SUPREME COURT OF QUEENSLAND

CITATION:	*Hytch v O'Connell* [2018] QSC 75
PARTIES:	**ROBERT PAUL HYTCH** (applicant) **v** **DAVID O'CONNELL** (respondent) **ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (intervener)
FILE NO:	BS No 8603 of 2016
DIVISION:	Trial Division
PROCEEDING:	Application for judicial review
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	18 April 2018
DELIVERED AT:	Brisbane
HEARING DATE:	19 March 2018
JUDGE:	Applegarth J
ORDER:	**The application for judicial review is dismissed**
CATCHWORDS:	ADMINISTRATIVE LAW – JUDICIAL REVIEW – REVIEWABLE DECISIONS AND CONDUCT – REVIEW OF PARTICULAR DECISIONS – APPLICATION FOR JUDICIAL REVIEW – where the applicant seeks a judicial review of a Coroner's findings that the applicant killed a missing person, then secreted her body and later disposed of it – whether findings liable to be set aside because of a lack of probative evidence STATUTES – ACTS OF PARLIAMENT – INTERPRETATION – GENERAL APPROACHES TO INTERPRETATION – where the applicant contends that an inquest was heard and determined under the *Coroners Act* 2003 (Qld) when it should have been conducted in accordance with the *Coroners Act* 1958 (Qld) – where the issue turns on the meaning of "death" in s 100(4) of the

Coroners Act 2003 (Qld) – whether "death" in that section should be read as "death or suspected death" or given its plain and ordinary meaning

Coroners Act 2003 (Qld) ss 3, 7, 11, 28, 45, 71, 100
Coroners Act 1958 (Qld) ss 7B, 41, 43
Judicial Review Act 1991 (Qld) ss 20(2)(e), 23(g).

Annetts v McCann (1990) 170 CLR 596 cited

Australian Broadcasting Tribunal v Bond (1990) 170 CLR 321 cited

Beale v O'Connell [2017] QSC 127 cited
Bermingham v Corrective Services Commission of NSW (1988) 15 NSWLR 292 cited
Briginshaw v Briginshaw (1938) 60 CLR 336 cited
Cody v J H Nelson Pty Ltd (1947) 74 CLR 629 cited

Crime and Misconduct Commission v Swindells [2009] QSC 409 cited
Fox v Percy (2003) 214 CLR 118 cited
Griffith University v Tang (2005) 221 CLR 99 cited

Helton v Allen (1940) 63 CLR 691 cited

Hurley v Clements [2010] 1 Qd R 215 cited
Leahy v Barnes [2013] QSC 226 cited
Marshall v Watson (1972) 124 CLR 640 cited

Minister for Immigration and Border Protection v Stretton (2016) 237 FCR 1 cited

Minister for Immigration and Citizenship v Li (2013) 249 CLR 332 cited

Minister for Immigration and Citizenship v SZMDS (2010) 240 CLR 611 cited

Minister for Immigration and Multicultural Affairs v Eshetu (1999) 197 CLR 611 cited
R v Atwell ex parte Julie [2002] 2 Qd R 367 cited
R v Hytch [2000] QCA 315 cited
R v The Central Cane Prices Board ex parte Colonial Sugar Refining Company Ltd [1917] St R Qd 1 referred to

Thomas v Attorney-General, Minister for Justice and Minister for Training and Skills [2017] QSC 308 cited

Waterford v The Commonwealth (1987) 163 CLR 54 cited

Wright v The State Coroner [2016] QSC 305 cited

COUNSEL: G R Rice QC and R W Haddrick for the applicant
E S Wilson QC and M T Hickey for the intervener

SOLICITORS: Ruddy Tomlins Baxter for the applicant
Crown Solicitor for the intervener

[1] In 1997 and early 1998, the applicant, then aged 24, and Rachel Antonio, then a 15 year old schoolgirl, had a clandestine, intimate relationship. By April 1998, the applicant had "moved on" and was in a relationship with another woman.

[2] Ms Antonio planned to meet the applicant at Queens Beach, Bowen on the evening of Saturday, 25 April 1998 to confront him about certain matters. She went to Queens Beach that night on the pretext of going to the movies, and waited to meet the applicant. She disappeared and was never seen again.

[3] Her disappearance was investigated by police, and suspicion fell on the applicant. Just before 7 pm that Saturday night he had left a birthday party, and could not satisfactorily explain his absence during a period of about 30 minutes. His absence during that period gave him an opportunity to meet Ms Antonio at the beach, and take her somewhere in his car.

[4] The circumstantial case that the applicant killed Ms Antonio went to a jury trial at which the applicant was convicted of manslaughter. Because of a misdirection to the jury, his conviction was set aside, and a new trial was ordered.[1] He was acquitted at the second trial.

[5] Investigations into Ms Antonio's suspected death continued, including hearings before the Queensland Crime Commission. In April 2013, the State Coroner directed the respondent, the Central Coroner, to investigate the suspected death. An inquest was held on various dates in 2014 and 2015. The Coroner considered a large number of witness statements, transcripts and other documents, and evaluated the credibility and reliability of the evidence of many witnesses, including the applicant. His findings, delivered on 28 July 2016, concluded that:

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[1] *R v Hytch* [2000] QCA 315.

1. Ms Antonio died shortly after 7 pm on 25 April 1998 as a result of an altercation with the applicant;

2. He then secreted her body; and

3. He later disposed of her body.

[6] In this judicial review proceeding the applicant seeks orders that those three findings be set aside. There are two limbs to his case.

[7] First, he argues that the inquest was heard and determined under the *Coroners Act* 2003 (Qld) when it should have been conducted in accordance with the *Coroners Act* 1958 (Qld). This argument turns on a point of statutory interpretation. The issue is whether the word "death" in s 100(4) of the 2003 Act has its ordinary meaning or whether it should be understood as if it read "death or suspected death".

[8] Second, he argues that the Coroner "erred in law" in making the three findings, or that those decisions were an improper exercise of power, because they were not supported by probative evidence. The three findings are said to be conjecture, not inferences of fact that were open on the available evidence.

I. The first limb of the applicant's case

Does the word "death" in s 100(4) of the *Coroners Act* 2003 have its ordinary meaning, or does it mean "death or suspected death"?

[9] Section 100 of the 2003 Act provides that the 1958 Act continues to apply to "a pre-commencement death". Section 100(4) states:

> "***pre-commencement death*** means a death—
>
> (a) that was reported to a police officer or coroner before the commencement of this section; or
>
> (b) in relation to which an inquest was held before the commencement of this section, but reopened after the commencement."

[10] There is no evidence that Ms Antonio's death, as distinct from her disappearance, was reported to the police or a coroner before s 100 commenced.

[11] The term "death" is not defined in the Act and therefore the word should be given its plain and ordinary meaning, unless the contrary is shown.[2]

[12] The applicant's argument that the inquest was heard and determined under the wrong Act requires additional words to be read into s 100(4) in the definition of "pre-commencement death". He argues that the section should be understood as if it reads:

> "***pre-commencement death*** means a death **or suspected death** …"

[13] The intervener contends that the section should be read in accordance with its plain and ordinary meaning.

[14] The parties' arguments require consideration of the terms of s 100(4) in their statutory context.

Statutory context

[15] The 2003 Act made significant changes to the coronial system. A principal object of the Act was to establish the position of the State Coroner.[3] The newly-established State Coroner's functions include the following:

> "(a) to oversee and coordinate the coronial system; and
>
> (b) to ensure the coronial system is administered and operated efficiently; and

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[2] Pearce & Geddes, *Statutory Interpretation in Australia*, 8th ed (2014) at 61-62 [2.24] ("Pearce & Geddes") citing *Cody v J H Nelson Pty Ltd* (1947) 74 CLR 629 at 647 and other authorities.

[3] *Coroners Act* 2003 (Qld) ("2003 Act") s 3(a).

(c) to ensure deaths reported to coroners that are reportable deaths are investigated to an appropriate extent; and

(d) to ensure an inquest is held if—

(i) the inquest is required to be held under this Act; or

(ii) it is in the public interest for the inquest to be held; and

(e) to be responsible, together with the Deputy State Coroner, for all investigations into deaths in custody; and

(f) to issue directions and guidelines about the investigation of deaths and for other matters under this Act; …"[4]

[16] Other objects of the 2003 Act were to:

- require the reporting of particular deaths;[5] and
- establish the procedures for investigations, including by holding inquests, by coroners into particular deaths.[6]

[17] Consistent with the object of requiring the reporting of particular deaths, Part 2 of the 2003 Act imposes an obligation upon certain persons, including a relevant service provider and a police officer who "becomes aware of a death that appears to be a reportable death".[7] Section 8 defines a "reportable death" and later sections define a "death in care", a "death in custody" and a "health care related death". The word "death" in this part would appear to have its ordinary meaning, and not the extended meaning contended for by the applicant.

[18] Part 3 of the Act is headed "Coroner's investigation, including by inquest, of deaths". Section 11 is important for present purposes and two aspects of it should be noted. The first is that s 11(2) is built upon the fact of a "reportable death". Simply stated, a coroner does not have a general power to investigate any death. A coroner must, and may only, investigate a death if the coroner considers the death is "a reportable death" and is not aware that any other coroner is investigating the death.[8] Also, a coroner must investigate "a death" if the State Coroner directs the coroner to investigate the death.[9]

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4 2003 Act, s 71(1)(a)-(f).

5 2003 Act, s 3(b).

6 Section 3(c).

7 Section 7(a).

8 Section 11(2).

9 Section 11(3).

[19] The second aspect is that ss 11(5) and (6) confers on the State Coroner power with respect to a "suspected death". An ordinary coroner does not have the general power to investigate a "suspected death". Suspected deaths are the province of the State Coroner, and the State Coroner may direct a coroner to investigate a suspected death if the conditions stated in s 11(6) are satisfied.

[20] It is appropriate to set out s 11 in full:

> "**11 Deaths to be investigated**
>
> (1) This section outlines—
>
> (a) the type of deaths that may be investigated under this Act; and
>
> (b) the type of coroner who conducts the investigations.
>
> (2) A coroner must, and may only, investigate a death if the coroner—
>
> (a) considers the death is a reportable death, whether or not the death was reported under section 7; and
>
> (b) is not aware that any other coroner is investigating the death.
>
> (3) Also, a coroner must investigate a death if the State Coroner directs the coroner to investigate the death.
>
> (4) The State Coroner may direct a coroner to investigate a death if—
>
> (a) the State Coroner considers the death is a reportable death; or
>
> (b) the State Coroner has been directed by the Minister to have the death investigated, whether or not the death is a reportable death.
>
> *Example—*
>
> The Minister might direct the State Coroner to investigate the death of a Queensland person that happened overseas, even though the death was investigated by a coroner overseas, if the Minister is concerned that the overseas investigation was not comprehensive enough.

