CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Min Young CHOI
Hearing dates:	10 July 2025, NSW Coroners Court - Lidcombe
Date of findings:	10 July 2025
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Stuart Devine, Deputy State Coroner
Catchwords:	CORONIAL LAW – unascertained cause and manner of death.
File number:	2024 / 112377
Representation:	Advocate Assisting the inquest: Sgt Durand Welsh

Findings:

Identity of deceased:

Min Young CHOI

Date of death:

Between 17 March 2024 and 24 March 2024

Place of death:

15 / 11-19 Mandemar Avenue, HOMEBUSH WEST NSW 2140

Manner of death:

Unascertained

Cause of death:

Unascertained

Recommendations: Nil

Publication orders: Nil

FINDINGS

Introduction

1 This is an inquest into the death of Mr. Min Young CHOI (who I will refer to as Mr. Choi).

2 The primary purpose of an inquest is to make formal findings as to the following five aspects of a death pursuant to s81 of the Act: (1) the identity of the person who died, (2) the date they died, (3) the place they died, and what was (4) the cause and (5) the manner of that person's death.

3 A coronial investigation precedes an inquest. During the investigation evidence, in form of witness statements, expert opinions, reports, photographic evidence and more are obtained by, and provided to, the Coroner.

4 In the case of the investigation into Mr. Choi's death, a 1 volume brief of evidence complied by the Officer in Charge of the coronial investigation, Constable Minsik HWANG, was tendered to the Court and became Exhibit 1 at the inquest that was held at Lidcombe on 10 July 2025.

5 In addition to the brief prepared by Constable HWANG, I also heard brief oral evidence from him and from Dr Maistry, Forensic Pathologist, who prepared a post-mortem report on Mr. Choi.

6 It is important to stress at the outset that the length of this inquest and the number of witnesses being called, is in no way a reflection of the importance this court places on Mr. Choi's life. That is more accurately reflected in the preparation and investigations undertaken by police and other responsible parties in an attempt to find out what happened to him.

7 Although I will touch on aspects of this evidence that I consider important, and not make mention of other aspects, I have had the opportunity to consider the entirety of this material during the coronial process.

The Court's Obligations

8 Notwithstanding a thorough post-mortem examination, for reasons which will become clear, the manner and cause of Mr Choi's death have been sufficiently disclosed. Section 27(1)(d) of the *Coroners Act 2009* ("the Act") therefore mandates that an inquest be held.

9 Section 81(1) of the Act requires that when an inquest is held, the coroner must record in writing his or her findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.

The Assistance of Sgt Welsh

10 In relation to non-contentious factual matters and issues in these findings I have drawn from the opening submissions of the advocate assisting the inquest, Sgt Welsh. I am grateful for his considerable assistance in this regard.

Mr Choi's Background

11 The police brief reveals little about Mr Choi beyond the fact that he was a 42-year-old male who resided alone at 15/11-19 Mandemar Avenue, Homebush West, that he was of Korean nationality and that he had been unlawfully residing in Australia since 1998.

The Circumstances Leading to Death

12 11-19 Mandemar Avenue, Homebush West is a four-storey apartment complex. Unit 15 is located on the top level.

13 About 2:45pm on 24 March 2024, Constable Hwang and Constable Fatima Bitiktas attended Mr Choi's unit complex following a report of a foul odour emanating from the premises. The odour had been present for three or four days prior to police attendance.

14 Police made enquiries with the resident of unit 14, 11-19 Mandemar Avenue, who informed them that the resident of unit 15 was anti-social and worked

during the night. The resident of unit 14 had not seen the resident of unit 15 for a week.

15 The door to unit 15 was locked and NSW Fire and Rescue were contacted to obtain entry. Upon forced entry by Fire and Rescue, Mr. Choi was found lying on the living room floor, partially decomposed and discoloured. There were no visible wounds or weapons near him.

16 Constable Hwang and Constable Bitiktas conducted an initial search of the premises and found no medication or medical records belonging to Mr. Choi. The unit was in a state of disarray, with food bowls on the table but there no signs of a struggle or foul play. Mr. Choi was declared life extinct at 3:40pm by paramedic Chloe Pale.

17 There was no suicide note, and no suspicious circumstances were evident.

18 Constable HWANG gave evidence at the inquest. Over and above what is recorded in his statement he told the Court:

(1) There was no sign of forced entry, tampering or the involvement of any third party inside or outside Mr. Choi's unit.

(2) He had been made aware from Mr. Choi's family in Korea that Mr. Choi used cannabis. He did not, however, find any cannabis or implements for administering cannabis in Mr. Choi's unit.

(3) He had not found any mobile phone inside the unit.

(4) From the position in which he found Mr. Choi, he believes that Mr. Choi was standing inside his unit when he had a sudden and unexpected medical event that caused his death and that, as he fell to the ground, he hit his head on a sliding glass balcony door.

