regarding the other two meetings than the statement which ZY later made to the police and in his oral evidence. However, ZY's description that the intended purpose of the Timeline was to only provide context and a summary of events, and that it was unnecessary to repeat matters already known to investigating police, is plausible. Further, the evidence establishes that CX confronted BX regarding his possible involvement in their mother's death on 6 August 2017, and that she made reasonably contemporaneous reports of at least the Strand Meeting to a number of her close friends. Finally, Dr Hayman's consultation notes reveal that BX conducted research regarding the identification of substances that might be used for euthanasia.

13.52 The evidence therefore establishes that the topic of euthanasia was raised, inferentially and directly, by BX during each of the three meetings in the manner described by CX and ZY. Of course, the raising of this topic by BX and his expressions of intent to act in relation to it does not equate to actual evidence of action. However, it is a significant matter to be taken into account when considering whether any competing cause of AX's death exists.

14. Evidence regarding the "doctor in Taylor Square"

14.1 In order to investigate the possibility that AX died as a result of euthanasia, the coronial investigation sought to identify the doctor referred to by BX as his "*doctor in Taylor Square*" according to CX's account of the White Rabbit Meeting. At the time of the inquest, Dr LC had been a practising GP at [REDACTED] for some 30 years. Dr LC agreed that his practice is located approximately 350 metres from Taylor Square.

14.2 Dr LC initially gave evidence that he was unsure whether BX was one of his Facebook friends. He explained that he has about 700 friends on Facebook and "*tends to forget*" who is a Facebook friend. Dr LC also gave evidence that it would not be his general practice to be friends on Facebook with a patient but that he might do so if they were to share similar interests. Later in his evidence, when shown a printout of his public Facebook profile, Dr LC agreed that BX is indeed one of his friends on Facebook. Dr LC explained that he first met BX at an art opening, which was an interest that they shared, in about 2006 and attended a New Year's Eve party at BX's house in the same year. These events occurred before BX became a patient of his in 2007.

14.3 Dr LC gave evidence that it is his almost invariable practice to make a contemporaneous note every time he sees a patient. When asked about some specific matters regarding any discussions that he might have had with a patient regarding the topic of euthanasia, Dr LC gave evidence that:

(a) it would be his usual practice to make a note if he spoke to a patient about euthanasia during a consultation, unless it was only mentioned in passing;

(b) his practice sees over 2000 patients with HIV and that "*a great many*" would discuss euthanasia at some point;

(c) the topic of euthanasia came up "*off and on*" probably more so in the 1990s, when there was no effective treatment for HIV, but more recently it is "*not mentioned as much*"; and

(d) whenever a patient raised the topic of euthanasia, he did not inform himself of the availability of drugs of euthanasia, he did not learn anecdotally where such drugs could be sourced, he did not inform himself as to the practices in NSW regarding when autopsies would be performed, and he did not acquire any anecdotal information about this process.

14.4 BX's medical records indicate that between August 2016 and August 2017, he saw three GPs: Dr Soper, Dr John Hart and Dr LC. Of these consultations, BX saw Dr LC on three occasions in 2017 prior to AX's death: 1 February 2017, 11 May 2017 and 20 June 2017. Dr LC gave evidence that he had a clear recollection of each consultation. Dr LC gave evidence that if the topic of euthanasia was raised during any of these consultations he would have recorded it in BX's medical record, although a philosophical discussion about euthanasia may not have been recorded. In evidence, Dr LC was asked whether any questions were posed to him by BX on a more general level about the practicalities of euthanasia, such as about drugs of euthanasia. Dr LC gave evidence that as he had no familiarity with such things it would have been better for him not to answer, and that in any event these issues were not discussed.

14.5 At around 1:30pm on 8 April 2019, Detective Senior Constable Prout (and another police officer) met Dr LC at [REDACTED]. Detective Senior Constable Prout prepared an Investigator's Note of the meeting which relevantly recorded the following:

> About 1:30pm that afternoon DSC PROUT and DSC COUGHLIN attended [REDACTED] and met with Dr LC. Dr LC appeared extremely nervous. He immediately requested a card from each detective and his hand shook as he wrote down the details.
>
> Dr LC was informed that an investigation was being conducted into the death of AX, her son BX was believed to be a patient of Dr LC's and that BX had seen Dr LC on days that were of significance to the investigation.
>
> Dr LC advised that following his phone call with DSC PROUT that morning, he had sought advice from a medical lawyer and been advised that due to patient / doctor confidentiality restrictions he could not provide any information to the police without a letter. The letter would need to outline the scope of the investigation and the reason why the information was required. Dr LC would send the letter to the lawyer who would then advise him whether he could divulge any information to police. DSC PROUT offered to write a letter in the presence of Dr LC so that he could speak to the lawyer straight away, but Dr LC refused the offer, saying he did not have time.

14.6 In evidence, Dr LC accepted that he was nervous during this meeting. He gave evidence that he had had a busy day, was struggling to get the information sought by police and was feeling quite anxious. When asked what made him nervous, Dr LC gave evidence that he felt that he had put the police to some trouble to see him, only for him to tell them that he was unable, after having sought legal advice, to provide the information that they were seeking.

14.7 Dr LC said that he could not recall whether his hand shook, or whether the police informed him they were investigating the circumstances of AX's death. He gave evidence that he had a memory of asking the police officers for a letter, but did not recall that the letter was to outline the scope and reason for the police request. Dr LC said that he told the police officers "*something along the lines"* that they needed a subpoena. He said that he could not recall indicating that such a letter would need to be sent to his lawyer. Initially, Dr LC said that he could not recall whether Detective Senior Constable Prout offered to write a letter in his presence, but later agreed that this was possible. Dr LC did not accept that it was possible he refused Detective Senior Constable Prout's offer and instead said that he felt that he could not release patient information without "*proper legal documents*".

14.8 On 23 April 2019, Detective Senior Constable Prout sent an email to Dr LC attaching a formal letter of request. Dr LC initially gave evidence that he did not recall receiving such an email with a letter attached to it. During a break in his oral evidence, Dr LC accessed his email account from his mobile phone and was able to confirm that the email had indeed been sent to him. However, he maintained that he had no recollection of seeing it. Dr LC agreed that he did not regularly receive emails from the police and that it was unusual to receive such an email. When asked whether this made it likely that he had read the email, Dr LC maintained that he had no recollection of seeing it.

14.9 Dr LC agreed that the letter indicated that AX's death was being investigated as a homicide. He said that if he had read this at the time he believed that he would have forwarded the letter to his medico-

legal advisory service. However, he acknowledged that he did not have any record that he had responded in this way.

14.10 Following her initial email of 23 April 2019, Detective Senior Constable Prout sent Dr LC a reminder email on 11 June 2019, asking him to confirm receipt and indicating when he would respond. On 17 June 2019, Dr LC sent Detective Senior Constable Prout an email apologising for missing her email and indicating that he would "*respond as soon as possible when I get the relevant advice*". On 18 June 2019, Dr LC sent Detective Senior Constable Prout a further email indicating that on legal advice he "*should only release patient information if the Police either obtain written authority from your [sic] patient or provide a warrant*". Dr LC apologised that he "*can't help further*".

14.11 Dr LC gave evidence that whilst he accepted that he sent the email responses to Detective Senior Constable Prout in June 2019, he had no recollection of seeing her original letter of April 2019 before sending these responses. When asked why this was the case when he had a clear recollection of his consultations with BX in 2017, Dr LC explained that he had his notes in front of him which enabled him to recall the relevant events. Dr LC gave evidence that when Detective Senior Constable Prout sent a follow-up email in June 2019, he went back to read the original letter of 23 April 2019. Dr LC accepted that he must have read at least part of the letter, but also gave evidence that he may have read all or only some of the letter but could not recall which parts of the letter he in fact read.

14.12 Dr LC also gave evidence that he recalled receiving by email a sufficient interest letter dated 6 February 2023 containing a link to a copy of the electronic brief of evidence and requesting that he provide a statement by 16 February 2023. Dr LC said that this prompted him to seek legal advice "*at least a couple of weeks*" later. When asked whether he regarded it as necessary to seek legal advice immediately, Dr LC gave evidence that he thought he had an "*extremely peripheral role*", and that he did not read the letter carefully enough to recognise its significance. Dr LC agreed that he had never received a letter of this kind before and said that he "*may not have*" sought legal advice by 16 February 2023. When asked why he did not provide the statement that was requested of him, Dr LC said that he was "*not good with paperwork*" and that he did not think that he had "*read the letter carefully enough*".