(5) Also, a coroner must investigate the suspected death of a person if the State Coroner directs the coroner to investigate the suspected death.

(6) The State Coroner may direct a coroner to investigate a suspected death if—

(a) the State Coroner—

(i) suspects that the person is dead; and

(ii) considers the death is a reportable death; or

(b) the Minister directs the State Coroner to have the suspected death investigated.

(7) Despite subsection (2), a death in custody, or a death mentioned in section 8(3)(h) that is not also a death in custody, must be investigated by—

(a) the State Coroner; or

(b) the Deputy State Coroner; or

(c) an appointed coroner or local coroner, approved by the Governor in Council to investigate a particular death in custody, or a death mentioned in section 8(3)(h) that is not also a death in custody, or any death in custody, or a death mentioned in section 8(3)(h) that is not also a death in custody, on the recommendation of the Chief Magistrate in consultation with the State Coroner."

[21] It appears, according to their terms, that ss 11(2), (3), (4) and (7) require a "death", not a "suspected death".

Section 100

[22] Part 6 of the 2003 Act contains transitional provisions, including s 100 which states:

"**100 When repealed Act still applies**

(1) The *Coroners Act* 1958 continues to apply to the following, as if this Act had not been enacted—

(a) a pre-commencement death;

(b) a pre-commencement fire.

(2) However, despite subsection (1), this Act applies to—

(a) the release of an investigation document relating to a pre-commencement death or fire for research purposes; and

(b) the fees payable for the release of an investigation document for any purpose.

(3) For a pre-commencement death or pre-commencement fire, the State Coroner has the functions and powers of a coroner under the *Coroners Act* 1958.

(4) In this section—

investigation document includes a document obtained under the *Coroners Act* 1958 that is similar in nature to an investigation document as defined under this Act.

pre-commencement death means a death—

(a) that was reported to a police officer or coroner before the commencement of this section; or

(b) in relation to which an inquest was held before the commencement of this section, but reopened after the commencement.

pre-commencement fire means a fire in relation to which—

(a) a coroner formed the opinion, before the commencement of this section, that an inquest should be held; or

(b) the Minister has, before the commencement of this section, directed a coroner to hold an inquest; or

(c) a person who requested that an inquest into the fire be held had complied with the *Coroners Act* 1958, section 8(1)(c) before the commencement of this section."

The applicant's argument on the point of statutory construction

[23] The applicant submits that where the 2003 Act uses the word "death" then, unless something in the context suggests otherwise, it should be understood as referring to a "death or suspected death".

[24] His first argument is that the reference in s 3(c) of the Act to the object of establishing procedures for investigations by coroners into "particular deaths" should not be given a literal reading, and that it is hardly to be supposed that investigation of suspected deaths is excluded. So much may be accepted, however, the extent to which the Act provides for investigation into a "suspected death" is to be found in the detailed terms of the Act. As noted, the terms of the Act are to the general effect that coroners investigate actual

deaths, and reportable deaths in particular, whilst suspected deaths are considered by the State Coroner who may direct a coroner to investigate a suspected death if the State Coroner:

- suspects that the person is dead; and
- considers the death is a reportable death.[10]

[25] The applicant observes that s 11(1)(a) states that s 11 outlines:

(a) the *type of deaths* that may be investigated under the Act; and

(b) the type of coroner who conducts the investigations.

[26] The words of s 11(1)(a) do not compel the conclusion that a "suspected death" is a type of death. Section 11 does outline the type of deaths (including reportable deaths) that may be investigated under the Act. It does so in ss 11(2), (3), (4) and (7), and in each case outlines the type of coroner who conducts those investigations.

[27] If, however, ss 11(5) and (6) indicate that a suspected death is a type of death that may be the subject of an investigation, this means little more than that a suspected death may be investigated by the State Coroner, who may direct a coroner to investigate it. It does not detract from the general proposition that absent such a direction a coroner must, and may only, investigate "a death", and that in general the word "death" means what it says.

[28] The applicant notes a number of sections within Part 3 (dealing with investigations) in which the word "death" appears. These include sections dealing with a coroner's "powers of investigation", how a coroner may seek the help of a lawyer or another person during the investigation of a death, provisions about when an inquest must be held and pre-inquest conferences. The applicant argues that the use of the word "death" in those sections should be taken to include a "suspected death", otherwise there would be no machinery provisions for an investigation into a suspected death. Reading these sections as if they applied to a suspected death is said to better serve the object of the Act in s 3(c) which is to establish the procedures for investigations, including by holding inquests, by coroners into particular deaths. However, the applicant's arguments cannot explain why, if "death" should be taken to include a "suspected death", s 45(2) of the Act would provide that a coroner who is investigating "a death or suspected death" must, if possible, find five stated matters. The inclusion of the words "or suspected death" would be unnecessary if the applicant's argument about the meaning of "death" was correct.

[29] Moreover, it is not obvious that unless the word "death" is given the meaning for which the applicant contends there would be no process for an investigation into a suspected death. If a coroner is directed by the State Coroner to investigate a "suspected death",[11]

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[10] Section 11(6)(a)(i) and (ii).

[11] Sections 11(5) and (6).

as distinct from being directed to investigate a "death",[12] and concludes the person died, and that the death is a "reportable death", then the coroner must investigate the death and will enjoy the powers contained in Part 3. A duty to hold an inquest will exist if one of the matters contained in s 27 if satisfied. Otherwise, an inquest may be held into a reportable death if the coroner investigating the death is satisfied it is in the public interest to hold the inquest.[13] In my view, the interpretation for which the applicant contends is not necessary in order to permit the investigation, at the direction of the State Coroner, of a "suspected death" or the investigation of an actual death.

[30] If it be assumed, however, that the word "death" in some, but not all, sections in Part 2 and Part 3 has an extended meaning so as to include a "suspected death", the issue remains whether the word "death" in s 100 should have other than its ordinary meaning. Whilst a word or phrase in a statute is generally given the same meaning, this is only a presumption and applies most strongly when the words are used in the same section.[14] There may be reasons why a word or a phrase is given a different meaning due to the statutory context in which it appears.[15] In this regard, the relevant inquiry is into the use of the word "death" in a transitional provision, and it is in that particular context that the word must be interpreted.

Objections to the applicant's extended meaning of the word "death" in s 100(4)

[31] The interpretation for which the applicant contends is not compelled by the terms of s 100 or its context, including the use of the word "death" and "suspected death" in different sections of the Act. There are four substantial reasons for not accepting that interpretation.

[32] First, it is inconsistent with the plain and ordinary meaning of s 100.

[33] Second, it requires words to be read into legislation, which is a "strong thing"[16] to do, particularly where the reading of additional words into all or most of the sections of the 2003 Act in which the word "death" appears would have significant consequences. The duty to report would be expanded beyond "reportable deaths" to "reportable deaths and reportable suspected deaths". It would greatly expand the role of ordinary coroners. To alter the operation of the Act in such a significant regard might be regarded as a "usurpation of the legislative function under the thin disguise of interpretation".[17] In any event, in order to read words as if they contained additional words, the court must

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[12] Section 11(3).

[13] Section 28(1).

[14] Pearce & Geddes at 208 [4.6].

[15] See, for example, *R v The Central Cane Prices Board ex parte Colonial Sugar Refining Company Ltd* [1917] St R Qd 1 at 16.

[16] *R v Atwell ex parte Julie* [2002] 2 Qd R 367 at 373 [26] citing *Thompson v Goold & Co* [1910] AC 409 at 420; see Pearce & Geddes at 69 [2.32]-[2.33].

[17] *Marshall v Watson* (1972) 124 CLR 640 at 649 citing *Magor and St Mellens R.D.C. v Newport Corporation* [1952] AC 189 at 191.

be satisfied, among other things, that by inadvertence Parliament has overlooked an eventuality required to be dealt with if the purpose of the Act is to be achieved.[18]

[34] Whilst on occasions it may be permissible for a court to read words into a statute or to give words a "strained construction" in order to give effect to the presumed legislative intent, for example, where it is obvious that certain words have been omitted by inadvertence, this is not such a case. The legislature in establishing the position of the State Coroner to ensure the coronial system is administered and operated efficiently made clear in s 11 by whom reportable deaths and by whom suspected deaths are to be investigated. The system replaced the processes which applied under the 1958 Act whereby coroners might inquire in respect of missing persons. To read the word "death" in different sections of Part 2 and Part 3 of the 2003 Act as if it includes missing persons who are suspected to have died would alter the process by which the 2003 Act provides for investigations into actual deaths and investigations into suspected deaths.

[35] Third, it is not necessary to read the word "death" as it appears in s 100(4) and in other sections of the 2003 Act as if it reads "death or suspected death". The Act is workable without adopting such a strained interpretation. Suspected deaths (whether suspected to have occurred before or after the commencement of the 2003 Act, and whether or not reported before the commencement of that Act) are within the authority of the State Coroner. It is not as if the interpretation contended for by the applicant is necessary, lest suspected deaths be placed outside the scope for investigation under the 2003 Act. Suspected deaths may be subject to investigation by the State Coroner in the first instance who may then decide to direct a coroner to investigate the suspected death. Giving the statutory words their ordinary meaning is consistent with the Act's objective of having the State Coroner oversee and coordinate the coronial system and to ensure efficient investigations.

[36] The fact that some provisions of the 2003 Act would be able to operate if the word "death" was understood as if it read "death or suspected death" does not lead to the conclusion that the word "death" has this unusual meaning in each of those provisions, let alone in s 100(4). The Act is workable without adopting such a strained interpretation of the meaning of "death". If a coroner, at the direction of the State Coroner, is required to investigate a suspected death and concludes that a "suspected death" in fact happened, then the coroner is equipped with powers to investigate the actual death.

[37] A fourth and compelling reason to not read the word "death" in s 100(4) as if it reads "death or suspected death" is that such an interpretation would create uncertainty and unsatisfactory consequences. The suggested, additional words "and suspected death" beg this question: "Suspected by whom, and on the basis of what information?"