19 He confirmed that the last time Mr. Choi was seen alive was about a week before police attended Mr. Choi's unit and the last person to see him alive was the resident of Unit 14.

The Post-Mortem Examination

20 The post-mortem examination conducted by Dr. Maistry revealed extensive decomposition, including partial skeletonisation, post-mortem disarticulation of the joints, marked tissue loss, and maggot infestation. The body was cold to the touch, and rigor mortis was not present. Lividity was not discernible due to advanced decomposition. There was no evidence of acute trauma.

21 Post-mortem CT imaging showed no acute skeletal trauma.

22 On internal examination, there were autolysed remnants of brain tissue and the prostate gland. A layered anterior neck dissection showed no trauma to the neck structures. The brain was completely liquefied, and no structures were discernible. The thoracic cavity showed tissue defects to the right and left anterior and posterior chest walls, and the diaphragm was absent. The lungs, oesophagus, heart, and major bronchi were absent. The abdominal cavity contained maggots, and the stomach, small and large bowel, liver, spleen, pancreas, kidneys, adrenal glands, and testes were absent.

23 Toxicological analysis of muscle (psoas) detected paracetamol at a concentration of 10 mg/kg. The sample decomposition was noted, and results should be interpreted with caution.

24 Based on the circumstances surrounding his death, the post-mortem findings, and ancillary investigations, Dr. Maistry concluded the cause of death to be unascertained due to advanced decomposition.

25 In her oral evidence, Dr Maistry set out her qualifications and experience in forensic pathology. I accept she is an eminent forensic pathologist with enormous experience. She told the Court:

(1) There are many variables, and it is very difficult to predict when a person has died merely by looking at a body, especially where (as with Mr. Choi) the body is in a state of decomposition.

(2) Based solely on what she observed of Mr. Choi during autopsy (and with the caveat that it was highly speculative) she thought Mr. Choi may have been dead for several days or several weeks before her examination.

(3) A full body CT scan of Mr. Choi was performed so she could look for bone breaks or fractures, foreign projectiles or evidence of acute trauma that could cause death. There was no evidence of acute trauma to Mr. Choi that may have led to his death.

(4) Toxicology results showed paracetamol at 10 mg/kg. The only inference to be drawn from the level of paracetamol detected is that at some point Mr. Choi had taken paracetamol.

(5) No illicit or prescription drugs were detected in toxicology testing. That result could have been influenced by the fact there was no blood available for testing and thus the testing was performed on muscle tissue.

(6) Of the organs of the body, only autolyzed brain and prostate gland remains were present on autopsy. The prostate was unlikely to be the cause of Mr. Choi's death and there was no evidence of acute haemorrhage to Mr. Choi's brain that might explain his death.

(7) Given Mr. Choi's age (42 years), his male gender, and the absence of obvious trauma, the most likely natural cause of death tends to be cardiac disease and thereafter some underlying infection.

(8) She would normally give an opinion as to the cause of a person's death but the problem in Mr. Choi's case is that the autolyzed brain and prostate gland remains are not sufficient to express an opinion (although brain injury is somewhat less likely given the absence of haemorrhage).

Identification & Medical History

26 On the 29 March 2024, a photograph of the right middle finger and left palm of Mr. Choi were taken for identification purposes. Through those photographs, NSW Police identified Mr. Choi from filed fingerprints maintained at the New South Wales Police Force, Fingerprint Operations, Parramatta.

27 Investigating police were unable to identify any medical records or a treating general practitioner for Mr. Choi. The officer in charge's belief is that his immigration status may have interfered with him seeking medical services in the event of illness. His medical history is unknown.

Conclusions

28 Mr. Choi's identity, time and place of death are sufficiently disclosed on the evidence. I am not able to ascertain the cause of Mr. Choi's death.

29 The circumstances surrounding Mr. Choi's death do not indicate any suspicious activity. There were no signs of trauma or foul play and there is no evidence before me of any intention to self-harm.

30 Having said that, I am not able to determine the manner of his death. Critical to that conclusion is the fact that Mr. Choi's medical and personal history is unknown, there is a paucity of evidence on the circumstances leading up to his death and his cause of his death remains unascertained.

Concluding remarks

31 I will close by conveying to Mr. Choi's family my sympathy for their loss and thank the officer in charge, for his work in conducting the investigation and compiling the brief of evidence.

Statutory findings required by s 81(1)

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

Identity of deceased:

Min Young CHOI

Date of death:

Between 17 March 2024 and 24 March 2024

Place of death:

15/11-19 Mandemar Ave HOMEBUSH WEST NSW 2140

Manner of death:

Unascertained

Cause of death:

Unascertained

28 I close this inquest.

Magistrate S Devine
Deputy State Coroner
Lidcombe

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