



Western

Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 7/17

*I, Sarah Helen Linton, Coroner, having investigated the death of **Subhas CHANDRA** with an inquest held at the **Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth** on **6 and 7 February 2017** find that the identity of the deceased person was **Subhas CHANDRA** and that death occurred between **3 and 4 November 2013** at **160 President Street, Kewdale**, as a result of **aspiration of vomit in a man with focal coronary arteriosclerosis** in the following circumstances:*

Counsel Appearing:

Ms F Allen assisting the Coroner.

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INTRODUCTION

1. In the early hours of the morning on Sunday, 3 November 2013 Subhas Chandra (the deceased) was involved in an altercation with a housemate at the house where he lived in Kewdale. Following the altercation the deceased called the police and made a complaint of assault. Shortly afterwards police officers attended the house and spoke to the deceased and the other occupants. The police officers then left the house, without making any arrests, and the deceased went to his bedroom. That was the last time the deceased was known to be alive.

2. The deceased was usually in regular contact with his family, who lived overseas, so they quickly raised the alarm when he was unable to be contacted during the day on 3 November 2013. At their request friends of the deceased went to his house in Kewdale to look for him. They spoke to a housemate of the deceased but they were not allowed to enter the house. On the first occasion they attended the friends were told the deceased had been seen that day, so they were reassured that he was alright and communicated that information to his family. However, when the deceased's family continued to raise their concerns about his welfare, the friends returned to the deceased's house for a second time. During the second conversation with the deceased's housemates the friends became concerned that the circumstances were suspicious. As a result, they contacted the deceased's family and told them they should report their concerns to the police.

3. The deceased's family contacted police and asked them to conduct a welfare check on the deceased. Police officers attended the deceased's home on the morning of 4 November 2013. After being unable to get a response from the deceased, they eventually gained entry to his locked bedroom, where they found the deceased lying unresponsive on his bed. It was apparent he had died some time earlier.

4. A police investigation commenced into his death. Initially, it was concluded by detectives from Major Crime Squad that there were no suspicious circumstances surrounding the death. However, as further evidence came to light some questions were raised as to the potential involvement of one of the deceased's housemates in his death. In order to explore this possibility further, the Acting

State Coroner concluded that it was desirable that an inquest be held pursuant to s 22(2) of the *Coroners Act 1996* (WA).

5. I held an inquest at the Perth Coroner's Court on 6 and 7 February 2017.
6. The documentary evidence included a comprehensive report of the investigation into the death prepared by the Western Australia Police, including statements and transcripts of interviews with the various housemates.¹
7. The inquest focused primarily on the witness accounts of events surrounding the reported assault on the deceased on 3 November 2013 and the objective evidence as to how the death occurred. In particular, the housemate who was involved in the physical altercation with the deceased prior to his death, Mr Dylan Mansfield, was called as a witness at the inquest and was questioned as to whether he had any involvement in the death. The two other housemates who were there that night, Mr Alexander Gilvary and Ms Bonnie Cugley-Turner, were not able to be served with witness summonses. Interestingly, despite having not been served with a witness summons, Ms Cugley-Turner did briefly attend the courtroom while the inquest hearing was proceeding, but before she was able to be called as a witness she left the courtroom and could not be contacted after this time. In the end, I heard oral evidence only from Mr Mansfield, Dr Clive Cooke who conducted the post mortem examination and some police officers involved in the investigation.

THE DECEASED

8. The deceased was born on a small farm in Fiji and was the second youngest of five children. He was of Hindi religion. The deceased and his wife migrated to New Zealand and he lived there with his wife, son and daughter. The deceased then moved to Australia in 2010 for work opportunities, leaving his family in New Zealand. The deceased was working while making plans for his family to move to Australia to reunite with him. Whatever he

¹ Exhibits 1 – 3.

did, he did for his family. The deceased worked in various parts of Australia before eventually moving to Perth.²