[38] One would expect the legislature to have enacted a reasonably certain basis upon which coroners, parties and other persons affected by the potential conduct of a coronial investigation would be able to determine whether the 1958 Act continues to apply. Reading the suggested words into s 100(4) would lead to controversies and uncertainties

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[18] *Bermingham v Corrective Services Commission of NSW* (1988) 15 NSWLR 292 at 302.

over whether something was a "suspected death" or not. For example, would the reporting of the fact that a person was unexpectedly missing be a "suspected death"? The answer to that question may depend upon the suspicions of the person making the report, the view taken by the person receiving the report or whether some objective bystander would have thought that the matter amounted to a "suspected death". Counsel for the applicant favoured the view that the characterisation of a matter as a "suspected death" would depend upon the appraisal of the information available by an objective observer. However, that involves the task of identifying with some precision the information that might be available. Whilst in some cases it may be apparent that one is dealing with a "suspected death", there would be many cases in which views would reasonably differ as to whether it was simply a missing person case. Even if the information which might be available to the hypothetical, objective observer could be identified with precision, whether or not that information gave rise to a "suspicious death" is a matter about which reasonable minds might readily differ.

[39] It is unlikely that the legislature intended the continuing application of the 1958 Act to be so uncertain, with unfortunate costs and consequences if a coroner reasonably but mistakenly concluded whether or not an objective bystander would assess an uncertain body of information to give rise to a "suspected death". A mistaken view on that contentious issue may invalidate an investigation under the wrong Act. It is more likely that the legislature intended the word "death" in the definition of "pre-commencement death" in s 100(4) to have its ordinary meaning, so as to avoid such consequences.

The intervener's argument about giving each part of the definition of "pre-commencement death" work to do

[40] A well-established principle of construction is that words and sentences are not to be treated as superfluous or insignificant, and that all words must, prima facie, be given some meaning and effect.[19] The intervener invites the Court to consider "what work there is to do for subparagraph (b) of the definition of 'pre-commencement death' in section 100(4) if 'death' is given the expanded meaning for which the applicant contends." According to the intervener, it is inconceivable that any death in relation to which an inquest was held before the commencement of s 100, but reopened after its commencement, would not also be one to which subparagraph (a) applies. It points out that such an inquest would have been one into a death that was reported to a police officer or coroner. The question is then posed as to what scenario is subparagraph (b) of the definition intended to respond?

[41] The intervener goes on to argue that the second part of the definition is apt to apply to a case in which a coroner has conducted an inquest into a "missing person" under the 1958 Act, and that, after the commencement of the 2003 Act, a missing person's body is discovered, such that there would then be known to have been a "death". In such a case the inquest into that "death" could be reopened after the commencement of the 2003 Act, but it would be obliged to be conducted under the 1958 Act.

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[19] See Pearce & Geddes at 62 – 63 [2.26].

[42] In my view, each part of the definition of "pre-commencement death" in s 100 has separate work to do. The first limb is apt to cover a case in which an actual death was reported to a police officer or coroner before 1 December 2003, but an inquest had not been held into the death before that date.

[43] The second limb of the definition might apply to a case in which an actual death was not reported, but in which there were inquiries by police and also a missing person inquiry undertaken by a coroner pursuant to s 10 of the 1958 Act into the cause and circumstances of the disappearance of the missing person. Those inquiries might lead the coroner to conclude that the missing person was dead, and to be of the opinion that the person died either a violent or unnatural death or in such circumstances as to require an inquest to be held.[20] Such an inquest would be into a "death", not a suspected death. However, it would not necessarily be the result of the report of "a death", as distinct from the report of a missing person, to a police officer or coroner.

[44] There may, of course, be cases in which an actual death is reported to a police officer or coroner before the commencement of s 100 of the 2003 Act, and in relation to which an inquest is held before the commencement date. Both limbs of the definition may be engaged in the same case. However, each limb has separate work to do if "death" is given its ordinary meaning. The intervener's argument, however, that the second part of the definition would have no work to do if "death" if given the expanded meaning for which the applicant contends is not persuasive. If the word "death" was given its expanded meaning, then the second part of the limb would apply to a case in which an actual death or suspected death was not reported, but police and coronial inquiries in relation to a missing person led to an inquest which was held before the commencement of s 100 of the 2003 Act.

Conclusion about the meaning of the word "death" in s 100(4) of the 2003 Act in its statutory context

[45] The word "death" in s 100(4) should be given its ordinary meaning, rather than the extended meaning contended for by the applicant so as to include a "suspected death". In summary:

1. The interpretation for which the applicant contends requires additional words to be read into legislation which is a particularly strong thing to do where reading those additional words would have significant, and apparently unintended, consequences. If the word "death" in the Act was interpreted to mean "death or suspected death" then the obligation to report contained in Part 2 of the Act would be significantly expanded, as would the ordinary jurisdiction of a coroner to investigate a "reportable death". If, however, the word "death" in Part 2 of the Act has its ordinary meaning but, on the applicant's case, an extended meaning in Part 3, then this means that "death" has a different meaning in different Parts of the 2003 Act, and the question remains as to whether it has its ordinary or an extended meaning in the definition in s 100 of "pre-commencement death", which appears in Part 6.

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[20] *Coroners Act* 1958 (Qld) reprint no. 3F ("1958 Act"), s 7B.

2. Part 2 of the 2003 Act has a workable operation if "death" is given its ordinary meaning. It also is not necessary to give the word "death" an extended or strained meaning in order for Part 3 of the Act to operate in accordance with the purposes of the Act. The 2003 Act works if the word "death" is given its ordinary meaning in Part 2 and Part 3. Such an interpretation permits an actual death to be investigated in accordance with the processes established by the 2003 Act and for a "suspected death" to be investigated in accordance with ss 11(5) and (6) of the 2003 Act.

3. The interpretation for which the applicant contends cannot satisfactorily explain the appearance of the words "a death or suspected death" in s 45(2). If "death" included "suspected death", the words "or suspected death" in s 45(2) would be unnecessary. The legislature chose not to use the words "a death or suspected death" in s 100(4), whereas it used those words in s 45.

4. Even if it be assumed that the word "death" in some of the sections contained in Part 3 has an extended meaning so as to include a "suspected death", this does not necessarily determine the meaning of "death" in s 100: a transitional provision in a different part of the Act which has a different purpose. The definition in s 100(4) is workable if "death" is given its ordinary meaning.

5. Reading the words "suspected death" into the definition in s 100(4) would create uncertainty and unsatisfactory consequences. It is unlikely that the legislature intended this. It is more likely that it intended the word "death" in the definition "pre-commencement death" in s 100(4) to have its ordinary meaning, so as to avoid such consequences.

[46] In conclusion, the arguments in favour of an unusual and extended meaning of "death" in s 100(4) are unpersuasive. An interpretation which gives the word "death" in that statutory context its ordinary meaning best serves the objects of the Act and the apparent intention of the legislature in enacting s 100 of the 2003 Act.

Extrinsic material

[47] I do not regard the word "death" in s 100(4) as ambiguous, and it is not necessary to refer to extrinsic material to resolve the question of interpretation. I shall, however, briefly address the parties' submissions which referred to extrinsic material. The material includes notes on the introduction of the *Coroners Bill* 2002 and notes that accompanied the Bill's third reading. The introductory notes relevantly noted in respect of the clause which was to become s 11 of the Act that the "suspected death" category replaces s 9 ("inquiry when body destroyed or irrecoverable") and s 10 ("inquiries respecting missing persons") of the 1958 Act. The intervener submits that these materials suggest that ss 11(5) and (6) of the 2003 Act were intended to replace ss 9 and 10 of the 1958 Act. The legislature specifically turned its mind to the operation of the Act on "suspected deaths" in certain circumstances by enacting ss 11(5) and (6), and chose not to refer at all to a "pre-commencement suspected death" in enacting s 100.

[48] The applicant's submissions in reply refer to the third reading of the Bill and amendments introduced by the then Attorney-General during the committee phase. One amendment inserted what became s 100(3) of the 2003 Act which provides:

> "(3) For a pre-commencement death or pre-commencement fire, the State Coroner has the functions and powers of a coroner under the *Coroners Act* 1958."

The then Attorney explained that this amendment would allow the State Coroner to continue an inquiry "under the existing law which he or she may have started prior to the commencement of the new Act". This was because, as a result of the amendment, the functions of the State Coroner under cl 70 of the Bill (which became s 71 of the Act) "will now specifically include functions under the *Coroners Act* 1958".[21]

[49] As the applicant's reply submissions point out, the legislature intended by s 100(3) that the newly-established State Coroner would have the power to continue an inquiry commenced under the 1958 Act which otherwise could only be exercised by a Coroner under that legislation. He submits that an "inquiry under the existing law" would include a missing person's inquiry under s 10 of the 1958 Act. According to the applicant, it is reasonable to conclude that the defined expression "pre-commencement death" s 100(4) of the 2003 Act was meant to include cases of suspected deaths, or missing persons who it was suspected had died.

[50] I doubt whether the extrinsic material illuminates the present issue of statutory construction. As earlier discussed, s 100(4) of the 2003 Act has a sensible operation if the word "death" is given its ordinary meaning. It would permit the State Coroner to continue to investigate a case in which a person who had disappeared had been the subject of a missing persons inquiry held by a coroner under s 10 of the 1958 Act. The State Coroner would be permitted to continue that investigation by virtue of ss 11(5) and (6) if the case was one of a "suspected death". If, however, what had commenced as a missing persons inquiry under s 10 culminated in the conclusion that an actual death had occurred, then s 7 of the 1958 Act permitted an inquiry by a coroner into that death, and s 7B of the 1958 Act permitted the coroner to hold an inquest into such a death if the coroner had reasonable cause to suspect that the person had died either a violent or unnatural death or that the person had died in such circumstances as to require an inquest to be held. In such a case the inquiry being undertaken by a coroner or the inquest being held by the coroner under the 1958 Act would be in relation to a "death". The introduction of what became s 100(3) permitted the newly-established State Coroner to undertake the functions and power of a coroner under the 1958 Act in such a case.

[51] In my view, the extrinsic material does not require the extended definition of "death" for which the application contends to be adopted. This extrinsic material certainly does not suggest that the legislature intended the word "death" in what became s 100(4) of the Act to have the extended meaning for which the applicant contends with its potential for contention and uncertainty over whether something was a "suspected death" or not.

Application of the definition in s 100(4) to the facts of this case

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[21] *Hansard*, *Queensland Parliamentary Debates*, 1 April 2003, pp 1070-1071.