14.13 Dr LC eventually provided a statement on 27 March 2023, the day he was scheduled to give evidence. Dr LC denied that he waited until this date to provide a statement because he had a conversation with BX regarding euthanasia.

14.14 It should be noted that on 14 March 2018, ZY sent Detective Senior Constable Prout an email attaching a document which referred to having lunch with BX a few days after AX's death. During that lunch, ZY describes the following:

> BX announced he was going to see a doctor in Darlinghurst or Surry Hills (perhaps Taylor Square) for sleeping pills. BX had mentioned he has a personal relationship with this Doctor and went to see them when he needed stuff he couldn't talk to his family doctor about.

14.15 When describing the same event in both his draft and final signed statement, ZY stated that BX referred to going to see "*his doctor in Taylor Square or Darlinghurst for sleeping pills*". As noted above, when ZY described the comments BX made about "*his doctor*" during the Strand Meeting, ZY

did not nominate the location of the doctor. It has also already been noted above that ZY's memory of the conversations with BX regarding euthanasia is imperfect and not always consistent. However, again for the reasons set out above, it is accepted that his account is reliable. In particular, the differences mentioned by ZY regarding the location of BX's doctor are not so significant as to detract from the reliability of ZY's account.

14.16 Senior Counsel for Dr LC submitted that BX only saw Dr LC on one occasion (1 February 2017) before the White Rabbit Meeting, whereas he saw Dr Hart on an occasion (8 April 2017) more proximate to this meeting. However, the evidence establishes that BX appeared to have a relationship with Dr LC that was both social and professional, and not confined only to a clinical doctor-patient relationship. This suggests an increased likelihood that if BX were to seek information regarding euthanasia he would do so from a medical practitioner that he trusted.

14.17 **Conclusions:** Dr LC's evidence regarding his communication and correspondence with police was unconvincing. Dr LC initially said that he could not recall receiving the very letter that he asked Detective Senior Constable Prout to provide in April 2019 regarding the information she was seeking. It was only when Dr LC was asked to check his email inbox during his oral evidence that he was able to confirm receipt of the letter and email it was attached to. Even then, Dr LC maintained that he could not recall receiving the letter. This is despite Dr LC acknowledging that receipt of such an email from a police officer was an unusual occurrence. There, the submission made by Senior Counsel for Dr LC that Dr LC's evidence was "*clear and forthright and believable*" cannot be accepted in most respects.

14.18 In addition, Dr LC did not respond to Detective Senior Constable Prout's follow-up email for almost two months. Even then, Dr LC was hesitant to acknowledge that he had read Detective Senior Constable Prout's letter of request. When it was pointed out to Dr LC that the content of his reply emails suggested that he must have at least read some of the letter, Dr LC gave equivocal evidence as to what parts of the letter he may have actually read.

14.19 This apparent lack of care in dealing with a request from the NSWPF also appears to have affected the request made of Dr LC in February 2023 to provide a statement addressing identified parts of the brief of evidence where his possible involvement was raised. Despite Dr LC acknowledging that he had never received a sufficient interest letter before and that it was of some significance, Dr LC did not comply with the request to provide a statement until the day he gave evidence at the inquest some seven weeks later.

14.20 Whilst Dr LC was entitled to seek legal advice with respect to the request made of him by Detective Senior Constable Prout and the sufficient interest letter (and indeed the letter explicitly noted that he may wish to do so), Dr LC's conduct demonstrates an almost complete lack of engagement with the important requests made of him. Further, Dr LC's apparent inability to recall with any precision the repeated requests made by Detective Senior Constable Prout during 2019 is in stark contrast to his ability to recall with clarity his consultations with BX in 2017. Senior Counsel for Dr LC attributed this difference in recall to Dr LC's ability to refer to his own contemporaneous notes of his consultations with BX. However, even when confronted with contemporaneous correspondence (some being emails which he had himself authored), Dr LC's recollection was vague and contradictory.

14.21 Despite the unsatisfactory nature of Dr LC's evidence, this does not establish that AX was administered a drug of euthanasia, that the manner of AX's death was a result of unnatural causes or even that he and BX had a discussion regarding euthanasia. However, the overall nature of Dr LC's evidence is another matter to take into account when considering whether any competing cause of AX's death exists.

15. Contents of BX's laptop

15.1 Investigating police intercepted a phone call between BX and MG on 28 February 2019. MG had previously worked as a receptionist at BX's workplace and had a sexual relationship with BX between about 2016 and 2019. The relevant portion of the intercepted conversation is reproduced in full below:

> MG: Oh well, so… got into your computer.
> BX: Sorry?
> MG: I got into the computer.
> BX: Oh yeah.
> MG: Yeah
> BX: Can you be really, really careful about stuff in there please.
> MG: What do you mean?
> BX: Can you delete everything that you can?
> MG: I think you can reset it.
> BX: Okay. Um…
> MG: [?], what? I love marijuana, or something [laughs]. I was like, I don't know.
> BX: Oh, right. That's not the stuff I'm worried about. I'm worried about other stuff from way back.
> MG: I don't know what any of that is.
> BX: No, you don't. No, you don't but obviously like I was… I've… I've literally trusted you with my life, so. Um… in normal circumstances…
> MG: Well, I think as you should.
> BX: As you give the code like that to... to someone who… doesn't… you know?
> MG: If that doesn't say something then, hello?
> BX: What?
> MG: Well, I wouldn't have taken it if I couldn't have trusted you if I wasn't going to look after it.
> BX: I wouldn't have given it to you if I hadn't of trusted you completely, that's the point I'm making.
> MG: Well… you need to have a little more faith in me, I think. Stop calling me a sociopath.
> BX: They're different things. Trust and faith …
> MG: Can you please meet me on Tuesday?

15.2 MG gave evidence that the computer she referred to in the conversation was BX's laptop. She initially said that BX gave her the laptop so that one of her children could use it for school although she could not recall when this occurred. However, MG later gave evidence that she used the laptop at home for her children to watch movies and videos on. When asked about the current whereabouts of the laptop, MG said that she did not know where it was, or that it was broken or that it had been thrown in the bin. She gave evidence that she did not know when any of this might have occurred.

15.3 MG initially gave evidence that she did not use the laptop because she had her own laptop. However, she later said that the only *other* person who had used the laptop was her son who had maybe opened it. MG agreed that when BX said to be "*really careful*" during their phone conversation, she understood that this meant there were things on the laptop that her children should not see. MG gave evidence that she did not know what BX was talking about and reiterated she had never looked on the laptop.

15.4 MG was asked about her reference to "*I love marijuana or something*" during the phone conversation. She gave evidence that she thought she was making a joke about BX's code or

password. However, MG later gave evidence that her children were able to use the laptop and was asked whether this meant that the laptop did not have a code or password. MG initially said that she did not think there was a code or password, but later said that she could not recall whether this was the case.

15.5 MG also gave evidence that she did not delete any items from the laptop and did not know how to do so. When asked whether she had in fact deleted any emails from the laptop, MG said that the laptop was "*blank*" from what she could remember and that when her children used the laptop, it was "*empty*". However, MG later gave evidence that she saw some "*notes*" that BX's wife had on the laptop that related to "*general administrative stuff*". When this apparent inconsistency was pointed out to MG she said that she only looked on the laptop's desktop and saw that it was "*blank*". She said that she did not know what was on the laptop and did not care.

15.6 MG gave evidence that she did not know why she did not simply tell BX that the laptop was blank when he asked her to delete everything on it. When asked about her comment regarding resetting the computer, MG said that she assumed that this could be done, even though she did not know how to do it herself.

15.7 MG gave evidence that BX's comment about being worried about "*stuff from way back*" did not cause her any concern. MG gave evidence that she did not take BX seriously and that BX was "*always worried about everything*" so she did not pay attention to it. She said that BX's comment about trusting her with his life could mean anything, and that BX would say things like that to her to make her trust him and to "*manipulate*" her. She said that BX "*said stuff like that all the time*" and that he was "*dramatic*". She said that every conversation with BX was dramatic like that and that she did not pay any mind to it most of the time. She described BX as "*always having issues and drama in his life constantly*".

15.8 MG said that she was scared about giving evidence because she thought that BX is "*an angry person*". However, when asked whether this affected her evidence she said, "*No, I don't think so*".

15.9 **Conclusions:** MG's evidence was unconvincing. Most of her evidence was inconsistent and contradictory. She was unable to provide a coherent account as to the circumstances in which she received and later came to dispossess the laptop, what the laptop was used for, whether she inspected the contents of the laptop in any way, and whether she deleted any of the laptop's contents or reset it.

