SUPREME COURT OF QUEENSLAND

CITATION:	*Neumann v Hutton and Anor* [2020] QSC 17
PARTIES:	**DAVID BRENDAN NEUMANN** (applicant) **v** **JOHN HUTTON** (respondent) **ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (intervener)
FILE NO/S:	BS No 1090 of 2018
DIVISION:	Trial Division
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	2 March 2020
DELIVERED AT:	Brisbane
HEARING DATE:	17 February 2020
JUDGE:	Martin J
ORDER:	**The application is dismissed.**
CATCHWORDS:	CORONERS ACT – NATURAL JUSTICE – ADVERSE COMMENTS – CONDUCT REFERRAL – where the applicant was a police officer who led the criminal investigation into a death – where the respondent was the coroner who presided over the inquest into the death – where the coroner made adverse comments about the applicant and referred the applicant's conduct to the Commissioner of Police – whether the making of the adverse comments and the conduct referral involved a breach of the rules of natural justice – whether there was any probative evidence to support the making of the comments – whether the conduct referral was made contrary to s 46(3) of the *Coroners Act* 2003 *Coroners Act* 2003, s 14, s 31, s 36, s 37, s 39, s 45, s 46, s 46A, s 48 s *Judicial Review Act* 1991, s 30(1), s 41(2) *Annetts v McCann* (1990) 170 CLR 596, cited *Commissioner for Australian Capital Territory Revenue v Alphaone Pty Ltd* (1994) 49 FCR 576, cited

Kioa v West (1985) 159 CLR 550, cited
Maksimovich v Walsh and the Attorney-General of New South Wales (1985) 4 NSWLR 318, cited
Perre v Chivell (2000) 77 SASR 282, cited
R v South London Coroner; ex parte Thompson (1982) 126 SJ 625, cited
Weaver v Law Society of NSW (1979) 142 CLR 201, cited
SZBEL v Minister for Immigration (2006) 228 CLR 152, cited

COUNSEL: M Black for the applicant
S McLeod QC and M Eade for the intervener

SOLICITORS: Gilshenan & Luton Legal Practice for the applicant
GR Cooper, Crown Solicitor for the intervener

[1] At about 7.40 pm on 22 August 2012, Shui Ki Chan was cycling home along the Warrego Highway after finishing his shift at the College View McDonalds. He was about one kilometre away from his home when, it appears, he was struck by a passing vehicle. His injured body came to rest in a ditch on the side of the road and he died, not from the injuries caused by the collision, but from hypothermia after lying in the ditch for the remainder of that cold winter evening.

[2] The death was investigated by police and an inquest was held by a coroner (Mr Hutton).[1] Detective Senior Constable Neumann had led the criminal investigation into the death. In his findings, Mr Hutton made some adverse comments about the applicant, Mr Neumann. He also referred Mr Neumann's conduct to the Commissioner of Police. The adverse comments forming the subject of this application were:

> "8. I find that:
>
> (a) The criminal investigation conducted by Detective Senior Constable Neumann was inadequate; and
>
> (b) The assistance provided to me by Detective Senior Constable Neumann, during my coronial investigation, was inadequate."

[3] The conduct referral was:

> "10. Due to the inadequacies I have found with Detective Senior Constable David Neumann's criminal investigation, and with the assistance he provided to me during my coronial investigation, I refer his conduct to the Commissioner of the Queensland Police Service, for consideration as to whether any disciplinary action should be taken."

[4] At the hearing, Mr Neumann's case was confined to seeking declarations that:

(a) The adverse comments were made in breach of the rules of natural justice.

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[1] Mr Hutton was granted leave to abide the order of the court and was excused from further attendance.

(b) The conduct referral was made in breach of the rules of natural justice.

(c) The conduct referral was made contrary to s 46(3) of the *Coroners Act* 2003.

[5] The issues that arise for consideration are:

(a) Did the making of either the adverse comments or the conduct referral involve a breach of the rules of natural justice?

(b) Was there any probative evidence to support the making of the comments?

(c) Was the conduct referral made contrary to s 46(3) of the *Coroners Act*?