[52] The applicant does not assert that Rachel Antonio is dead and that her actual death (as distinct from her suspected death) was reported to a police officer before the commencement of s 100 of the 2003 Act. The applicant's argument that the inquest was heard and determined under the wrong Act depends upon acceptance of the interpretation of s 100(4) which I have rejected. For completeness, I should mention some factual matters as to whether the applicant's argument would have prevailed, had I adopted the interpretation for which he contends.

[53] Rachel Antonio went missing on the night of 25 April 1998. Her mother reported her "missing" at about 9.20 am on 26 April 1998. There is no evidence that her actual death was reported to police. Instead, the report that she was missing prompted searches for her and a police investigation, in the course of which suspicion fell upon the applicant. None of this means, and the applicant does not contend, that her "death" was "reported" to a police officer or coroner before the commencement of the 2003 Act.

[54] Even if, in context, what was reported as a missing person case aroused suspicions and the suspicion of her possible death, the 1958 Act is not engaged when a police investigation becomes one into a suspected death. The first limb of the definition of "pre-commencement death" in the 2003 Act requires a "death" to be reported to a police officer, not for a death or suspected death to become the subject of a police investigation after someone is simply reported to be missing.

[55] If I had concluded that the word "death" in s 100(4) extends to a "suspected death", the applicant has not proven that a "suspected death" was reported. In a case in which a party seeks to demonstrate the absence of power, and seeks to prove that a "suspected death" was reported to police so that, on his argument, the 1958 Act applies, the fact which is alleged to engage the 1958 Act must be proven. This proceeding has had a lengthy interlocutory course, having been filed in August 2016. The applicant asserts that "the disappearance and suspected death of Rachel was reported to police in Bowen soon after her disappearance in 1998." However, this submission is not supported by evidence, and when this point was taken by the intervener in written submissions, the applicant's submissions in reply did not address the point.

[56] The evidence before me indicates that Ms Antonio's disappearance was reported to police and that thereafter the police conducted an investigation which led them to suspect that she was dead. This does not mean that either her death or her suspected death was "reported to police". Therefore, if "pre-commencement death" in s 100(4) has the interpretation for which the applicant contends, there is an inadequate factual basis to conclude that Ms Antonio's "suspected death" (as distinct from her disappearance) was "reported to a police officer or coroner" before the commencement of s 100 of the 2003 Act.

Arguments about whether conduct of the inquest under the wrong Act would have resulted in invalidity

[57] My conclusion that the coroner did not hear and determine the matter under the wrong Act makes it unnecessary to decide alternative arguments that the powers which he purported to exercise were available to him under the 1958 Act and that the impugned findings would not be set aside. Therefore, I need not review the authorities about the

circumstances in which a decision-maker's determination will be unaffected by a mistake as to the source of power. It is sufficient to make some brief observations.

[58] As previously noted, the 2003 Act introduced significant changes into the conduct of the coronial system. The 1958 Act permitted a coroner holding an inquest to order that a person be committed to stand trial in certain situations.[22] The 2003 Act does not permit a coroner to commit people to stand trial. There are different provisions in relation to privilege against self-incrimination.[23] It is unnecessary to survey all of the differences. It might be said that, notwithstanding the significant differences between the provisions of the 1958 Act and the 2003 Act, the essential function of a coroner conducting an inquest into a death is to make findings into when, where, and how the deceased came to die.[24] On this basis, there is a substantial argument that even if the coroner had incorrectly purported to act under the 2003 Act instead of the repealed 1958 Act, the process of his investigation and the conduct of the inquest would have been directed to the same matter, namely the circumstances under which Ms Antonio died. If the 1958 Act had applied, then much would have depended upon when the investigation and the inquest ceased to be one into a "missing person" and became an inquiry or an inquest into a death. This would have had implications for the availability of the privilege against self-incrimination. As presently advised, I am not persuaded that the process of fact finding or the coroner's conclusions on the matters which are in contest on this application would have been substantially different.

Conclusion on the first limb of the applicant's case

[59] The applicant has failed to establish that the impugned findings of fact involved an error of law because the coronial inquest was heard and determined pursuant to the 2003 Act, rather than the 1958 Act.

II. The second limb of the applicant's case

[60] The applicant seeks judicial review of three findings or decisions of the Coroner:

(a) That Rachel Antonio died shortly after 7 pm on 25 April 1998 as a result of an altercation with the applicant in which she suffered an injury or injuries;[25]

(b) That the applicant then secreted her body;[26] and

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[22] 1958 Act, s 41.

[23] In *Wright v The State Coroner* [2016] QSC 305, Henry J explained how the 1958 Act abrogated the privilege against self-incrimination in s 10 (missing persons) inquiries about s 10 topics.

[24] See 1958 Act, s 43(2); 2003 Act, s 45(2).

[25] Inquest into the death of Rachel Antonio <www.courts.qld.gov.au/__data/assets/pdf_file/0005/476843/cif-antonio-r-20160728.pdf > ("Coroner's Reasons") [123], [147].

[26] Coroner's Reasons [123].

(c) That the applicant later disposed of her body.[27]

Judicial review of findings of fact

[61] Judicial review does not review the merits of a decision. It is not a proceeding in the nature of an appeal, such as an appeal by way of rehearing from one court to an appellate court. In essence, it concerns the legality of a decision which is amenable to judicial review. The scope for judicial review of a finding of fact is "very narrow".[28] Judicial review of findings of fact is subject to demanding requirements if a challenge is to succeed. It is not sufficient that the decision is unreasonable in the sense of being against the overwhelming weight of the evidence. It must be perverse or capricious, for instance, because there was no probative evidence to support it.[29]

[62] A decision or the process of reasoning by which it is reached is sometimes described as "illogical" or "unreasonable" or even "so unreasonable that no reasonable person could adopt it". However, these descriptions are sometimes merely emphatic ways of saying that the wrong decision was reached.[30] A decision which no rational or logical decision-maker could arrive at on the available evidence may be properly described as "illogical" or "irrational". The starting point remains, however, that there is "no error of law simply in making a wrong finding of fact".[31] Instead, a finding or inference of fact will be amenable to judicial review if there is no probative evidence to support it.[32]

[63] An application for judicial review of a Coroner's decision is not to be confused with the statutory process provided for in s 50 of the *Coroners Act* 2003 by which a person dissatisfied with a finding at an inquest may apply to the State Coroner or District Court to set aside the finding.[33]

[64] In this matter, the applicant contends that each of the three challenged findings is a "decision" which is amenable to judicial review under the *Judicial Review Act 1991* (Qld) ("*JRA*"), being a decision of "an administrative character under an enactment". The respondent concedes this and also accepts that the applicant is a "person aggrieved". A Coroner's finding that a person killed the deceased is plainly likely to affect adversely the interests of the person in respect of whom such a finding was made, "even if that person is not committed for trial and the finding is not framed in such a

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27 Coroner's Reasons [124].

28 *Thomas v Attorney-General, Minister for Justice and Minister for Training and Skills* [2017] QSC 308 at 22 [51].

29 *Crime and Misconduct Commission v Swindells* [2009] QSC 409 at [12].

30 *Minister for Immigration and Multicultural Affairs v Eshetu* (1999) 197 CLR 611 at 626 [40].

31 *Waterford v The Commonwealth* (1987) 163 CLR 54 at 77.

32 *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321 at 359-360.

33 As to which see *Hurley v Clements* [2010] 1 Qd R 215.

way as to appear to determine any question of civil liability or guilt of an offence".[34] However, in the context of the *JRA*, the word "decision" has a "relatively limited field of operation".[35] It has been said that in general terms a decision must be one that has the quality of "affecting legal rights and obligations".[36] Whilst findings of the kind made in this application are apt to affect a person adversely in his or her reputation and thereby adversely affect his or her interests, the decision is unlike a decision to commit a party to stand trial on a charge of unlawful killing.[37] Nevertheless, the amenability of each of the decisions to judicial review under the Act having not been contested, I am prepared to proceed on the basis that the Court has jurisdiction to entertain the application for judicial review.

[65] When judicially reviewing each decision, the Court is not engaged in some general review of the three findings, let alone subsidiary factual findings made in the course of the Coroner's Reasons. An application for judicial review is not the occasion to substitute assessments of credibility and reliability, or to conduct a rehearing in order to determine whether a finding was against the weight of the evidence. Even in the context of an appeal by way of rehearing, the Court recognises the advantages enjoyed by the decision-maker. The limitations that affect an appellate court in proceeding wholly or substantially on the record of the proceeding at first instance include:

> "… the disadvantage that the appellate court has when compared with the trial judge in respect of the evaluation of witnesses' credibility and of the 'feeling' of a case which an appellate court, reading the transcript, cannot always fully share. Furthermore, the appellate court does not typically get taken to, or read, all of the evidence taken at the trial. Commonly, the trial judge therefore has advantages that derive from the obligation at trial to receive and consider the entirety of the evidence and the opportunity, normally over a longer interval, to reflect upon that evidence and to draw conclusions from it, viewed as a whole."[38]

[66] A similar disadvantage applies in a case such as this in which findings of fact depend on evaluations of the credibility and reliability of numerous witnesses. In this matter the inquest occupied 12 hearing days. The inquest was presented with 367 witness statements, more than 2,600 pages of court transcripts from prior proceedings, seven recorded interviews with the police, four days of Queensland Crime and Commission hearings and the examination of 60 witnesses. The Coroner had an opportunity over the lengthy period when evidence was given to reflect upon it. His reasons indicate that he carefully considered the evidence and provided substantial reasons for his conclusions. I should add that the information which the Coroner was required to analyse included

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[34] *Annetts v McCann* (1990) 170 CLR 596 at 608; and see *Beale v O'Connell* [2017] QSC 127 at [45] – [46].

[35] *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321 at 336.

[36] *Griffith University v Tang* (2005) 221 CLR 99 at 128 [80].

[37] cf *Leahy v Barnes* [2013] QSC 226 in which judicial review was granted in respect of a Coroner's decision to commit the applicant to stand trial.

[38] *Fox v Percy* (2003) 214 CLR 118 at 126 [23] (citations omitted).

much more information than had been made available at the two criminal trials which the applicant faced.