15.10 It can be inferred from the nature of the intercepted conversation between BX and MG that BX was concerned about the contents of the laptop being seen by another person to the extent that he requested MG to delete such contents. However, there is otherwise no evidence as to the exact nature of the contents of the laptop or whether they had anything to do with AX and euthanasia. Notwithstanding, the nature of MG's evidence raises a considerable degree of disquiet and is yet another factor to be taken into account when considering whether any competing cause of AX's death exists.

16. Financial matters relating to AX and BX

Forensic accounting analysis

16.1 Jessie-Ann Baldwin, a Chartered Accountant and Forensic Accounting Specialist with the NSWPF Forensic Accounting Unit was asked to analyse and interpret the financial records of AX, BX and FV in the period from 1 January 2012 to 31 December 2017.

16.2 Ms Baldwin relevantly identified the following information in relation to 11 accounts controlled and/or held in AX's name:

(a) these accounts had a total balance of $896.819.47 at 1 January 2012 and a total balance of $85,519.82 at the time of AX's death;

(b) between 30 June 2014 and 30 June 2015, AX's accounts decreased by $719,183.37 (a 79% decrease) from $914.428.75 to $195,245.38. This decrease was the result of AX entering into several investments through her Macquarie Pension and Super Consolidation accounts;

(c) AX's net financial position as at 1 January 2012 was $2.596 million. By 31 December 2017, this had decreased to $0.853 million;

(d) during the period from 1 January 2012 to 31 December 2017, 13 transactions totalling $584,600 were received from accounts controlled and/or held in BX's name;

(e) during the same period there were inter-account deposits, and corresponding withdrawals, between multiple accounts controlled and/or held in AX's name totalling $1,681,750.59;

(f) 558 transactions totalling $174,252.29 were withdrawn as either cash or cheque; and

(g) 28 transactions totalling $1,108,382.68 were paid to accounts controlled and/or held in BX's name, with approximately $300,000 transferred to BX in the first half of 2017 which was subsequently spent on travel and other personal expenses.

16.3 Ms Baldwin identified the following information in relation to 70 accounts controlled and/or held in BX's name during the period between 1 January 2012 and 31 December 2017:

(a) these accounts had a net bank account balance of -$1.442 million as at 1 January 2012, -$3.361 million at the time of AX's death (6 August 2017), and -$1.346 million at 31 December 2017;

(b) transactions totalling $1,108,382.68 were received from accounts controlled and/or held in AX's name;

(c) transactions totalling $589,600 were paid to accounts controlled and/or held in AX's name.

16.4 Ms Baldwin states that a summary of these bank accounts highlights the liquidity issues faced by BX given that for the financial years ending between 2012 and 2015, the total current liabilities exceeded

the total current assets. Ms Baldwin opined that this meant that BX "*had insufficient cash and/or cash equivalents to repay financial obligations as and when they fell due*".

16.5 In her oral evidence, Ms Baldwin explained that the above statement should be understood as being made with the assumption if all of BX's financial obligations should fall due. She explained that when considering BX's ability to repay financial obligations, it was also necessary to take into account further aspects of liquidity, such as the ability for shares to be sold or for any loans to be rolled over and refinanced. Ms Baldwin agreed that whilst these transactions would not amount to the difference in BX being in surplus or deficit, one could argue they represented contributing factors towards BX being able to meet his financial obligations.

16.6 Within the summary of incoming and outgoing transactions for accounts controlled and/or held in BX's name, Ms Baldwin further highlighted the calculated net cash movements. This is calculated as the difference between the total incoming (credit) transactions and total outgoing (debit) transactions. Ms Baldwin opined:

> Where the net cash movement is negative, BX incurred expenses greater than the income that was being earnt. This resulted in additional loan facilities or accounts being overdrawn to meet financial liabilities as they fell due. The net cash deficit calculated for BX further increases if transactions, both incoming and outgoing, with AX are excluded. This indicates that amounts received from AX were necessary to ensure that BX could continue to meet his financial obligations.

16.7 Ms Baldwin gave evidence that her conclusion was based on assets needing to be sold in order to maintain outgoings or facilities drawn upon to maintain BX's lifestyle. Ms Baldwin gave evidence that when the transactions controlled and/or held in AX's name were excluded, this had a detrimental effect on BX's financial position.

16.8 In evidence, Ms Baldwin accepted that there was the possibility of variability with some of her calculations. For example, she agreed that her calculations of the value of the Inner West property was based upon the recorded purchase price for the property and not market value. Ms Baldwin agreed that she had not factored in her calculations increases and decreases due to repairs, inflation or capital growth. When asked whether she may have underestimated the value of the property as at the end of the 2017 financial year, Ms Baldwin explained that she could have overestimated the value of the property depending on circumstances over which she did not have visibility.

16.9 Cassandra Michie is a partner at PricewaterhouseCoopers with a specialty in forensic accounting. She was asked to provide a report summarising any variances between the financial records provided by Rees Pritchard Pty Ltd (the accountants for BX and FV) and the opinions expressed by Ms Baldwin. Ms Michie calculated that there was a variance of less than 5% with respect to the calculations of the net financial positions for AX, BX and FV.

16.10 Ms Michie gave evidence that whilst the calculations performed by Ms Baldwin were mathematically correct, in order to assess the liquidity of BX's position she would need to take into account other matters which she did not have information about. By way of example, one such matter concerned whether shareholdings could be sold at short notice and the intention of parties as to whether they intended to trade within 12 months. Overall, Ms Michie gave evidence that she did not have enough

information to agree with whether or not the transactions received from AX's accounts contributed to BX's financial position.

16.11 However, Ms Michie went on to explain that the summary prepared by Ms Baldwin of BX's net financial position was relevant to cash flow rather than net current assets. She explained that the summary showed that the net cash flow for the 2017 financial year was negative. Ms Michie gave evidence that if a person had consistent negative cash outflow this would create a negative financial position if they were unable to borrow or liquidate current assets. In addition, Ms Michie explained that such negative cashflow would not be sustainable without sourcing income from other means.

Management of AX's financial affairs

16.12 The evidence establishes that by mid-2015, BX exercised complete control over AX's finances. By this time, AX's superannuation savings had been transferred to investment accounts with Credit Suisse and Macquarie. From these accounts, BX provided instructions for monthly transfers of $5000 to AX's credit union account for day-to-day expenses. However, by August 2016, these transfers ceased and funds were instead distributed to an account in BX's name. Thereafter irregular transfers were made from BX's account to AX's credit union account.

16.13 Correspondence between BX and FV confirms the nature of the control exercised by BX over AX's financial affairs. On the 27 August 2015, FV sent BX an email querying whether they needed to manage AX's "*money or accounts*". BX replied by indicating that he wanted to exercise such management, regardless of CX's views about the matter.

16.14 It is evident that AX deferred to BX regarding such management. For example, AX signed an Enduring Power of Attorney on 19 August 2015 appointing BX as Attorney. Three days later on 22 August 2015, AX signed a document jointly appointing BX and FV as Enduring Guardians. BX, FV, and a witness (William Fuggle, solicitor) also signed the document although there is an anomaly in that their signatures are dated 24 August 2015. Mr Fuggle explained that his recollection is that the document was "*pre-filled*" at the time that he signed it. In addition, the 2016 Will appointed BX and FV as executors and trustee. Whilst a handwriting examiner has verified that AX's signature is genuine, the 2016 Will contains several anomalies:

(a) RD, BX's personal secretary, stated that she is sure that she did not sign the document in the presence of AX and FV. Indeed, RD said that she never met AX;

(b) The document incorrectly describes AX as a solicitor;

(c) The document incorrectly refers to CX's surname as [REDACTED].

Further, CX was unaware of the 2016 Will until she was told by FV of its existence on 6 August 2017.

16.15 ZY gave evidence that at least by August 2016, it was difficult to obtain visibility regarding the amounts that were to be transferred to AX for her day-to-day expenses, and the regularity of these transfers. According to ZY, AX was concerned about having no money and the lack of visibility meant that he and CX were unable to provide her with any reassurance. ZY described that it was "*quite*

distressing" to see AX, who was "*completely together*", "*just panicking about being destitute for no reason*". ZY gave evidence that as far as he and CX knew, there was money available for AX but she simply could not access it.

16.16 On 13 June 2017, ZY sent BX an email describing AX as being "*incandescent about the money arrangements*" and indicating that he wanted to create a chart for AX that she could place on her fridge which provided her with information in clear and simple terms regarding the management of her finances. ZY gave evidence that at this time he observed AX to be "*incredibly angry*" and that he had never before seen her so angry. He also describes AX as "*not making sense, jumping from one thing to another*" and being "*very confused*" as to why this was happening to her. ZY gave evidence that he ultimately did not receive information from BX regarding AX's financial affairs and that no chart was created. In addition, CX instructed AK to draft a letter to BX seeking to formalise management of AX's financial affairs and requesting clarification of the nature of the financial arrangements which BX had instituted for AX. Ultimately, however, this letter was not sent.