9. Most recently the deceased had been working as an electrician for a company in Perth. Prior to his death the deceased had experienced some workplace issues and had lodged a worker's compensation claim in September 2013 for injuries he alleged he had suffered as a result of sexual harassment, bullying and racism committed by another employee. The deceased was subsequently made redundant on 2 October 2013, which he was concerned was related to his compensation claim.³ The deceased had apparently initially been a little sad about his redundancy but at the time of his death was in a better frame of mind and was looking for work.⁴
10. As far as the deceased's family were aware he was a healthy and active man, so his early death was unexpected.⁵
11. The deceased's doctor, Dr Elaine Soon, provided a report to police after his death. Dr Soon advised that the deceased first visited her on 13 September 2013 after he had sustained a head injury, with possible loss of consciousness, when he tripped over a pole at work. This incident was later the subject of a worker's compensation claim. The deceased also sustained soft tissue injuries to the left side of his neck, his left shoulder, left mid-thoracic spine, lower back and left ankle in the fall. The deceased had already seen one of Dr Soon's colleagues on 5 September 2013 in relation to a worker's compensation injury to his left shoulder sustained on 4 September 2013. That injury resolved on 11 September 2013 and his compensation claim was finalised.⁶
12. When Dr Soon saw the deceased on 13 September 2013 she prescribed Panadol Osteo and Celebrex for his soft tissue injuries. She continued to review him for his soft tissue injuries over the following weeks and on 4 October 2013 she prescribed Panadeine forte as his left ankle injury was causing him a lot of pain. On 18 October 2013 Dr Soon added Flexall (menthol) gel as

² Email to counsel assisting from Sylvia Chandra 6.2.2017.

³ Exhibit 1, Tab 17.

⁴ Exhibit 1, Tab 16.3.

⁵ Exhibit 1, Tab 16.1 and 16.2 [4].

⁶ Exhibit 1, Tab 17.

the deceased had strained his left posterior thigh muscles when performing a strengthening exercise on his left ankle.⁷

THE HOUSE IN KEWDALE

13. Approximately two months prior to his death the deceased had moved into shared accommodation at an address in President Street, Kewdale.⁸ There were a number of occupants of the house, who moved in at different times. At the time of his death the deceased shared the house with Mike McLaughlin (who had lived there since May 2013),⁹ Alex Gilvary (who had lived there since August 2013), Dylan Mansfield and Bonnie Cugley-Turner (who had moved in to the house in late October 2013) and another male who was a shift worker and was not living in the house for the three weeks leading up to the deceased's death. Each of the occupants had their own room and their own financial arrangement with the landlord, other than Mr Mansfield and Ms Cugley-Turner, who shared the main bedroom together.
14. The deceased was nearly 50 years of age, whereas the other occupants were mostly in their late teens. According to Mr Gilvary, the deceased was initially hard to get to know, which was perhaps not surprising given their significant disparity in age and lifestyle. However, after Mr Gilvary helped the deceased with a computer problem one night they apparently became friends.¹⁰ Mr Gilvary described the deceased as a "good man"¹¹ and "a modest, proud man"¹² who spent most of his time in the house cooking or talking to his family on the phone or via Skype.¹³ He showed Mr Gilvary how to make curries and had given him a lift on occasion but otherwise usually kept to himself, as did the other housemates generally.¹⁴
15. Mr Gilvary was aware that the deceased did not get on with all of the other housemates. In particular, the deceased and Mr Mansfield did not get on and would fight over petty issues.¹⁵ Mr

⁷ Exhibit 1, Tab 17.

⁸ Exhibit 1, Tab 16.2 [5].

⁹ Exhibit 1, Tab 15.

¹⁰ Exhibit 1, Tab 8.2 [7] – [8].

¹¹ Exhibit 1, Tab 9, p. 7.

¹² Exhibit 1, Tab 9, p. 7.

¹³ Exhibit 1, Tab 9, p. 24.

¹⁴ Exhibit 1, Tab 9, p. 7 and Tab 15 [5], [11].

¹⁵ Exhibit 1, Tab 8.2 [7] and Tab 8.3 [2] and Tab 9, p. 10.