The basis for judicial review of the three decisions

[67] In essence, the applicant asserts:

1. The decisions were not reasonably open on the evidence. In other words, the decisions were affected by an error of law because there was no evidence to support the finding. The making of findings and the drawing of inferences in the absence of evidence constitutes an error of law.[39]

2. Alternatively, the finding was an improper exercise of power, being "an exercise of a power that is so unreasonable that no reasonable person could so exercise the power".[40]

[68] To the extent that s 23(g) of the *JRA* imports general administrative law principles of unreasonableness, reference may be made to the High Court's decision in *Minister for Immigration and Citizenship v Li* and the concept of "legal reasonableness".[41] A decision may be unreasonable in the legal sense when it lacks a rational foundation. However, if there is an evident and intelligible justification for the decision, and if the decision is within the "area of decisional freedom" of the decision-maker, it would be an error for a court to overturn the decision simply on the basis that it would have decided the matter differently.[42] Where the conclusion "falls within the range of legally and factually justifiable outcomes, the exercise of power is not legally unreasonable simply because the Court disagrees, even emphatically, with the outcome or justification."[43]

[69] A decision will be amenable to judicial review on the grounds of unreasonableness if it is one at which no rational or logical decision-maker could arrive on the same evidence.[44] The following passage from the joint judgment of Crennan and Bell JJ in *Minister for Immigration v SZMDS* is apposite in a challenge to findings of fact which are alleged to lack an evident and intelligible justification:

> "… the test for illogicality or irrationality must be to ask whether logical or rational or reasonable minds might adopt different reasoning or might differ in any decision or finding to be made on evidence upon which the decision is based. If probative evidence can give rise to different processes of

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[39] *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321 at 355-356; *Minister for Immigration and Citizenship v SZMDS* (2010) 240 CLR 611 at 646 [124].

[40] *Judicial Review Act 1991* (Qld) ss 20(2)(e); 23(g).

[41] (2013) 249 CLR 332 at 351 - 352 [30].

[42] *Minister for Immigration and Border Protection v Stretton* (2016) 237 FCR 1 at 3 [4] – 5 [10]; 15 [52] – 19 [59]; 30 [92].

[43] At 30 [92].

[44] *Minister for Immigration v SZMDS* (2010) 240 CLR 611 at 648 [130].

> reasoning and if logical or rational or reasonable minds might differ in respect of the conclusions to be drawn from that evidence, a decision cannot be said by a reviewing court to be illogical or irrational or unreasonable, simply because one conclusion has been preferred to another possible conclusion."[45]

The issue

[70] These general principles fall to be applied in a case in which it was open to the Coroner to accept or reject the evidence of certain witnesses, including the applicant, on the basis of assessments of their credibility and reliability, when judged against other evidence which the Coroner accepted. There is no suggestion that the Coroner did not use or misused the advantage which he enjoyed in evaluating the evidence of witnesses who gave evidence before him. Whether the application for judicial review is approached on the "error of law" ground or the "unreasonableness" ground, the challenge to the three findings of fact involves two essential issues:

1. Has the applicant established that there was no probative evidence to support the finding; or

2. Has the applicant established that no reasonable decision-maker could reach the finding on evidence which it was open to the decision-maker to accept?

The contested findings in context

[71] Many findings made by the Coroner are not contested. They provide an evidentiary basis by reference to which these issues are to be decided. The application for a statutory order of review, as filed, sought to challenge additional findings. Those challenges are not pressed and include challenges to findings that:

- an intimate relationship existed between Rachel Antonio and the applicant for some time during 1997 and 1998; and

- the applicant, in denying the nature of this relationship before the inquest, made statements which were deliberately false.

[72] The Coroner's Reasons are substantial. For present purposes it is appropriate to summarise a number of key findings which are not in contest, and to consider whether they may provide an evidentiary basis to support the contested finding that Rachel Antonio died shortly after 7 pm on 25 April 1998 as a result of an altercation with the applicant in which she suffered an injury or injuries.

The relationship

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[45] At 648 [131].

[73] Despite the applicant's repeated denials at the inquest that any intimate relationship whatsoever existed between him and Ms Antonio, the evidence of such a relationship was substantial. The applicant's counsel at the inquest conceded that the contents of Ms Antonio's diary and other evidence supported a finding that a relationship of a sexually intimate and personal nature existed between the two.[46] The applicant was aged 24 and Ms Antonio was aged only 15 in 1997. She turned 16 on 20 March 1998. Because of the difference in their ages, it was a clandestine relationship.[47] Some who knew or suspected such a relationship existed discouraged the applicant from continuing it.

[74] The applicant met and had a liaison with a young woman from another State who he met when he attended a Surf Lifesaving event in New South Wales.[48] Ms Antonio told her mother and her schoolfriends that the applicant had met a girl from interstate, and also, that he had told Ms Antonio that the other girl was now pregnant.[49] As the Coroner observed, being told by the applicant about his relationship with another girl who was allegedly pregnant would be "a crushing revelation to a young, 'relationship-naïve',
15-year-old girl".[50]

[75] The evidence is that Ms Antonio then schemed, and wished to confront the applicant with the claim that she too was pregnant. She arranged a fake "positive" pregnancy test result. By this time the applicant had "moved on" and was in a publicly-known relationship with another woman.[51] The Coroner concluded that a false pregnancy issue was devised by Ms Antonio, and that she intended to confront the applicant about the alleged pregnancy of the young woman he had met at the Surf Lifesaving event. She planned to confront him on the weekend of 25 April 1998.

Ms Antonio's plan to meet the applicant

[76] There was abundant evidence that Ms Antonio intended to meet the applicant on the evening of Saturday, 25 April 1998. A few days earlier she told a local businessman that she had falsely told her "boyfriend" that she was pregnant. She said:

> "I am meeting my boyfriend this weekend. We [are] going to sort it out then."[52]

[77] On Thursday, 23 April 1998 she told a school friend that she was going to meet the applicant on the beach that Saturday night and have a talk. She told her friend that she

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[46] Coroner's Reasons at [36].

[47] At [43].

[48] At [61].

[49] Ibid.

[50] Ibid.

[51] At [67].

[52] At [68].

was going to tell her mother that she was going to the movies, but she would meet the applicant at the beach that Saturday. She had spoken to him in the last few days and was upset with him. She proposed to ask him if he was lying about the other woman being pregnant. If he said "Yes", then she proposed to tell him that she was not pregnant, and that what she had earlier told him about that had been a lie.[53] This evidence supported the Coroner's finding that Ms Antonio intended to confront the applicant about the fake pregnancy that Saturday evening.

Ms Antonio's presence at the proposed meeting place that Saturday night

[78] On the Saturday morning, Rachel, who was an Air Cadet, attended Anzac Day services. At around 12.30 pm she went to the Bowen swimming pool, where she worked from time to time. The purpose of her attendance that afternoon is unclear. She did not bring any swimming clothes or towel and stayed for only about half an hour. When she left through the foyer of the pool office, the pool manager asked, "What, didn't anyone else turn up?" to which she replied "No".[54] Rachel went home and at around 4 pm she asked her mother's permission to go to the cinema that evening. Her mother agreed. Some time after 4 pm Mrs Antonio left the home to attend to some errands. The inquest received evidence about certain telephone calls, including a telephone call which the applicant made to the Antonio residence at 5.08 pm. I will return to the evidence about these telephone calls.

[79] At around 6 pm Mrs Antonio dropped her daughter at the cinema. This was about an hour before the session was due to commence because Mrs Antonio's car had a problem with its headlights and she wished to drive while it was still light. Rachel was to catch a taxi home or obtain a lift from a friend at the cinema if she could arrange it.[55]

[80] Whilst waiting after 6 pm, she sat in a lifesaver's elevated lookout chair. At around 6.45 pm she spoke with two gentlemen and told them that she was waiting for her boyfriend.[56] Ms Antonio was observed in the vicinity of the beach at around 7 pm. She did not purchase a ticket to the cinema and she did not attend the movie that started at 7 pm.[57]

The applicant's departure from a party at around 7 pm and the opportunity for him to meet Ms Antonio

[81] That evening, the applicant was attending his brother's eighteenth birthday party at his family's home. Just before 7 pm he left the party, saying that he was going to hire a movie for some young children who were at the party. Before he left the house, his mother asked him to buy more ice.

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[53] At [70] – [71].

[54] At [73].

[55] At [84].

[56] At [85].

[57] At [86] – [87].

[82] The applicant gave a number of conflicting accounts about how he spent the following period of about 45 minutes. He arrived back at his home at about 7.45 pm in what appeared to others to be a slightly agitated state, and not wearing a shirt.[58]

[83] The Coroner's Reasons carefully and comprehensively analyse the evidence about this important period. It would have taken somewhere between five and seven minutes to drive to the video store. However, the store's computerised system recorded that the applicant hired the video at 7.39 pm, and the evidence was that he was only in the store for three or four minutes. By this time he had discarded the shirt he had been wearing. The store employee who served him said the applicant's hands were clean.[59]

[84] The applicant, when first spoken to by police, said that he left the party a little before 7 pm, and the Coroner found this to be accurate. However, the applicant gave different accounts of his movements, which the Coroner rejected. The applicant said that on the way to the video store, his car's engine simply stopped. He attempted to restart it and reached into the engine bay. His hands became covered with grease, and some grease was transferred to his shirt. He said he took off his T-shirt and used it to wipe his hands. The car restarted and he drove on to the video store. The applicant said that after hiring a video, which would only have taken a few minutes, and when he was travelling back to the party his car broke down again. He said that he lifted the bonnet and moved some cables and the engine restarted.

[85] At different times the applicant gave different estimates of how long he stopped on each occasion. The versions varied from between five, six to possibly 30 minutes. A critical fact is that the applicant left the party a little before 7 pm and only hired the video at 7.39 pm, after being in the store for a few minutes. He left home in a T-shirt, but turned up at the video store shirtless. His explanation was that he got his hands dirty with engine grease while trying to restart the car on the way to the video store. Even if, as he says, he used his T-shirt to wipe his hands, he did not use soap or another cleansing agent. Yet, the employee of the store described the applicant's hands as clean.

[86] The period during which the applicant stopped on the return journey from the video store was contradicted by the evidence of an eye witness who saw a vehicle, which generally matched the description of the applicant's vehicle, pull up for a very short time. The Coroner, having carefully considered all of the evidence, rejected the applicant's evidence that his car suffered a mechanical breakdown on the way to the video store.[60] Based on the observations of the witness who saw the applicant's car pull up briefly on its return journey from the video store, the Coroner concluded that the applicant pulled up at that time briefly because he "needed to establish a reason for why his simple journey to town and back took so long".[61] It was at this time that the applicant dirtied his hands, shorts and shirt. The Coroner found the applicant's evidence not credible, and found there was no "breakdown" of his car on either leg of

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[58] At [94].

[59] At [104].

[60] At [108].