16.17 **Conclusions:** The evidence establishes that by mid-2015, BX exercised control over AX's financial affairs. From this period until AX's death, AX expressed frustration and distress regarding her access to money and payment of day-to-day living expenses. Whilst CX and ZY sought to reassure AX by attempting to provide her with visibility regarding the nature of her finances, they were unable to obtain the necessary information from BX to do so.

16.18 The evidence also establishes that the forensic analysis that has been performed in relation to the accounts held and/or controlled in the names of BX and AX carries certain limitations. The ability of BX to meet financial obligations as and when they fell due depends in part on the ability to liquidise assets in the short term which cannot be accurately assessed. Further, the property values used as part of the forensic analysis created some degree of variance. In addition, it is not entirely clear whether the transactions received from AX's accounts contributed to BX's financial position. However, at the least, the forensic analysis establishes that a persistent negative cash outflow for BX from 2017 onwards posed a potential difficulty if he was unable to borrow, or liquidate current assets, and which was not sustainable without other sources of income.

16.19 Overall, it cannot be said that the evidence establishes any convincing financial motive relevant to the possibility that AX might have died as a result of euthanasia. Whilst BX had previously voiced an opinion regarding the cost of placing AX in nursing home care, the comments attributed to him by CX and ZY about this issue seem more concerned with AX's quality of life.

16.20 It could also be inferred that the increasing insistence of CX and ZY for greater visibility regarding AX's financial affairs might prove detrimental to BX given his management of AX's finances. However, it is not possible to determine whether AX's death would have exposed the nature of BX's management in a manner adverse to him, or whether the nature and degree of the control which he exercised would allow him, as joint executor, to distribute AX's estate without such scrutiny.

16.21 However, the increasing difficulties encountered by CX and ZY in their attempts to gain visibility over AX's finances, and AX's corresponding distress, indicates at least some degree of financial irregularity. When this is coupled with the anomalies identified in the 2016 Will and Enduring Power of Attorney and the potential difficulties faced by BX to meet his financial obligations, they raise additional layers of concern regarding consideration of any competing cause of AX's death.

17. Other circumstantial evidence

17.1 The following categories of circumstantial evidence are also to be taken into account when assessing the cause and manner of AX's death:

17.2 *First*, the evidence indicates that in the days leading up to AX's death, BX departed from his usual practice regarding contact with AX. It was well known to CX and ZY that BX and FV would typically have breakfast with AX every Sunday morning. However, BX went to AX's home on Friday, 4 August 2017 and reportedly brought something over for her to sign. BX saw AX again for dinner the following evening, and was the last person to see AX alive when he dropped her home after dinner.

17.3 *Second*, BX's conduct after arriving at AX's home on the morning of 6 August 2017 appears unusual. Although BX sent AX a text message earlier that morning to inform her that he was running late, he did not first attempt to call AX's mobile phone after presumably attempting to raise her (for example, by knocking on the door). Instead, BX called CX's mobile number, ZY's mobile number, and the landline for CX and ZY on two occasions. Eventually, BX called AX's mobile number, approximately eight minutes after his first call to CX.

17.4 *Third*, CX considers the circumstances in which AX was found to be unusual because:

(a) she had never seen AX drink wine in bed and stated that AX would regard such behaviour as "*slovenly*";

(b) she had also never seen AX use the crystal wine glass that was found resting in AX's hand on 6 August 2017, and that AX had previously described the glass as for "*best*";

(c) she described AX as not liking dessert wine because it was too sweet for her taste, in circumstances where the bottle of dessert wine found in AX's kitchen was approximately two thirds empty.

17.5 *Fourth*, there is conflicting evidence regarding whether BX raised an objection to an autopsy being performed for AX. Leading Senior Constable Spooner gave evidence that BX did not at any time on 6 August 2017 raise an objection to an autopsy being performed. This is supported by the P79A and DOFM file, both of which record there being no objection made by BX, as the senior next of kin.

17.6 In contrast, CX gave evidence that whilst at AX's house on 6 August 2017, BX said that he did not want an autopsy to be performed. According to CX, BX said that he was going to "*ring the Coroner*" and raise an objection due to his daughter being "*traumatised*". CX gave evidence that this conversation occurred with BX on the back deck at AX's house with no police officer being present. CX rejected a suggestion from Senior Counsel for BX that she only referred to the conversation on the back deck for the first time after hearing the evidence of Leading Senior Constable Spooner.

17.7 ZY gave evidence that BX raised an objection to an autopsy being performed whilst in the lounge room at AX's house on the 6 August 2017 when a "*senior [police] officer*" was present. When asked whether it was possible that BX had raised no such objection, given the contents of the P79A, ZY maintained that it was his recollection that such an objection was raised.

17.8 Given the conflicting accounts of CX and ZY, the evidence of Leading Senior Constable Spooner and the documentary material which notes no objection being raised by BX or any other family member, it is most likely that if any objection was voiced by BX it was not done in the presence of a police officer. That said, unlike the other categories of circumstantial evidence identified above, the issue regarding any objection to autopsy is not a matter which features in consideration of any competing cause for AX's death.

18. Medical evidence as to the cause of AX's death

18.1 The medical evidence in relation to the cause of AX's death falls into a number of discrete areas of medicine: cardiology, forensic pathology and toxicology. Each of these areas is dealt with in more detail below.

Relevance of hypertension

18.2 In his first report, Associate Professor Adams opined that the "*only definite cardiovascular problem that [AX] had was that of hypertension*". This can cause hypertensive heart disease and "*act as a major risk factor for coronary atherosclerosis leading to myocardial infarction and angina*", although AX did not have many other risk factors for coronary artery disease (such as diabetes, obesity, high cholesterol, smoking or family history). Associate Professor Adams explained that hypertensive heart disease first manifests as thickening of the left ventricular walls, known as left ventricular hypertrophy, due to the increased work required by the cardiac muscle. Overall, Associate Professor Adams considered that there is no good evidence that AX had either hypertensive heart disease or significant coronary artery disease, but indicated that it is not uncommon for sudden death to be the first manifestation of coronary artery disease in many people.

18.3 Associate Professor Adams explained generally that he would expect a person to have a history of hypertension for at least 12 months before developing hypertensive heart disease. Indeed, Associate Professor Adams noted that most of the patients that he sees with hypertensive heart disease have longer periods of known hypertension, often a decade or more. Associate Professor Adams also gave evidence that sometimes evidence of hypertensive heart disease is unknown until a person presents with heart failure, where the body's blood flow requirements outstrip the capacity of the heart to provide it. In other words, the heart is unable to pump enough blood because it is under too much stress.

18.4 Associate Professor Adams gave evidence that it was clear that AX had hypertension, which emerged in 2014 and possibly existed before this time. Given AX's age, Associate Professor Adams considered AX to have essential (or primary) hypertension, meaning that it was attributable to AX's age and lifestyle choices, rather than due to an underlying medical condition.

18.5 Associate Professor Adams noted that AX's blood pressure measurements in June and December 2016 were "*really good*" and within normal limits. Although AX had an elevated blood pressure reading in March 2017, Associate Professor Adams considered that this did not warrant any change in her prescribed medication, only reiteration of making certain lifestyle changes (such as reducing intake of salt and processed food and alcohol). Overall, Associate Professor Adams expressed difficulty, on the information available, in categorising where AX's hypertension would fall on a scale. However, he considered that she likely fit with stage II hypertension; that is, elevated but on treatment.

18.6 Associate Professor Adams gave evidence that AX's history of complaining of headaches could be due to a number of reasons, including episodes of high blood pressure. Associate Professor Adams also agreed that untreated hypertension with increased alcohol consumption could increase the risk

of developing a fatal arrhythmia, with the most common cause being myocardial ischaemia due to coronary artery disease. Associate Professor Adams explained that whilst cardiac enlargement is not a cause of arrhythmic death, an increase in heart size lowers the threshold for developing an arrythmia.