Relevant provisions of the *Coroners Act*

[6] The provisions that are of particular importance for the issues in this case are:

> "**36 Right to appear etc.**
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> (1) The following persons may appear, examine witnesses, and make submissions, at an inquest—
>
> (a) a police officer, lawyer or other person assisting the Coroners Court;
>
> (b) the Attorney-General;
>
> (c) a person who the Coroners Court considers has a sufficient interest in the inquest.
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> *Examples for paragraph (c)—*
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> 1 a family member
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> 2 the representative of a department
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> 3 the representative of a company that manufactured a product that is believed to have killed the deceased person
>
> …
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> **45 Coroner's findings**
>
> (1) A coroner who is investigating a suspected death must, if possible, find whether or not a death in fact happened.
>
> …
>
> (5) The coroner must not include in the findings any statement that a person is, or may be—
>
> (a) guilty of an offence; or
>
> (b) civilly liable for something.
>
> (6) This section applies whether or not an inquest is held.

46 Coroner's comments

(1) A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to—

(a) public health or safety; or

(b) the administration of justice; or

(c) ways to prevent deaths from happening in similar circumstances in the future.

…

(3) The coroner must not include in the comments any statement that a person is, or may be—

(a) guilty of an offence; or

(b) civilly liable for something.

48 Reporting offences, corrupt conduct or police misconduct

…

(4) A coroner may give information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's profession or trade if the coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct.

(5) In this section—

disciplinary body for a person's profession or trade means a body that—

(a) licenses, registers or otherwise approves the carrying on of the profession or trade; or

(b) can sanction, or recommend sanctions for, the person's conduct in the profession or trade."

The requirement to afford natural justice

[7] The parties agree that the Coroner was required to afford natural justice to Mr Neumann.[2]

[8] The requirement is also spelled out in the guidelines issued under s 14 of the *Coroners Act.* It provides that the State Coroner must issue guidelines to all coroners about the performance of their functions in relation to investigations generally. A coroner must, when investigating a death, comply with the guidelines to the greatest practicable extent (s 14(5)).

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[2] *Annetts v McCann* (1990) 170 CLR 596.

[9] The State Coroner has issued guidelines under s 14 and they relevantly provide in Chapter 9 that:

> "Although not bound by the rules of evidence, coroners are obliged to ensure that the principles of procedural fairness are applied. One consequence of this is that if evidence adverse to any party is led, that party must be given an opportunity to respond. If the leading of such evidence has not been anticipated and the party whose conduct is criticised has not been involved from the outset of the inquest it will be necessary to adjourn the inquest and allow that party time to obtain representation and familiarise him/herself with all of the evidence that has been given …"

[10] It is also provided in the guidelines that:

> "Coroners should ensure a person who may be the subject of a possible referral [under s 48 of the *Coroners Act*] is given an opportunity to be heard before the referral is made."

What does natural justice require in a case like this?

[11] The "rules" of natural justice are flexible and will adjust to the circumstances.[3] The content of the rule in a case like this requires consideration of the relevant legislation, the nature and purpose of a coronial inquest, the circumstances being considered in the inquest, and the particular statements or actions being impugned.[4]

[12] The protean nature of the content of the rules allows for them to be moulded by the nature of an inquest itself. A coroner is in a singular position as to the scope and consequences of an inquest. It has been described in this way:

> "Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accuser defends, the judge holding the balance or the ring, whichever metaphor one chooses to use."[5]

[13] In an inquest there are no predetermined boundaries in the nature of, for example, pleadings. A coroner's court may, within reason, go wherever it is necessary to consider the issues and to reach its findings.

[14] There are particular provisions in the *Coroners Act* which bear upon this. They include the following:

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[3] *Kioa v West* (1985) 159 CLR 550 at 584-585.

[4] *Maksimovich v Walsh and the Attorney-General of New South Wales* (1985) 4 NSWLR 318 at 327, per Kirby P, and 341, per Samuels JA.

[5] *R v South London Coroner; ex parte Thompson* (1982) 126 SJ 625 at 628 per Lord Lane CJ. See also *Annetts v McCann* (1990) 170 CLR 596 at 616.

(a) The rules of evidence do not apply and the coroner may inform him or herself in any way appropriate - see s 37(1).