[61] At [109].

the journey. Instead, he simply stopped on his return journey so he could add some credibility to his story of a mechanical issue, and apply engine grease to his hands and clothes.[62]

[87] The applicant's account of his movements and of two breakdowns having been rejected, this left a period of about 30 minutes unaccounted for, or a "window of opportunity" for the applicant to have met Ms Antonio between leaving the house and hiring the video. The Coroner attached appropriate significance to the fact that this unaccounted period of about 30 minutes occurred at the same time that Ms Antonio's last movements were accounted for.[63] The unexplained period of about 30 minutes was sufficient time for the applicant to drive to Queens Beach, meet Ms Antonio and for her to go with him in his car.[64]

The applicant's behaviour in the middle of the night

[88] After returning to the party at around 7.45 pm the applicant remained there until everyone had left, or gone to bed. Ms Anderson, who was staying at the house that night, encountered the applicant walking out of the bathroom at 1 am. She said that he appeared "really nervous". Of course, such a reaction may simply have been because of an unexpected encounter with Ms Anderson. However, it was a further piece of circumstantial evidence.

The applicant's return home at about 7.30 am

[89] At around 7.30 am on 26 April 1998 on the morning after the party, a neighbour saw the applicant returning home. The applicant was not wearing his usual sporting attire. He was in shorts, with no shirt and no shoes. The Coroner was left with the question of why a person who had been at an eighteenth birthday party and awake at 1 am would get up so early to train, without appropriate clothing, before then going on to do a complete day of patrolling as a lifesaver. When asked at the inquest what he had done that morning, the applicant was unable to recall.[65] It is remarkable that he could not recall where he had been, because at around 7.38 am he received a telephone call from Mrs Antonio. Given the significance of Rachel's disappearance, one might expect the applicant to have recalled what he had been doing just before he received that important call, for example, whether he woke up at home and simply had breakfast before receiving Mrs Antonio's call, or whether he had been out training or doing something else before he was observed returning home at around 7.30 am.

Lies told by the applicant

[90] The Coroner rejected the applicant's evidence in a number of respects. There is no submission that he was not entitled to do so, based upon his analysis of the evidence and

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[62] At [112].

[63] At [113].

[64] At [116].

[65] At [124] fn 205.

his assessment of the credibility and reliability of witnesses, including the applicant. The matters in respect of which the Coroner rejected the applicant's evidence include:

- his denial of the existence of an intimate relationship with Ms Antonio;[66]
- the contents of a telephone call between them at around 5.08 pm on the Saturday evening;[67]
- his evidence about vehicle breakdowns on the way to and from the video store;[68] and
- his explanation for Ms Antonio's blood being on the sandals he was wearing.[69]

The circumstantial nature of the case and the standard of proof

[91] Each of the challenged findings depended on circumstantial evidence. Of course, it is possible for a criminal charge, which must be proven beyond reasonable doubt, to depend substantially or entirely on circumstantial evidence. The Coroner's findings did not require proof beyond reasonable doubt. Instead, as he explained, he was required to apply the civil standard of proof, but in doing so have a high level of satisfaction before finding that the applicant caused Ms Antonio's death. The principle in *Briginshaw v Briginshaw* requires a high degree of satisfaction before a finding can be made that one person killed another.[70] However, the fact that an individual has been acquitted of criminal charges does not preclude a subsequent finding by a court applying the civil standard of proof that the defendant did in fact kill the deceased.[71]

[92] In criminal proceedings in which the prosecution case relies substantially or entirely on circumstantial evidence, the tribunal of fact must be satisfied that any reasonable hypothesis consistent with innocence has been excluded. In the different legal context of an inquest in which findings about the cause of death are based on circumstantial evidence, the test explained in *Briginshaw v Briginshaw* "does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not".[72] However, a process of considering and, if appropriate, excluding other possibilities is appropriate in the course of reaching findings of the kind which s 45 of the *Coroners Act* 2003 requires a Coroner to make. This was the approach of the Coroner in this case.

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66 At [114].

67 At [82].

68 At [114].

69 At [121].

70 (1938) 60 CLR 336 at 361-362, which discussed the standard of proof in civil cases in which allegations of serious misconduct are made.

71 See *Helton v Allen* (1940) 63 CLR 691.

72 *Hurley v Clements* [2010] 1 Qd R 215 at 233.

[93] The Coroner in this case correctly identified the standard of proof, and in a number of places in his reasons demonstrated his appreciation of the significance of making certain findings, and the need to be satisfied to a high standard in doing so.

[94] Consistent with the provisions of the *Coroners Act* 2003, the Coroner was required to find, if possible, whether Ms Antonio had died, how and when she died and what caused her to die.[73] He also was required to apply s 45(5) of the Act, which states that a coroner must not include in the findings any statement that a person is, or may be, guilty of an offence or civilly liable for something.

[95] In some circumstantial cases in which a finding is made that a person caused another's death, there are some intermediate facts which are essential to that conclusion. For example, the fact that two persons were present at the same place at the same time, being the place at which the deceased was killed, would be an essential intermediate fact in support of a finding that A killed B at that place and time. Other circumstantial facts are not essential, and a lack of satisfaction as to their occurrence does not mean, even in a criminal case, that the killing cannot be proved to the required standard. If other circumstantial evidence proves the ultimate fact to the required standard, then a finding that A killed B may be made.

[96] In this case, the fact that the applicant and Ms Antonio met each other shortly after 7 pm on 25 April 1998 is an essential intermediate fact to the Coroner's finding that the applicant caused her death soon after.

[97] The evidence I have summarised would appear to support the inference that they did meet. The evidence to support such an inference includes:

1. The fact that Ms Antonio intended to meet the applicant at Queens Beach that evening. On its own, the fact that Ms Antonio intended to meet the applicant would not prove that she in fact did so. On its own, it could only "satisfactorily prove that she did all within her power to effect the intention".[74]

2. Steps taken to give effect to her intention to meet. The evidence did not consist simply of Ms Antonio's intention, expressed a few days earlier, to meet the applicant that Saturday night. The evidence included the fact that she carried that intention into effect. She went to the place where she expected to meet the applicant and told others shortly before 7 pm that she was waiting for her boyfriend.

3. The applicant's absence from the birthday party at the time of the expected meeting.

4. The applicant's unexplained movements between just before 7 pm and his arrival at the video store shortly before 7.39 pm, when he was not wearing a shirt.

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[73] *Coroners Act* 2003, s 45(1) and (2).

[74] *R v Hytch* [2000] QCA 315 at [28].

I leave to one side a topic to which I will return, namely the presence on the applicant's sandals of a small amount of Ms Antonio's blood. I also leave to one side the applicant's subsequent behaviour at around 1 am, and his unexplained absence from the house prior to his return there at around 7.30 am.

[98] The matters which I have summarised above permit the inference to be drawn that the applicant and Ms Antonio met shortly after 7 pm on Saturday, 25 April 1998.

[99] I note in passing that the Court of Appeal, in granting the applicant a retrial based upon an inadequate direction to the jury at his first trial, concluded that there was sufficient evidence to go to the jury, applying the requirement of proof beyond reasonable doubt, on a charge of manslaughter.[75] The evidence included Ms Antonio's statement of intention, the applicant's absence from the party, his explanations about his vehicle breaking down and his denial of a close relationship with Ms Antonio.[76]

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[75] At [7], [88].

[76] At [32].

The applicant's challenge to a finding that the applicant and Ms Antonio arranged to meet

[100] The applicant submits that the Coroner's finding that the applicant was a party to an arrangement to meet involved an error of law, was not reasonably open, and was no more than speculation.

[101] The circumstantial evidence which I have summarised above and which supported the inference that the applicant and Ms Antonio in fact met at Queens Beach shortly after 7 pm made it extremely unlikely that such a meeting was by chance. Ms Antonio was there for the purpose of meeting the applicant. Unless there was a plan to meet, there was no reason to suppose that the applicant would go to Queens Beach at that time when he was expected to either be at a party or running errands associated with the party.

[102] The Coroner's finding that the applicant and Ms Antonio arranged to meet at around 7 pm at Queens Beach was supported, in part, by his analysis of evidence of certain telephone calls and other evidence. This evidence led the Coroner to conclude that after her mother left the Antonio home some time after 4 pm, Ms Antonio went to the Bowen pool and made two telephone calls from it. The first occurred at 4:51:04. It was to the Antonio residence and there was no connection. The attempted call may have only taken a few seconds. The second call was to the applicant's home. This call was made at 4:51:17. It was of 38 seconds duration. A more important matter was the telephone call which the applicant made from his home to the Antonio home at 5:08:50. Its duration was 86 seconds. The Coroner found that the applicant made this call at 5:08 pm, on the pretence of confirming Ms Antonio's attendance at surf patrol the next day, but for the real purpose of discussing a meeting that evening at 7 pm at Queens Beach.

[103] The Coroner's Reasons closely analyse the evidence about the telephone calls and the possibility that Ms Antonio walked to the pool after her mother had left home and called the applicant from the pool at 4.51 pm. He analysed the evidence logically. This included an analysis of who may have made the telephone calls from the pool. It included a critical assessment of the evidence of the pool manager who would have been present at the pool and near its office that afternoon at the relevant times. The manager denied having made the calls and there was no reason to suggest why he would telephone the Antonio residence. The Coroner, having assessed his evidence carefully, concluded that the manager, Mr Pate, knew who made those telephone calls, and wished to place himself the furthest distance possible from the kiosk when those calls were being made.[77]

[104] Another witness (who was not called to give evidence) was at the Bowen pool from 3.20 pm until 4.55 pm, with his young son. When he was leaving he noticed the manager, Mr Pate, in his office. This witness, Mr Paul, described the few persons he had seen at the pool that afternoon. He did not observe the applicant. However, this is understandable if he was directing his attention to the care of his young son and other activities. His evidence and the other evidence left open the possibility that Ms Antonio

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[77] Coroner's Reasons at [78].

went to the Bowen pool for a short time, entered the office with which she was familiar and used the phone at 4.51 pm.

[105] I do not accept that the finding that Ms Antonio made calls from the Bowen pool at 4.51 pm was conjecture.

[106] Mrs Antonio gave evidence of her conversation with Rachel in which she gave Rachel permission to attend the cinema that evening. Mrs Antonio said that she left the house "just after 4 o'clock" and she was gone for "about half an hour". On one view of this evidence, Mrs Antonio would have been home by 4.51 pm, when Rachel was making a telephone call from the pool, could have answered the incoming call and would have noticed that Rachel was not home. However, Mrs Antonio's evidence that she went out for "about half an hour" may have been an inaccurate estimate of time.