18.7 Associate Professor Adams gave evidence that AX did not appear to have any symptoms of coronary artery disease, other than the non-specific finding of coronary artery calcification seen on the PMCT. Associate Professor Adams noted that such calcification correlates well with coronary atherosclerosis, although the absence of calcification does not necessarily exclude it. Associate Professor Adams also noted that coronary atherosclerosis is common for persons over the age of 50, and often causes no symptoms or detrimental effects throughout life. However, Associate Professor Adams explained that myocardial infarction secondary to coronary artery disease is by far the most common cause of sudden, non-violent deaths of persons over the age of 35, and accounts for more than 70% of such deaths. Associate Professor Adams noted that AX had two relevant risk factors: her age and history of hypertension. However, Associate Professor Adams noted that whilst hypertensive heart disease makes an individual more vulnerable, it is not usually the absolute cause of death; rather it is usually coronary artery disease or heart failure.

18.8 Ultimately, in his report Associate Professor Adams expressed the following opinion:

> Of natural causes I think that the most likely cause of death is myocardial infarction causing a sudden fatal arrhythmia and that hypertension was a large contributing factor to this. This opinion is based simply on that being by far and away the most common cause of sudden death and those other natural causes such as stroke, massive bleeding, ruptured aorta, and pulmonary embolism would almost likely have caused changes on the post mortem CT scan.
>
> I cannot comment on the likelihood of the cause of death being unnatural as this is not within the area of my expertise.

18.9 **Conclusions:** The only definite cardiovascular condition that AX had was hypertension. There is no definitive clinical evidence that she had either hypertensive heart disease or coronary artery disease. There is no evidence that AX had left ventricular hypertrophy, which is typically the first manifestation of hypertensive heart disease. It is acknowledged that the first manifestation of hypertensive heart disease and coronary artery disease can be sudden cardiac death. However, given that AX's hypertension was identified in 2014 and that, according to Associate Professor Adams, it takes at least 12 months for hypertensive heart disease to develop, with most patients having known hypertension for at least 10 years before its development, this reduces the likelihood that AX had hypertensive heart disease at the time of her death.

18.10 Whilst Associate Professor Adams considered myocardial infarction secondary to coronary artery disease and hypertension to be the most likely cause of AX's death, this opinion is subject to two important qualifications. First, and most importantly, it is premised on AX's death being due to natural causes. Second, it is based on statistical probability rather than any demonstrable medical condition.

Interpretation of the post-mortem CT scan

18.11 Two questions which arise in relation to the PMCT are whether it demonstrates any finding supportive of cardiomegaly (an enlarged heart) or left ventricular hypertrophy. Dr Du Toit-Prinsloo expressed the view that the PMCT is "*not the most accurate modality*" to interpret heart size. Professor Cordner similarly indicated his agreement with this view. Notwithstanding, in evidence Dr Du Toit-Prinsloo deferred to the view of Dr Watkins and indicated that his view assisted in reinforcing her opinion of hypertensive heart disease as the cause of AX's death. However, it should be noted that Dr Du Toit-Prinsloo's view was qualified on the basis that AX died from natural causes.

18.12 Associate Professor Adams also noted some limitations in using PMCT to determine heart size but also deferred to Dr Watkins' interpretation. However, Associate Professor Adams explained that either magnetic resonance imaging (**MRI**) or echocardiography is the gold standard for determining cardiac size and that PMCT is inferior compared to these other modalities when determining cardiac size. In any event, Associate Professor Adams explained that a degree of cardiac enlargement for AX would not be surprising given her age and history of hypertension. In addition, Associate Professor Adams expressed the view that it would be difficult to assess whether AX had left ventricular hypertrophy from the PMCT scan alone.

18.13 In his report Dr Watkins stated that "*[a]ssessment of cardiomegaly (enlarged heart) on PMCT is possible however can be prone to post mortem artefact*". Dr Watkins went on to explain that measurement thresholds used in clinical medicine, such as the cardiothoracic ratio[4] (**CTR**), are not readily applicable to PMCT. Dr Watkins also noted that one academic study found that a CTR threshold of 0.57 can identify cardiomegaly with high specificity, with the CTR measurement of AX being 0.59. However, Dr Watkins noted that "*the utility of CTR in isolation to identify cardiomegaly has been questioned*".

18.14 In addition, Dr Watkins referred to another study which proposed an adjusted CTR-based score to predict cardiomegaly/cardiac hypertrophy on PMCT using a formula with reference to an individual's age, gender and body mass index in addition to the PMCT CTR. This produces a score with a cut off value of 32 or above for the diagnosis of cardiac hypertrophy. In AX's case, the adjusted CTR-based score was 33.73. Dr Watkins gave evidence that this was only "*just above*" the cut off value of 32.

18.15 Associate Professor Adams identified similar limitations in interpreting AX's cardiac size using CTR. He explained that CTR in assessing cardiac size in a patient during life is not accurate, "*particularly in determining what type of enlargement is present*". Notwithstanding, Associate Professor Adams considered that a degree of cardiac enlargement would not be surprising given AX's age and history of hypertension.

18.16 Dr Watkins gave evidence that on his initial assessment, AX's cardiac size looked enlarged. He explained that determining cardiac size can be challenging as enlargement may be a post-mortem artefact. However, when using measurements reported in literature to provide a more quantitative

[4] The ratio of the horizontal diameter of the heart to the maximum thoracic diameter measured on a posterior to anterior direction chest radiograph.

assessment, Dr Watkins explained that the thresholds described in literature were supportive, but not certain, of cardiac enlargement in AX's case. Dr Watkins agreed in evidence that there is scope for doubt given the potential for post-mortem artefact to affect cardiac size.

18.17 **Conclusions:** It is doubtful whether the PMCT demonstrates any finding consistent with cardiomegaly. This is due to PMCT not being the most accurate modality to interpret cardiac size, any such assessment being prone to post-mortem artefact, recognised limitations using CTR as a means of assessment, one formula of CTR assessment producing a result only marginally above the required threshold, and relevant academic literature being only supportive, rather than definitive, of cardiac enlargement.

18.18 There is therefore no clearly demonstrable evidence that AX had cardiomegaly. Even if a degree of cardiac enlargement was present in AX's case, this would not be surprising given her age and history of hypertension.

Evidence of possible injection sites

18.19 Dr Du Toit-Prinsloo gave evidence that she did not see any evidence in the P79A or medical material that would allow her to conclude that AX's death was due to poisoning. During her evidence, Senior Counsel for BX invited Dr Du Toit-Prinsloo to assume that an inexperienced person had injected an older person with a toxic substance in circumstances where the latter was not consenting. With this assumption in mind, Dr Du Toit-Prinsloo was asked whether she would expect to find evidence of any struggle. Dr Du Toit-Prinsloo gave evidence that this would depend on a number of circumstances that may exist with respect to a particular case:

(a) if a depressant had first been administered to the person being injected, then Dr Du Toit-Prinsloo noted that this would limit their ability to resist and reduce the likelihood of there being any injuries present;

(b) if alcohol had been used to sedate a person, then the level of sedation would depend on the individual's level of tolerance and ability to metabolise alcohol; and

(c) in the elderly population, bruises tend to remain for some time, therefore making them difficult to differentiate from a bruise which might have been sustained during a struggle.

18.20 Dr Du Toit-Prinsloo also agreed in evidence that suffocation may be used to prevent resistance from a person. She noted that this will depend on the degree of pressure applied, noting that in many cases signs of suffocation cannot be demonstrated at autopsy.

18.21 Overall, Dr Du Toit-Prinsloo agreed that from the available photos of AX and the scene there was nothing present to indicate that there was a non-natural contribution to her death. However, Dr Du Toit-Prinsloo agreed that the photos were limited in nature in that they did not show all areas of AX's body, noting that if an external examination had been performed at the DOFM photos of the body would have been taken from head to toe. Dr Du Toit-Prinsloo agreed in evidence that had this

occurred it would have allowed for greater confidence in expressing an opinion as to the presence or absence of things such as blood (from an injection) or defensive wounds.

18.22 In his report, Professor Cordner expressed the view that he was "*reasonably sure*" that needle marks and slight injuries on the neck "*which should not be there*" were not present in AX's case. When asked about this in evidence, Professor Cordner explained that the photos taken at AX's house showed that AX's hair was not disturbed, there were no visible injuries to the parts of the neck shown in the photos, and that there were no signs of blood smears or blood on her clothes. Taking this evidence in combination with what Professor Cordner described as an "*overall sense of a peaceful death scene*" led him to express the view that he was reasonably sure that no injuries or needle marks were present.

18.23 Professor Cordner gave evidence that "*we can be reasonably sure*" that there was no bandaging or covering up of any bleeding from an injection site. He noted that even if an injection site was located in an area of lividity, there was every possibility that there might be bleeding subsequent to an injection even if it had been thought that the bleeding had been stopped. However, Professor Cordner noted that whilst he could not rule out the possibility of a needle mark being present he did not consider it to be a reasonable possibility.