(b) Unless leave is granted, nobody (apart from counsel assisting and the Attorney-General) has any right to appear, examine witnesses, or make submissions - see s 36(1) and (4).

(c) There are no parties to an inquest. No-one can, as of right, call anybody as a witness nor compel the production of any documents. Those are powers reserved for the coroner - see s 37(2), (3) and (4).

(d) The privilege against self-incrimination is partly abrogated - see s 39.

(e) An inquest is required to be held in open court unless an order is made to the contrary - see s 31.

[15] The coroner is required to find the facts described in s 45 (if possible) and may make "comments" concerning the matters referred to in s 46(1). Those findings and any comments are required to be provided to any person who had a sufficient interest in the inquest and appeared at the inquest. They must also be published - see s 46A.

[16] In a case like this, when the coroner forms the view that he or she may make, or is likely to make, an adverse comment or a conduct referral, then the following must be done:[6]

(a) the relevant person must be alerted to the possibility that an adverse comment or conduct referral may be made,

(b) if all the material relevant to the possible adverse comment or conduct referral is not already in the possession of the person, then it should be provided,

(c) allow the person to appear, if requested, and examine witnesses relevant to the issue, and

(d) allow the person, if requested, to make submissions and provide material in response.

[17] If the evidence has closed, then, if it is sought by the person, the inquest should be re-opened for the purpose of receiving any further evidence on this issue.

Did the making of the adverse comments and the conduct referral involve a breach of the rules of natural justice?

[18] Mr Neumann argues that the making of the adverse comments involved a breach of the rules of natural justice. He relies upon a series of events in the history of the inquest to support that contention. They are:

(a) Before the pre-inquest conference, Mr De Waard (counsel assisting the coroner) prepared and provided a statement of issues which did not identify Mr Neumann's conduct as an issue to be considered in the inquest.

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[6] *Annetts v McCann* (1990) 170 CLR 596 at 599-601, per Mason CJ, Deane and McHugh JJ, 608-609, 612, per Brennan J, and 621, per Toohey J.

(b) There was nothing said at the pre-inquest conference that would have put Mr Neumann on notice that his conduct was to be considered as an issue.

(c) Mr De Waard showed the coroner copies of emails that passed between himself and Mr Neumann. Some of them were relevant to a consideration of Mr Neumann's conduct, but they were not tendered in evidence and Mr Neumann was not told that the coroner had been shown that correspondence.

(d) Mr Neumann did not attend any part of the hearing of the inquest. He was the investigating police officer and waited outside the courtroom while other witnesses gave evidence. It was intended that he would give evidence and he was listed as the last witness but he became ill and unable to do that.

(e) Mr De Waard says that, during the inquest, he told Mr Neumann's solicitor "that there were some concerns about the method in which" Mr Neumann "had obtained evidence and his responses and timeframes for completing tasks". Mr Neumann says there was no suggestion that this was notice that his conduct was to be an issue considered in the inquest.

(f) At the end of the evidence, the coroner excused Mr Neumann from giving evidence but did not tell him that his conduct was to be considered.

(g) Mr Neumann says that significant information was not put before the coroner with respect to contentions that Mr Neumann had attempted to obtain statements from many of the people proposed be called as witnesses by counsel assisting.

(h) After being excused from giving evidence, Mr Neumann took no part in the inquest and heard nothing further until receipt of Mr De Waard's submissions.

(i) Mr De Waard's submissions to the coroner were received by Mr Neumann on 13 October 2017. He was allowed until 9.00 am on 30 October 2017 to provide submissions regarding the allegations against him. He provided those submissions.

[19] Mr Neumann accepts that the written submissions of 13 October 2017 raised the adequacy of his conduct as an issue. But, he argues, this was insufficient to provide natural justice because:

(a) By that time the hearing of evidence had closed. The applicant had not heard any of the evidence and could not, for reasons of cost, obtain copies of the transcripts.

(b) He had not had the opportunity to examine witnesses at the inquest in relation to the issue of his conduct.

(c) He had had no opportunity to call any witnesses or to give evidence himself with respect to his conduct.

(d) The written submissions failed to refer to any evidence which would support the allegations made against him.