[107] It was open to the Coroner to conclude that, having received her mother's permission to go to the cinema that evening, Ms Antonio waited for her mother to leave the house to run errands some time after 4 pm, then walked the few blocks to the Bowen pool and made the calls at 4.51 pm, including the 38 second call to the applicant's residence. There was no other persuasive evidence of who may have made such a call from the pool to the applicant's home at 4.51 pm.

[108] Once it is accepted that Ms Antonio obtained permission to go to the cinema at Queens Beach that evening, intended to meet the applicant at that beach that evening, and telephoned him at 4.51 pm, a clearly available inference is that the subject matter of the call was the planned meeting. The Coroner's finding that after she received permission to go to the cinema that evening she spoke to him about a plan to meet is understandable. It was an inference that was supported by the evidence about her intention to meet the applicant that evening and the fact that she now had an opportunity to go to Queens Beach for such a meeting that evening.

[109] The 4.51 pm call from the Bowen swimming pool was a subsidiary matter. The Coroner correctly described it as "just a small component of the events which unfolded that evening".[78] The applicant's challenge in this judicial review proceeding is to the ultimate finding that the applicant killed Ms Antonio, and the intermediate essential fact that he and she met at Queens Beach shortly after 7 pm that evening. The applicant's challenge would not succeed even if I was persuaded that the Coroner engaged in impermissible speculation about the parties to the 4.51 pm telephone call. However, I do not consider that the Coroner did so. He analysed the evidence and was entitled to reach the conclusion, by a process of elimination, that it must have been Rachel Antonio who made the call at 4.51 pm to the applicant at his residence.

[110] The Coroner did not speculate about why Ms Antonio would have walked a short distance to the pool to make a call which she could have made from her own home. Possibilities exist including the fact that she may not have wished a call by her to the applicant to be interrupted by the return of her mother or by some other member of the family. She may not have wished outgoing calls by her to the applicant to appear in telephone bills, prompting questions as to why such calls were made. It is sufficient to

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[78] At [83].

conclude that the Coroner's subsidiary finding that Ms Antonio made a call to the applicant at 4.51 pm from the Bowen pool was a finding which was open to him. The likely content of that call, in the circumstances, is not a matter for speculation. Given Ms Antonio's plans and availability to meet, the obvious inference is that they spoke about a planned meeting at Queens Beach that evening.

[111] There is no doubt that the applicant called Ms Antonio at her home at 5.08 pm. The Coroner concluded that he called at that time on the pretence of confirming her attendance at surf patrol the next day, but so as to confirm the meeting at Queens Beach that evening at 7 pm.

[112] The Coroner found that the applicant's evidence that the call was made to confirm that Ms Antonio would attend patrol the next day was deliberately untrue.[79] The Coroner explained that Ms Antonio was a very diligent attendee at patrols, as the applicant told police. She did not need to be followed up or reminded. The Coroner regarded as telling against the applicant that he did not call any other person rostered for the Sunday.

[113] The applicant points out that there is no direct evidence that the 5.08 pm call had anything to do with arranging to meet later that evening. The real issue, however, is whether it was open to the Coroner to infer, in making a finding about a subsidiary fact, that part of the conversation related to the planned meeting. In my view, it clearly was. The Coroner was entitled to reject the applicant's explanation for the calls as being deliberately untrue. The applicant points to the fact that Mrs Antonio overheard part of the call, which was said to relate to the next day's patrols. However, Mrs Antonio gave evidence that she did not hear the full conversation. At best, she could only listen to what her daughter said during the call, and she did not hear all of the call. Both the applicant and Ms Antonio had reason to conceal from Mrs Antonio the true nature of their relationship and a plan to meet at the beach that night. The finding that during the telephone call the applicant confirmed that he would meet Rachel Antonio that evening at 7 pm was an inference of fact, or a subsidiary finding, that was open to the Coroner to make.

[114] More generally, it was open to the Coroner to conclude that the telephone calls at 4.51 pm and 5.08 pm between Ms Antonio and the applicant discussed a planned meeting at 7 pm at Queens Beach. The circumstances support such a conclusion because it was only after 4 pm that Ms Antonio knew that she would be able to go to Queens Beach, having secured her mother's permission to go to the cinema there. In addition,

Ms Antonio had a strong desire to meet the applicant that evening. I do not accept the applicant's submission that the Coroner's decision that there was an arrangement to meet at around 7 pm at Queens Beach was made without evidence, and was an error of law. There was evidence to support such a conclusion. As to the 5.08 pm telephone call, as the Coroner explained, there was no need for the applicant to call Ms Antonio at that time. Ms Antonio acted consistent with an arrangement to meet. She went to the beach, rather than the cinema, that evening. Unless she had some assurance from the

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[79] At [82].

applicant that he would be there, it is unlikely that she would sit on the lifesaving lookout and tell others that she was waiting for her boyfriend.

[115] The Coroner's finding that there was an arrangement to meet that evening at Queens Beach did not rest simply on his analysis of the two telephone calls. It rested on all of the evidence, including the evidence which I have summarised above. That evidence includes Ms Antonio's clear intention to meet the applicant that evening, the applicant's opportunity to meet her at that time, his unexplained absence for a period of about 30 minutes after 7 pm and the lies that he told about a mechanical breakdown. It is possible that any arrangement that was made, and which was discussed in the two telephone calls that evening, was provisional. For example, the applicant might have said that he would meet Ms Antonio if he could absent himself from his brother's birthday party. However, the possible conditional or provisional nature of the arrangement does not alter the fact that the evidence is capable of supporting a reasonable inference that there was an arrangement to meet that evening.

The fact of a meeting

[116] The matters which I have surveyed, including an arrangement to meet, were capable of supporting the finding that the applicant and Ms Antonio met at Queens Beach at around 7 pm on 25 April 1998.

The finding that the applicant caused Ms Antonio's death

[117] The Coroner considered other possible scenarios which might explain Ms Antonio's disappearance. These included the possibility that she chose to disappear and was discreetly living elsewhere; that she chose to disappear and was being actively hidden by others; that she went off on an adventure of her own and died, with her death being concealed; that she met an unfortunate accident, for example, a motor vehicle accident as a pedestrian, and the incident went unreported; that she committed suicide and that she died at the hands of another person. The Coroner gave convincing reasons as to why various possibilities do not command acceptance. I need not detail them. They include the fact that Ms Antonio had no means of living independently elsewhere and that it is unlikely that she went for a swim that evening and drowned accidentally. She came from a happy family and was much loved. She had advanced plans to join the Air Force. The Coroner had no difficulty in dismissing suicide as a possible explanation for her disappearance.

[118] The Coroner considered the possibility that Ms Antonio was killed, perhaps unintentionally. The Coroner considered the possibility that she was abducted against her will from Queens Beach. However, he thought it likely that she would scream or call out, or that there would be some commotion which would draw the attention of passers-by. The evidence did not suggest that there was an abduction, or that she was taken against her will.[80] Instead, it was far more probable that the applicant met Ms Antonio that evening, as planned. Her act of simply hopping into his car would be unlikely to come to anyone's notice. She did not have to be coerced to get into the car. There would have been no struggle or commotion at Queens Beach. Having hopped

[80] At [88].

into the applicant's car, there was sufficient time for them to drive to a nearby, secluded location.

[119] It is appropriate to quote an important conclusionary paragraph of the Coroner's Reasons:

> "Accordingly I find that a meeting between the two of them occurred on that evening at a little after 7.00 PM and that shortly after that time My Hytch has caused a fatal injury to Rachel and thereby caused her death. Mr Hytch has then secreted her body at a location, and then likely realising he would be missed by his absence from the party, continued with his errands[81] and driven to the video store. At this time he is shirtless as very likely he has used his T-shirt to wipe his hands or it was torn. It was evident to the employee that he was in a hurry at the store and he himself admits he has then driven straight home, forgetting the request for ice, only briefly stopping on Horseshoe Bay Road. At this stop I find that he then dirties his hands and shorts with grease, in an attempt to give credibility to his story that his car broke down on two occasions."[82]

[120] Although in accordance with the principles discussed in *Hurley v Clements* it was not strictly necessary for the Coroner to exclude other possibilities, he carefully considered them and, in effect, excluded them in favour of the far more probable scenario that the applicant met Ms Antonio shortly after 7 pm that evening.

[121] Given the nature of their relationship, the fact that the applicant had "moved on", and the "fake pregnancy" issue between them, it was reasonable to infer that their encounter became an unpleasant one with verbal arguments. It was reasonable to infer also that such an argument escalated into a physical encounter.

[122] The sad fact is that Ms Antonio was never seen again. Her suspected death was thoroughly examined by the Coroner who concluded that she died. Her body was never found. All this pointed to the probability that she died on the evening of 25 April 1998. Having concluded that the applicant met Ms Antonio shortly after she was last seen alive, that they left in his car, and that Ms Antonio had intended to confront him about certain matters, the inference or conclusion that the applicant caused her death was supported by probative evidence. This conclusion was further supported by the applicant's conduct later that night and his unexplained behaviour in returning to his home in shorts at around 7.30 am.

[123] The first finding which is challenged is that Ms Antonio "died at the hands of Mr Robert Paul Hytch".[83] The relevant finding was that she died following a physical altercation with him, being an altercation which caused her bodily injury, and that she died from the injury or injuries she suffered during that altercation.

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[81] Or more correctly, one of them.

[82] Coroner's Reasons at [123].

[83] At [146], [147B(b)].

[124] The Coroner was not required to find, and did not find, that the killing was a very violent one.[84] Possibilities abound, and in the absence of her body and a forensic examination of it, those possibilities include simple, but life-threatening acts. They would include the application of force in the nature of strangulation, perhaps for a very brief period. That such acts may unintentionally cause death or serious grievous bodily harm is reflected in the enactment of special laws directed against such conduct. Similarly, Ms Antonio may have been pushed or punched, resulting in her head hitting a hard object. The criminal justice system is all too familiar with deaths arising from persons being pushed or punched, whose heads fall onto hard surfaces such as vehicles or roads.

[125] The Coroner was not required to find, and did not find, that the applicant intended to cause death or grievous bodily harm. He was required to find, if possible, what caused Ms Antonio's death. His finding was based upon a detailed analysis of a large body of circumstantial evidence. There was probative evidence to support subsidiary findings including:

- Ms Antonio's intention to meet and confront the applicant that night;
- an arrangement to meet that night; and
- the opportunity which the applicant had to meet at the time and place Ms Antonio planned to meet him, his unexplained absence for a period of about 30 minutes and the lies which he told about mechanical breakdowns.