18.24 Senior Counsel for BX referred to the evidence that the attending police at AX's house had examined the whole of AX's body and not found any marks or injuries, apart from signs of lividity, and no vomit or spittle. Professor Cordner gave evidence that the extent of the police examination gave him a "*greater level of comfort*" that "*all signs point to*" AX's death being due to natural causes.

18.25 Professor Cordner expressed comfort in expressing the view that AX's death was most likely due to hypertensive heart disease, either with or without contribution from coronary artery disease. Indeed, Professor Cordner gave evidence that a pathologist would have greater confidence in 2023 than in 2017 that there was nothing to suggest "*anything untoward*" regarding AX's death. This is because, according to Professor Cordner, of having the benefit of seeing the police photos of AX and the scene at AX's house which depicted a "*calm, undisturbed death scene*". In expressing that view, Professor Cordner noted that the possibility of poisoning cannot be ruled out but that he was unable to attribute any weight to any such allegation in that regard.

18.26 Professor Cordner's views regarding a "*calm, undisturbed death scene*" and "*overall sense of a peaceful death scene*" are of limited utility in two important respects. *First*, as noted above, NSWPF officers, and NSWPF forensic investigators in general, approach a death scene with the view that a sudden unexpected death is the result of homicide, until proven otherwise. In this regard, NSWPF officers and forensic investigators are cognisant of the possibility that an actual homicide may be staged to appear to be due to natural causes.

18.27 *Second*, in his report, Associate Professor Roberts relevantly noted the following:

> In the case of Nembutal (pentobarbital), or in fact any drug in the barbiturate class, poisoning would most likely cause no specific clinical findings at autopsy for someone who is resting at the time of the poisoning, for example in bed as in the case of AX. This is because the mechanism of action of barbiturates involves sedation progressing to coma and cessation of breathing. There are also

varying degrees of low blood pressure depending on the barbiturate, for example blood pressure is lower from pentobarbital poisoning than phenobarbital poisoning. A person would 'die peacefully', as if they had just fallen asleep. This is one of the reasons that barbiturates are preferred for voluntary assisted suicide. Specifically, barbiturate poisoning may manifest in the manner that AX was found, but other drugs or poisons can appear similarly.

18.28 **Conclusions:** Both Dr Du Toit-Prinsloo and Professor Cordner opined that there is no clear evidence of any injection sites being identified on AX, or any clear evidence that another person injected her with a substance which caused her death. However, the evidence upon which these opinions are expressed is limited in a number of important respects.

18.29 *First*, Dr Du Toit-Prinsloo did not conduct an external examination of AX at the DOFM. This would have required authorisation from the Duty Coroner which was not provided. According to the Forensic Medicine Clinical Standard: Post-mortem Examination Definitions, such an examination would have involved "*[a]n examination of the external surface of the body including palpation and manipulation of the body*". It also would have involved taking head to toe photos of AX.

18.30 *Second*, whilst Dr Du Toit-Prinsloo and Professor Cordner were able to review photos taken of AX by attending police at AX's house, the evidence of Detective Sergeant Kremers and Superintendent Best is that the photos are inferior in quality to those that would have been taken if a CSSB investigator had attended the scene.

18.31 *Third*, Dr Du Toit-Prinsloo's evidence leaves open the possibility that sedation or suffocation might have been used before AX was injected with any substance. Relevantly, Dr Du Toit-Prinsloo noted that even if a post-mortem examination had been conducted it may not have been possible to demonstrate any findings consistent with suffocation and that any bruising found which might have indicated a struggle could be difficult to interpret given AX's age.

18.32 *Fourth*, Professor Cordner's reliance upon what he described as a "calm, undisturbed death scene" is equally consistent with an actual death due to natural causes, a homicide staged to appear as a death due to natural causes, and death following the administration of a drug of euthanasia.

18.33 The above matters should be weighed against the opinion expressed by Professor Cordner that he did not consider it a reasonable possibility that there was an injection site on AX's body. Overall, the evidence is simply too equivocal to arrive at any conclusion regarding the presence or absence of any injection site or whether AX was injected with a substance which caused her death.

Evidence of substance use or administration

18.34 Associate Professor Roberts explained that there are a wide range of poisons, with each "*inducing a potentially wide range of effects to the human body*". In this regard, the potential for such effects to be observed at autopsy depends on the poison ingested or administered. Associate Professor Roberts noted that "*many poisons can cause death with minimal observable signs on external review*" and that toxicology testing is required to identify any potential poisons. Overall, Associate

Professor Roberts opined that in AX's case, there are no post-mortem signs that either rule in or rule out poisoning.

18.35 Associate Professor Roberts indicated difficulty in commenting on what medications and toxic substances were available to the general public in 2017 "*due to rapid changes in the use of the Internet and darknet for purchasing such substances*". He gave evidence that most of the data that he is aware of relates to barbiturates being the most commonly used drug for inducing death. Associate Professor Roberts explained that the most common barbiturates are pentobarbital, phenobarbital and thiopentone. However, he considered it unlikely that thiopentone would be used as it is available for injection only and is short acting.

18.36 In his report, Associate Professor Roberts postulated two theories about the way in which AX might have been poisoned against her wishes by another person:

(a) A toxic substance being administered by injection. Associate Professor Roberts noted that for many poisons, the volume needed to cause death would be relatively large and would usually (with the exception of a substance such as insulin) require injection via an intravascular device. This would involve the cooperation of the person being injected and Associate Professor Roberts anticipated that if this had occurred in AX's case she would not have been found resting comfortably in bed. However, in evidence, Associate Professor Roberts acknowledged that in this scenario if sedation preceded injection it might account for a person being found in such a position.

(b) Poisoning by ingestion. This would require two considerations: the poison being hidden within a food or drink and the taste of the poison being masked, either with using a small volume of the poison or with the taste of the food or drink.

18.37 However, Associate Professor Roberts acknowledged in his oral evidence that both of these methods of administration were entirely speculative and that he did not know how either of these theoretical possibilities would be applied in practice.

18.38 From a radiological perspective, Dr Watkins explained that "*[g]enerally speaking, PMCT has limited utility in identifying changes specific to poisoning*". This is largely in part due to the fact that the "*radiological signs of poisoning will depend on several factors, and these may vary between different agents that cause the poisoning, however often no changes from poisoning are evident on radiological imaging*".

18.39 In AX's case, Dr Watkins noted that the PMCT showed heterogeneous density material in the stomach. However, "*it is not possible to reliably determine if this represents residue of ingested tablets and/or other ingested material*", such as food. Dr Watkins also noted the following:

> When tablets are undigested or partially digestive, they may result in layering of the tablet material in gastric fluid, however this is difficult to confidently separate from other ingested material, fluid or food. Digester tablets may also dissolve into the gastric fluid and disbursed through the lumen of the stomach or bowel or be absorbed rendering them undetectable.

18.40 Dr Watkins gave evidence that radiology was of limited utility in identifying whether there were any signs of poisoning present. Ultimately, Dr Watkins agreed that there was nothing to either include or exclude poisoning as the cause of AX's death or as a contributor to it. Dr Watkins explained that from a PMCT a finding of density in the stomach may give an indication as to whether a person has ingested a substance, but that it is very difficult to determine whether the substance is toxic and its degree of toxicity. Overall, Dr Watkins indicated that from the PMCT he was unable to see anything which either supported the possibility of poisoning or excluded it.

18.41 **Conclusions:** There is no clear evidence that AX was injected with any substance, or given a substance to ingest, the toxic effects of which caused her death. Importantly, the evidence of Associate Professor Roberts is unable to take the comments attributed to BX by CX and ZY about being able to source a drug of euthanasia and knowing how to use it, any further.

18.42 That said, the circumstances in which AX was found, the evidence gathered from the scene at AX's house and the PMCT findings do not rule in or rule out the possibility that AX died from the injection or ingestion of a toxic substance.

19. What was the cause and manner of AX's death?

19.1 Ultimately, Dr Du Toit-Prinsloo expressed the view that on the assumption that AX died from natural causes, the most probable cause of her death was hypertensive heart disease. This is the view which Dr Du Toit-Prinsloo formed in 2017 and which she adhered to in 2023. In this regard it should be noted that, as to the possibility of anything other than a natural cause of death, Dr Du Toit-Prinsloo based her opinion on the contents of the P79A which noted no suspicious circumstances. Dr Du Toit-Prinsloo did not have available to her all of the subsequent evidence gathered after 2017 during the coronial investigation.