(e) The coroner was aware of email correspondence relevant to the adequacy of Mr Neumann's conduct without that having been disclosed to Mr Neumann.

[20] The applicant was not prevented from attending the hearing. It was his decision to remain outside the courtroom while evidence was being given. He was entitled to be present unless he was excluded by the coroner and that did not occur.

[21] Provision of the transcript of the evidence was not within the coroner's gift. Mr Neumann could have, in the time between the end of the evidence and receipt of the submissions of counsel assisting, obtained a copy of the transcript in the ordinary way.

[22] Mr Neumann was able, through his solicitors, to make a detailed submission about the matters concerning his conduct. Those submissions do not disclose any difficulty in understanding what was said to constitute the concerns about the way he had investigated the death. Indeed, he was able to set out a list of persons from whom he had sought statements and the evidence which he said would have been available about other aspects of his work.

[23] It was accepted on Mr Neumann's behalf that he could have asked for the inquest to be re-opened to deal with the matters raised in his submissions. He could have sought leave to be represented and to examine witnesses. But he did not. One of the unusual elements in this case is that the coroner was obliged to conclude the inquest because his retirement date was fast approaching. This restricted the time available to Mr Neumann to make his submissions but it was not contended that a request to reopen could not have been granted in the circumstances.

[24] One of the requirements of natural justice, or procedural fairness, is that fairness be afforded in a practical way to a person affected. While Mr Neumann had not been present during the hearing, all of the exhibits tendered at the inquest were provided to him on 15 March 2016. A lot of that material consisted of documents which had been prepared or written by him.

[25] The submissions from counsel assisting also need to be read in light of the interaction between Mr Neumann, counsel assisting and the coroner. Mr Neumann must be taken to have been aware of the various directions issued to him by the coroner both before and during the inquest, as well as the correspondence he had received from counsel assisting over that period of time. The extent of the obligation of the coroner falls within the description given by the Full Court of the Federal Court of Australia in *Commissioner for Australian Capital Territory Revenue v Alphaone Pty Ltd*:[7]

> "Where the exercise of a statutory power attracts the requirement for procedural fairness, a person likely to be affected by the decision is entitled to put information and submissions to the decision-maker in support of an outcome that supports his or her interests. That entitlement extends to the right to rebut or qualify by further information, and comment by way of submission, upon adverse material from other sources which is put before the decision-maker. It also extends to require the decision-maker to identify to the person affected any issue critical to the decision which is not apparent from its nature of the terms of the statute under which it is made. The decision-maker is

[7] (1994) 49 FCR 576 at 591-592. Approved by the High Court of Australia in *SZBEL v Minister for Immigration* (2006) 228 CLR 152 at 162, [32].

required to advise of any adverse conclusion which has been arrived at which would not obviously be open on the known material."

[26] The obligation on the coroner was satisfied by counsel assisting generally informing Mr Neumann of the possible adverse findings and conduct referral, the terms of those findings, and the various aspects of conduct subject to criticism.

Was there probative evidence to support the adverse comments?

[27] The applicant submits that there was no probative evidence that could reasonably support the coroner's findings concerning the applicant. That, it is argued, is because:

(a) the written submissions of counsel assisting do not refer to, or identify, any evidence before the coroner that could support his conclusions,

(b) the coroner's report fails to refer to, or identify, any evidence that could support those conclusions, and

(c) there was no evidence before the coroner (as identified in the exhibits list) that could support the conclusions.

[28] The written submissions of counsel assisting refer to some documents that were not in evidence and to assertions made by counsel assisting about the conduct of Mr Neumann. But, the task confronting a person who asserts that there was no probative evidence is a heavy one.