[126] There also was probative evidence to support the intermediate essential finding that they in fact met. That important finding was not a matter of conjecture. Based on the fact of a meeting and the evidence which the Coroner concluded merited acceptance, it was open to the Coroner to find that, shortly after the meeting, the applicant caused a fatal injury to Ms Antonio. Other possibilities which might explain her disappearance and death were either fanciful or not supported by a similar body of probative evidence.

[127] In summary, the finding that Ms Antonio died shortly after 7 pm on 25 April 1998 as a result of an altercation with the applicant was a finding that was reasonably open on the evidence. There was probative evidence to support the finding. The decision was not affected by an error of law. In addition, the finding was one which a reasonable decision-maker could reach, based on the evidence which the Coroner accepted. The judicial review challenge to this finding should be dismissed.

The challenge to the finding that the applicant secreted Ms Antonio's body

[128] Once the conclusion is reached that the applicant killed Ms Antonio, a finding that he secreted her body is an available and reasonable inference in the circumstances. There is no evidence or suggestion to support the inference that, the applicant having killed Ms Antonio, someone else would hide her body, and no apparent reason why any such

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[84] He found at [122] that it was "an altercation of a violent nature". But any physical altercation which causes death might be so characterised.

third party would do so. The judicial review challenge to this finding should be dismissed.

The challenge to the finding that the applicant later disposed of her body

[129] Once the conclusion is reached that the applicant killed Ms Antonio, a finding that he later disposed of her body is an available and reasonable inference in the circumstances. Such a conclusion follows not simply from a finding that he killed her. However, that fact, coupled with the fact that her body has never been recovered, would support such an inference.

[130] In addition, there is the evidence of the applicant's odd behaviour in the middle of the night and his being observed by a neighbour returning home, dressed only in shorts, at around 7.30 am. Ms Anderson encountered the applicant walking out of the bathroom at about 1 am. She asked him for some Panadol. She said that he appeared "really nervous", and that he was "shaking and could not stand still". The applicant's inability to recall where he had been and what he had been doing before his return home at 7.30 am, in conjunction with the Coroner's finding that the applicant had caused a fatal injury to Ms Antonio, supported the inference that in the middle of the night the applicant left the residence and walked to a beach or nearby location where Rachel's body had been left. The Coroner was unable to conclude how he disposed of her body. One possibility was that he dug a shallow grave. Another more imaginative possibility was mentioned by the Coroner. However, the Coroner was unable to determine what the applicant did with Ms Antonio's body. It was sufficient for him to conclude that the applicant disposed of it. This conclusion was supported by earlier findings and probative evidence. It was a finding that a reasonable decision-maker could reach on the evidence which the Coroner accepted. The judicial review challenge to this finding should be dismissed.

The subsidiary finding about Ms Antonio's blood on the applicant's sandals

[131] A piece of circumstantial evidence was the presence of two small droplets of Ms Antonio's blood on the pair of reef sandals that the applicant was wearing on the evening of 25 April 1998. This evidence was not essential to the three findings which are challenged. If there had been no evidence about blood on the sandals, then there remained a sufficiently strong circumstantial case to reach the three conclusions which have been challenged, applying the high level of satisfaction required in accordance with *Briginshaw v Briginshaw*.

[132] DNA testing supported the conclusion that the two droplets were Ms Antonio's blood, and for the purpose of this proceeding the applicant does not contest this proposition. The amount of blood required to leave the two droplets would be extremely small. There was no attempt to date the bloodstains and an expert called by the defence at the applicant's second trial agreed that her blood could have been on the sandals for quite some time.

[133] The applicant attempted to explain the presence of the droplets. His explanation was that on some unspecified occasion during lifesaving training, Ms Antonio was injured and the blood spots were transferred to his sandals at that time. Whilst acknowledging

that was a possible explanation, the Coroner found the explanation unconvincing and preferred the possibility that the blood was transferred to the sandals on the evening Ms Antonio disappeared.[85] The Coroner found the applicant's explanation for the blood on the sandals to be an invention, and simply untrue.

[134] Surprisingly, when questioned about the sandals at the inquest, the applicant suggested, for the very first time on record, that the pair of sandals taken by the police were in fact his brother's. The Coroner noted that this claim had not been made to the police when they seized the sandals or during any interview the applicant had with police. Why Ms Antonio's blood, allegedly from a lifesaving incident, would be on the applicant's brother's reef sandals was left unexplained. The Coroner concluded that this was a desperate and unconvincing attempt by the applicant to deflect suspicion.[86]

[135] Apart from the possibility that the blood was transferred to the sandals when Ms Antonio was injured during lifesaver training, the applicant offered no other plausible explanation as to how the blood spots came to be on the sandals. Faced with two possibilities for the blood transference, namely:

(a) the applicant's explanation of it having occurred during lifesaver training; and

(b) that it occurred on the night of the disappearance

the Coroner preferred the second possibility.

[136] The applicant's submissions to me are that these two possibilities were not the only possibilities. It is said that the applicant and Ms Antonio regularly interacted and, based on her diary, she and the applicant met many times in the course of a clandestine relationship. This opened up the opportunity for blood transference to occur on such an occasion, including an occasion when the applicant and Ms Antonio were in the back seat of his vehicle on 25 January 1998. Whilst these possibilities existed, it remained open to the Coroner to conclude that the blood transference occurred on the evening of 25 April 1998. The possibility that blood was transferred on some occasion other than at lifesaver training was not mentioned by the applicant. There was no evidence that he was wearing his sandals when he and Ms Antonio were in the back seat of his vehicle on 25 January 1998. The applicant's vehicle was extensively examined forensically, and there was no evidence of Ms Antonio's blood in it.

[137] In choosing between the possibility which the applicant had suggested and the possibility which the Coroner preferred, the Coroner was entitled to evaluate the applicant's explanation as untrue due to his lack of credibility. The fact that the blood could not be dated did not prevent the Coroner from concluding that, having regard to the two canvassed possibilities, a recent deposit on 25 April 1998 was the more probable. Whilst it was possible that the blood was transferred at some earlier, unspecified occasion, the fact that the applicant offered no explanation other than transfer at lifesaver training permitted the Coroner to conclude that the most likely scenario was blood transference on the night of 25 April 1998. This subsidiary finding

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[85] Coroner's Reasons at [120] – [121].

[86] At [121].

was open on the evidence. The deposit of two small droplets of blood on that occasion was not implausible. Such a small deposit would not have required an especially violent incident, let alone the use of a weapon.

[138] The inference that there was a blood transference on 25 April 1998 was open in all the circumstances, including evidence that supported a finding that the applicant and Ms Antonio met that night, and that Ms Antonio intended to confront him. The finding about blood transference to the sandal was open in circumstances in which the Coroner had good reason to form an adverse view of the applicant's credibility and reliability.

The applicant's lies

[139] One final matter warrants consideration, given the applicant's submissions about the relevance of the Coroner's rejection of his evidence. I have earlier mentioned a number of respects in which the Coroner rejected the applicant's evidence. Leaving aside the Coroner's conclusion that the applicant's explanation for the blood on the sandals was an invention and simply untrue, and the conclusion that the applicant gave deliberately untrue evidence about the 5:08 pm telephone call, two adverse findings about the applicant's credibility loomed large in the Coroner's assessment. The first was the applicant's denial of an intimate personal relationship with Ms Antonio. The second was his finding that the applicant's vehicle did not suffer any mechanical breakdown. The Coroner appreciated the significance of his findings in relation to the applicant's credibility.[87] His reasons expose the basis for making significant findings against the applicant's credibility, and show that the Coroner considered possible reasons for the applicant's difficulty, hesitation and reluctance in answering questions about the two issues which were critical to the adverse findings on credibility. Having considered such possibilities, including the applicant's unfamiliarity in the witness box and possible nervousness in giving evidence about central issues at the inquest, the Coroner concluded that his answers on those issues were deliberately untruthful and evasive.

[140] The applicant's submissions note that, whilst rejecting the applicant's credibility and reliability, the Coroner did not conclude that he lied out of consciousness of guilt and did not rely upon consciousness of guilt in reaching the conclusions that he did. In my view, it was open to the Coroner to conclude that the applicant's lies about the nature of the relationship and his vehicle breaking down were lies told out of a consciousness of responsibility for Ms Antonio's disappearance and death. Other possible explanations existed, such as embarrassment concerning the existence of a sexual relationship with a 15 or 16 year old, panic at the time he first gave these accounts and fear of false accusation. However, if those other possible explanations were excluded, it was open to the Coroner to conclude that certain lies reflected a consciousness of guilt. In circumstances in which the Coroner did not expressly conclude that the applicant lied out of consciousness of guilt, it is unnecessary to pursue this aspect.

[141] If the lies were not due to a consciousness of guilt, it was nevertheless open to the Coroner to conclude that the applicant lied, including lies told in his evidence at the inquest, and to adopt a generally adverse view of the applicant's credibility. If the applicant's lies were relevant only to credibility, rather than proving a consciousness of

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[87] At [114].

guilt, then it was necessary not to rely upon his lies to automatically jump to a conclusion that the applicant was responsible for Ms Antonio's death. There is no suggestion by the applicant that the Coroner, having rejected the applicant's evidence, simply adopted a scenario contrary to that evidence. The rejection of the applicant's evidence as lacking credibility and reliability required the Coroner to return to evidence which he accepted. This is what the Coroner did.

Conclusion

[142] The Coroner had jurisdiction to proceed under the 2003 Act to investigate the suspected death of Ms Antonio. He diligently evaluated a large body of circumstantial evidence, including evidence which was not available to the juries at either of the applicant's criminal trials. The Coroner applied the appropriate standard of proof, and appreciated that a high degree of satisfaction was required before certain adverse findings could be made.

[143] A reasonable decision-maker in the Coroner's position was entitled to reject key aspects of the applicant's evidence, and to conclude that the applicant gave deliberately false evidence. There was probative evidence to support each of the three challenged findings. Each finding had an evident and intelligible justification. Each finding was one which a reasonable decision-maker could reach on the evidence which the Coroner accepted. It was open to a reasonable decision-maker to find that:

1. Ms Antonio died shortly after 7 pm on 25 April 1998 as a result of an altercation with the applicant;

2. The applicant then secreted her body; and

3. The applicant later disposed of her body.

[144] The application for judicial review is dismissed. I will hear the parties on the question of costs.