19.2 Senior Counsel for BX submitted that significant weight should be placed on the opinion expressed by Professor Cordner in firstly agreeing with the opinion expressed by Dr Du Toit-Prinsloo above, and secondly, that both hypertensive heart disease and coronary artery disease can be substituted for one another, and that both are a reasonable cause of death for AX. In this regard, several matters should be noted about the opinions expressed by Professor Cordner in both his report and in his oral evidence.

19.3 There is no doubt that Professor Cordner possesses the requisite training and experience to express an opinion with respect to matters of forensic pathology. However, in his report Professor Cordner appeared to express opinions about matters that were not within his areas of expertise. This should be taken into account when considering the opinions expressed by Professor Cordner as a whole. In addition, his opinion is subject to the same important qualification that Dr Du Toit-Prinsloo's opinion is premised upon.

19.4 *First*, Professor Cordner appeared to express an opinion about the role, functions and decision-making of a CSSB Investigator or general duties NSWPF officers when attending a death scene. Professor Cordner said the following in his report:

> There may be criticism of the failure to impound the bottle of wine and/or the wine glass for forensic examination. This would be unfair in my view. There was no indication to do that at the time. Taking the bottle and glass as exhibits would only occur if there was a policy to require all apparent sudden unexpected natural deaths to be investigated as suspicious deaths. This is because the practical and logistical consequences of such a policy would be very significant in terms of the management of such exhibits.

19.5 These comments ignore the provisions of PSN 01/20 and the version of the NSWPF Handbook which were in force as at 6 August 2017. In addition, the evidence of both Detective Sergeant Kremers and Superintendent Best, who are more qualified to express opinions about examination of a death scene, contradict the comments of Professor Cordner.

19.6 *Second*, Professor Cordner appeared to express an opinion about the quality of the police investigation. Whilst there is no doubt that Professor Cordner has performed many post-mortem examinations in cases involving homicide, or suspected homicide, and is familiar with the way in which investigating police examine a death scene, his expertise does not extend to discrete matters of police investigation. In his report, Professor Cordner made the following comments:

> The P79A as completed in this case, and the overall police investigation in this case in my view are exemplary. They should be held up in police training as the standard to be achieved when police attend a sudden unexplained death. The description of the scene and related information is about 900 words – many times more than the norm in my experience.

19.7 To the extent that Professor Cordner appears to express an opinion about the quality of the police investigation in AX's case based upon the word count of the P79A, this should be rejected. It has already been explained above that the police investigation was inadequate in two respects in relation to examination of the scene at AX's house and contemporaneous note-taking.

19.8 *Third*, the letter of instruction to Professor Cordner indicates that he was briefed with mostly medical material contained within the brief of evidence: the statements of Dr Du Toit-Prinsloo, the DOFM file, AX's HCS, the statements and letters from AX's treating healthcare practitioners, and the reports of the various other experts engaged as part of the coronial investigation. In addition, Professor Cordner was briefed with the P79A, and the statements of the police officers and NSW Ambulance officers who attended AX's house on 6 August 2017. Relevantly, Professor Cordner was not provided with the statement of Detective Senior Constable Prout nor with the majority of the material contained in the brief, which was largely gathered and compiled by Detective Senior Constable Prout, which amounts to some 1900 pages.

19.9 As Professor Cordner noted, since 8 August 2017, the circumstances of AX's death "*have become more controversial*". In this regard, Professor Cordner recognised the following:

> It is not the pathologist's function to divine the truth of controversial circumstances except insofar as forensic knowledge might contribute to unravelling those circumstances. We do not have the American medical examiner system here. Unravelling those circumstances is the function of the coroner. It is, in my view, the strength of the coroners [sic] system (compared to, say, the medical examiner system) that where there are controversial circumstances all the power of a public inquest can be brought to bear to try and determine the issue. I would leave the cause of death untouched – that is, I would say that insufficient has changed for me to change the cause of death I gave in 2017; but I would say that knowing that I may not have all the evidence in the matter. And I would say that, also being able to say – as Dr Du Toit-Prinsloo has said – that I cannot, on forensic pathology grounds, rule out the possibility of poisoning. Having said that, there is no evidence that I can see to rule it in.

19.10 Two matters are of significance from the above:

(a) Professor Cordner correctly acknowledges that in expressing his opinion as to the cause of AX's death he did not have available to him all of the relevant evidence.

(b) The question of whether a competing cause of death for AX exists cannot be determined having regard only to the medical evidence, and opinions expressed by medical experts. Regard must equally be had to the significant body of non-medical evidence.

19.11 Senior Counsel for BX submitted that, consistent with the opinions expressed by Professor Cordner and Dr Du Toit-Prinsloo, a finding should be made that the cause of AX's death was hypertensive heart disease. It was further submitted that any other cause of death is speculative and not

referenced in the available evidence. Finally, it was submitted that there is no uncertainty based on the evidence that would allow for, essentially, an open finding to be made with respect to the cause and manner of AX's death.

19.12 However, on the medical evidence alone, there is some doubt about whether there is sufficient evidence to establish, on balance, that the cause of AX's death was hypertensive heart disease or, in the alternative, coronary artery disease. This is because:

(a) the only definitive cardiovascular condition that AX had was hypertension, with no definitive clinical evidence of either hypertensive heart disease or coronary artery disease;

(b) there is no definitive clinical evidence of left ventricular hypertrophy or cardiomegaly;

(c) the medical evidence does not support or exclude the possibility of there being an injection site on AX's body ;

(d) the medical evidence does not support or exclude the possibility that AX was injected with, or ingested, a toxic substance; and

(e) the opinions expressed about AX's cause of death rely significantly on statistical probability and the absence of a non-natural contribution to, or cause of, death.

19.13 The Non-Medical Evidence described above is not speculative, as submitted by Senior Counsel for BX, for the reasons already set out above. This body of evidence is sufficiently cogent to raise a competing cause of death, namely the administration of a toxic substance to AX, either by injection or ingestion. However, neither the medical evidence or the Non-Medical Evidence is sufficiently persuasive to allow for a conclusion to be reached that AX either died from natural causes, or that she died from a non-natural cause.

19.14 In this regard, it should be noted that it is not necessary to consider the issue of whether section 78 of the Act is enlivened. Indeed, at the conclusion of the evidence in the inquest an indication was given to Counsel that submission with respect to this issue was not required.

19.15 **Conclusions:** Having regard to the matters described above, the available evidence does not establish, on the balance of probabilities, the cause of AX's death. Therefore, a finding cannot be made as to the cause of AX's death. This in turn means that a finding also cannot be made as to the manner of AX's death, as the probability of death due to natural causes and a non-natural cause both remain reasonably open on the available evidence.

20. Are any recommendations necessary or desirable in connection with AX's death?

20.1 The letter of instruction to Professor Cordner posed a question which asked what recommendations Professor Cordner would make, if any, arising from his review of the evidence. In his response, Professor Cordner proposed a number of recommendations. Professor Cordner appropriately recognised a number of limitations with his recommendations:

(a) he is unfamiliar with, and has not reviewed, "*the specific detail operations of the [NSW] Department of Forensic Medicine/Coroners Court*";

(b) the recommendations which he proposed may therefore be "*redundant*"';

(c) the proposed recommendations "*are offered as food for thought for those responsible*"; and

(d) "*there are complexities in NSW associated with the management of death referred to coroners in rural areas, where there is not access to the same sort of facilities as are available in Sydney and the main regional cities*".

20.2 In addition, Professor Cordner gave evidence that whilst he is well placed to comment on forensic pathology practices in Victoria, he has no direct experience or familiarity with the operations of the DOFM or with the provisions of the Act apart from section 88. Further, the briefing material provided to Professor Cordner did not comprise any relevant policy, guideline or clinical standard issued by the DOFM or NSW Health Pathology.

20.3 Given the limited basis upon which Professor Cordner proposed his recommendations, it is arguable whether there is a sufficient basis to invite consideration of the exercise of the power provided for by section 82 of the Act. However, the investigation into AX's death conducted after 8 August 2017, and the inquest itself, identified several matters regarding post-mortem examinations in general, which warrant further consideration.

20.4 That is, if an external examination had been performed on AX, and if a blood sample had been taken and stored, the cause and manner of AX's death may have been sufficiently disclosed and the need for an inquest obviated. Beyond this case, these types of examination and investigation have implications for members of the community who, because of the reportable death of a family member or loved one, come into contact with the coronial jurisdiction. Answers about the questions of what caused a person's death, and what were the circumstances in which that person died, may be provided in a more timely manner. Further, the coronial process may be concluded more quickly, minimising the distress and trauma that comes with a prolonged coronial investigation and eventual inquest.