[29] The law on this issue is well set out in *Judicial Review of Administrative Action*:[8]

> " … there must be absolutely *no* evidence. If there is some evidence, no matter how unconvincing, and no matter how overwhelmed it might have been by evidence to the contrary, the traditional approach is to treat the complaint as being factual (although that is not to preclude the possibility of there being a jurisdictional error). The "no evidence" ground cuts out when even a skerrick of evidence appears. Perverse results for which there was some evidence do not amount to error of law. According to Mason CJ in *Australian Broadcasting Tribunal v Bond*:
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> > But it is said that "[t]here is no error of law simply in making a wrong finding of fact:" *Waterford v Commonwealth*, per Brennan J. Similarly, Menzies J observed in *R v District Court; Ex parte White*:
> >
> > > Even if the reasoning whereby the Court reached its conclusion were demonstrably unsound, this would not amount to an error of law on the face of the record. To establish some faulty (eg illogical) inference of fact would not disclose an error of law.
> >
> > Thus, at common law, according to Australian authorities, want of logic is not synonymous with error of law. So long as there is some basis for an inference – in other words, the particular inference is reasonably open – even if that inference appears to have been drawn as a result of the

[8] M Aronson and M Groves, *Judicial Review of Administrative Action* (5th ed, Lawbook Co, Pyrmont, 2013) at [4.600].

> illogical reasoning, there is no place for judicial review because no error of law has taken place." (authorities omitted)

[30] It should also be borne in mind that the Coroner's Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate – see s 37(1) of the *Coroners Act*. Thus, the coroner could take into account the matters referred to in the submissions of counsel assisting.

[31] The coroner was entitled to rely upon material tendered during the inquest including electronic recordings and transcripts of those recordings, the statements of witnesses, the statements of the applicant and the other documentary material generated by the applicant during the investigation. That is sufficient material to demonstrate that the applicant has not discharged the heavy onus under this aspect of his case.

Was the conduct referral prohibited s 46(3) of the *Coroners Act*?

[32] Sections 45(5) and 46(3) of the *Coroners Act* provide that a coroner must not include in the findings or comments "any statement that a person is, or maybe – … (b) civilly liable for something."

[33] Mr Neumann contends that the conduct referral falls within that description. He argues that the statements in [10] of the findings and the reference to the Police Commissioner "for consideration as to whether any disciplinary action should be taken" are statements which indicate that the applicant's conduct might render him liable to a disciplinary sanction.

[34] The heart of the argument for the applicant is that to be liable to a disciplinary sanction for misconduct is to be "civilly liable for something" because disciplinary proceedings are civil, not criminal.

[35] Disciplinary proceedings, it is true, are not criminal proceedings. It is convenient, then, for them to be included in the broad description of civil proceedings as a point of distinction. But that does not require a conclusion that a disciplinary sanction is the same as being civilly liable for something. Being "civilly liable for something" should be read as referring to the type of liability which might arise, for example, from a negligent or reckless act, that is, an act or omission which causes loss or damage to another.

[36] The referral was "for consideration as to whether any disciplinary action should be taken". It was not an expression of a view that Mr Neumann was liable to anyone for anything only that his conduct was to be referred for further consideration by the Police Commissioner. That, in turn, might lead to disciplinary proceedings. Disciplinary proceedings in the police service consider the conduct of police officers and can consider, for example, whether there has been a breach of the various regulations, codes and guidelines which govern police behaviour. Such a proceeding may involve consideration of conduct in a disciplined force and the protection of the public. When considering disciplinary proceedings under the *Legal Practitioners Act* 1898 (NSW), Mason J described them as "not criminal proceedings, they are proceedings sui generis."[9]

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[9] *Weaver v Law Society of NSW* (1979) 142 CLR 201 at 207.

[37] A similar provision, s 26 of the *Coroners Act* 1975 (SA), was considered by Nyland J in *Perre v Chivell*[10] where he said that the factual findings of a coroner cannot be said to be findings of criminal or civil liability. He went on to say:

> "A finding of criminal or civil liability requires the application of the relevant law to the facts in order to determine whether the essential elements of a given crime or civil obligation have been made out. It is not the coroner's role to undertake this process, it is the role of the courts, and this is what s 26(3) was enacted to ensure."

[38] The same consideration applies under s 46(3) of the *Coroners Act*. It is concerned with preventing the making of findings, or the suggestion thereof, of criminal or civil liability. It is not concerned with a reference to a disciplinary body which may result in a disciplinary proceeding.

Conclusion

[39] The applicant has not demonstrated any reason to make the declarations sought. The application is dismissed.

[10] (2000) 77 SASR 282 at 295, [56]