20.5 In this regard, Counsel Assisting submitted that the following recommendation is necessary or desirable:

> That the NSW Minister for Health and the relevant agency including but not limited to NSW Health Pathology give ongoing consideration to the utility of:
> (a) the taking and storage of a blood sample; and

(b) conducting an external examination and report thereon,
for each body admitted to a forensic medicine facility.

It is suggested that such consideration might also include consultation with the Office of the State Coroner including the State coroner and the Senior Coroners.

20.6 As noted above, section 88A of the Act already provides for a pathologist to carry out a preliminary examination in relation to a deceased person, which includes the taking of samples of bodily fluids including blood. However, Dr Isabella Brouwer, the former DOFM Clinical Director and Chief Forensic Pathologist noted the following:

> In theory therefore, a blood sample may be collected on all deaths referred to the Coroner in NSW. It is however unclear whether it would be legal or ethically acceptable clinical practice to take blood samples from all natural deaths where a MCCD or even a Coroner [sic] Certificate is issued without consent or consultation with senior next of kin and where the Coroner does not assume further jurisdiction on these matters.

20.7 There is some considerable force to Dr Brouwer's comments given:

(a) the provisions of section 88(1) and 88(2) of the Act;

(b) that many reportable deaths in NSW result in no post-mortem examination of any kind being conducted, with instead a MCCD being issued by a GP or a Coroner's Certificate being issued following consultation between a Duty Coroner and a Duty Pathologist;

(c) that the taking of a sample of bodily fluid is still regarded as an invasive examination; and

(d) that the taking of a sample of bodily fluid may be contrary to many culturally and religiously held beliefs of a senior next of kin and families of a deceased person.

20.8 In addition, there are logistical issues with both the taking of a sample of bodily fluid and the conduct and report of an external examination. Both require a deceased person being transported to a forensic medicine facility within NSW. Whilst reportable deaths within the Sydney metropolitan region result in the deceased person being transferred to the DOFM facility in Sydney, the same process does not occur in relation to reportable deaths occurring in rural and regional areas. This is because, as noted above, in many cases transfer of a deceased person to a forensic facility can be avoided if a MCCD or Coroner's Certificate are issued, and the cause and manner of the death is sufficiently disclosed in accordance with the requirements of section 27 of the Act.

20.9 Requiring the transfer of all deceased persons whose deaths are reportable to a forensic medicine facility in NSW so that a blood sample could be taken and an external examination be conducted would:

(a) as Dr Brouwer notes, be "*unnecessary and externally time-consuming*", "*place an unnecessary burden on the Coronial system*", and "*be counter-productive and against initiatives to improve timeliness of the coronial procedures*";

(b) cause unnecessary distress to bereaved families in transporting a loved one to, in many cases, a distant location away from a family's support network and requiring a family to travel some distance to allow for a post-mortem viewing to occur;

(c) cause further unnecessary distress to bereaved families by extending the timeframe within which a deceased person can be returned to their loved ones so that appropriate burial or cremation arrangements can be made in a timely manner, and in accordance with any culturally or religiously held beliefs.

20.10 Finally, there is an additional consideration regarding the proposed recommendation that an external examination be conducted, and reported on, in relation to every reportable death in NSW. Such an examination would require a direction given by the Duty Coroner pursuant to section 89(1) of the Act. Such a direction in the case of every reportable death in NSW would place similar burdens on the Coroner's Court of NSW and the Office of the State Coroner in discharging the functions and requirements of the Act in an efficient, timely and minimally invasive manner.

20.11 For completeness, consideration has also been given to a proposed recommendation by Professor Cordner regarding provision of an overnight rapid toxicology service. Professor Cordner appropriately recognises that whilst such a service would assist in making evidence-based decisions regarding the need for post-mortem examinations, it has "*resource implications*".

20.12 In this regard, Dr Santiago Vasquez, Operations Director of NSW Health Pathology, Forensic & Analytical Science Services notes the following:

(a) permanent technical and scientific staff above current staffing levels would be required in order to sustainably deliver an overnight rapid toxicology service;

(b) the onboarding and training of such additional staff would require 6 to 12 months to reach a suitable operational capacity;

(c) such a service would result in additional workloads for forensic pathologists in reviewing toxicology results on a daily basis; and

(d) transit times of samples from regional NSW forensic medicine facilities would not allow for an overnight service and instead create notable differences in rapid toxicology analysis times.

20.13 **Conclusions:** The recommendation proposed by Counsel Assisting is aspirational, well-intentioned, supported by the evidence in this particular case, and address broader considerations. These are all common features of robust and worthwhile recommendations. However, it is evident that there are practical, ethical, legal, cultural and religious considerations involved with the potential implementation of such a recommendation. It is not clear that its potential benefits outweigh the potential detrimental effects it would likely have on the coronial system more broadly, particularly where that system most directly interacts with bereaved families who have lost a loved one. For these reasons, it is neither necessary nor desirable to make any recommendations pursuant to section 82 of the Act.

21. Findings

21.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Sophie Callan SC and Ms Emma Sullivan, Counsel Assisting, and their instructing solicitors, Ms Bianca Holliday-O'Brien and Ms Alexis Mcshane from the Department of Communities & Justice, Legal. The Assisting Team has provided tremendous assistance during the conduct of the complex coronial investigation and throughout the course of the inquest. I am extremely grateful for their commitment and tireless efforts, and for the sensitivity that they have shown during all stages of the coronial process.

21.2 I also thank Detective Senior Constable Prout for her role in conducting a meticulous investigation in a professional and comprehensive manner.

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

Identity
The person who died was AX.

Date of death
AX died on 5 or 6 August 2017.

Place of death
AX died at Ashfield NSW 2131.

Cause of death
The available evidence does not allow for a finding to be made, on the balance of probabilities, as to the cause of AX's death.

Manner of death
As a finding cannot be made as to the cause of AX's death, the available evidence also does not allow for a finding to be made, on the balance of probabilities, as to the manner of AX's death.

21.4 On behalf of the Coroner's Court of New South Wales, I offer my sincere and respectful condolences, to AX's family and loved ones for their tragic and heartbreaking loss.

21.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
26 April 2023
Coroner's Court of New South Wales

Inquest into the death of AX

Annexure A

Non-Disclosure Orders

1. Disclosure of any information in relation to the coronial investigation or coronial proceedings which tends to identify the deceased, the Applicant and the Applicant's children (which necessarily includes members of the deceased's family) is prohibited, except for the following purposes:

   a) the conduct of any police investigation;

   b) police chain of command reporting in relation to the coronial investigation or coronial proceedings;

   c) to allow for solicitors representing an interested person in these proceedings to provide trust accounting records and documents to an approved external examiner or a trust account auditor or investigator from the NSW Law Society, as required, to comply with the *Legal Profession Uniform Law (NSW)* and the *Legal Profession Uniform General Rules 2015;*

   d) the making of any self-notification, disclosure or complaint to the NSW Legal Services Commissioner and/or the NSW Law Society regarding the conduct of any legal practitioner pursuant to the *Legal Profession Uniform Law (NSW)* and the exercise of any statutory functions by the NSW Legal Services Commissioner or the NSW Law Society in relation to any such self-notification, disclosure or complaint;

   e) the making of any self-notification or disclosure to the legal practitioner's professional indemnity insurer and disclosures required for the insurer to fulfill its contractual obligations in respect of any self-notification, disclosure or complaint to the NSW Legal Services Commissioner and/or the NSW Law Society; and

   f) allowing the legal practitioner to obtain legal advice and representation in respect of any such self-notification, disclosure or complaint to the NSW Legal Services Commissioner and/or the NSW Law Society.

2. Any party has liberty to restore to seek variation of these orders.

Magistrate Derek Lee
Deputy State Coroner
26 April 2023
Coroner's Court of New South Wales

Inquest into the death of AX

Annexure B

Non-Publication Orders

1. Disclosure of any information in relation to the coronial investigation or coronial proceedings which tends to identify Dr LC is prohibited, except for the following purposes:

   a) the conduct of any police investigation;

   b) police chain of command reporting in relation to the coronial investigation or coronial proceedings;

   c) allowing a sufficiently interested party to prepare for, and participate in, the coronial proceedings, including obtaining any necessary instructions and legal advice; and

   d) conducting the coronial proceedings by Deputy State Coroner Lee and those assisting his Honour.

2. Order 1 is to apply until the conclusion of the coronial proceedings, or until further order.

Magistrate Derek Lee
Deputy State Coroner
26 April 2023
Coroner's Court of New South Wales