Mansfield does not appear to have been popular with any of the other housemates during his short stay in the house, with complaints about his alleged drug taking and bringing unwanted guests into the house. Mr Mansfield acknowledged that there had been complaints about his behaviour to the landlord prior to the deceased's death, which was part of his explanation for his odd behaviour later when people began looking for the deceased.¹⁶

THE ALTERCATION

16. Sometime before midnight on Saturday, 2 November 2013, the deceased came home, slammed the front door and started yelling. It seems he was angry as he had not been able to open the garage door. The deceased came up to Mr Mansfield and Mr Gilvary and asked them about the garage door. According to Mr Gilvary, Mr Mansfield had previously unplugged the garage door so the deceased couldn't get his car inside, so there was some history to this issue. Mr Gilvary thought Mr Mansfield had done something similar again this night.¹⁷ According to Mr Mansfield, on the other hand, Mr Gilvary had put a chair under the connecting door that accessed the garage to stop the door from banging, which had forced the deceased to enter through the front door and made him angry.¹⁸
17. According to Mr Gilvary, Mr Mansfield and the deceased began to argue. He recalled the deceased seemed angry and Mr Mansfield also became "worked up."¹⁹ However, according to Mr Mansfield, it was Mr Gilvary and the deceased who initially began to have a heated argument.²⁰
18. What seems to be agreed is that the fight then escalated into a physical confrontation, which became mainly between the deceased and Mr Mansfield.²¹ Mr Gilvary described Mr Mansfield as the main aggressor but the deceased was also an active participant in the scuffle.²² They threw a few punches at each other, but according to Mr Gilvary neither man looked like they

¹⁶ Exhibit 1, Tab 11, p. 17.

¹⁷ Exhibit 1, Tab 8.2 [11] and Tab 8.3 [5] and Tab 9 p. 4.

¹⁸ T 18.

¹⁹ Exhibit 1, Tab 8.1 [6].

²⁰ T 18.

²¹ T 18.

²² Exhibit 1, Tab 9, p. 15.

were hurting the other.²³ He described it as like “a school playground fight.”²⁴ The deceased pushed Mr Mansfield and as he stumbled back Mr Mansfield’s head struck Mr Gilvary’s head, causing Mr Gilvary’s nose to bleed. Mr Gilvary pushed Mr Mansfield back into the deceased and then went back into his room, as he was in the process of completing a timed online test for his new job.²⁵

19. At the inquest Mr Mansfield admitted throwing a punch at the deceased.²⁶ He acknowledged that the graze later seen on the deceased’s cheek would have come from him punching the deceased, and said it occurred after he had been pushed back into Mr Gilvary. He stated he thought he had hit the wall but accepted he must have got the deceased on the cheek.²⁷ Mr Mansfield’s evidence was that he then pushed the deceased with a flat palm to his chest and forced the deceased towards his bedroom door.²⁸ Mr Mansfield accepted he then followed the deceased into the deceased’s bedroom. Mr Mansfield admitted that he pushed the deceased onto his bed and made him sit down. In his evidence at the inquest he denied continuing to fight with the deceased. It was put to Mr Mansfield that he told the police in his second statement that he had hit the deceased twice, and “threw the last punch when [the deceased] was sitting on his bed.”²⁹ He indicated that he did not recall hitting the deceased a second time.³⁰
20. Mr Mansfield was asked if he had put the deceased in a sleeper hold or choke hold at any stage and he denied having done so.³¹ Mr Mansfield maintained that after pushing the deceased onto the bed he told the deceased to calm down and then went and stood in the doorway of the bedroom.³²
21. In the meantime, Mr Gilvary had returned to his own bedroom. He recalled that after approximately five minutes had elapsed Mr Gilvary finished a question on his test so the timer would stop

²³ Exhibit 1, Tab 8.3 [8] and Tab 9, p. 4.

²⁴ Exhibit 1, Tab 9, p. 14.

²⁵T 19; Exhibit 1, Tab 8.2 [12] and 8.3 [9].

²⁶ T 18.

²⁷ T 20.

²⁸ T 18, 20.

²⁹ Exhibit 1, Tab 10.2 [10].

³⁰ T 29 – 31.

³¹ T 19, 32

³² T 19.

then walked out of his bedroom again. He called out to Mr Mansfield and said words to the effect of, "Leave it man."³³ At that time Mr Mansfield's partner was heard to scream loudly from the other end of the house as she had hurt her ankle. Mr Gilvary saw Mr Mansfield come running out of the deceased's bedroom to see what had happened to his partner. As Mr Mansfield ran out of the bedroom the deceased was heard to yell out, "I'm calling the police."³⁴ The deceased then slammed his bedroom door closed and Mr Gilvary could hear the deceased talking on the telephone.³⁵ Mr Gilvary went to Mr Mansfield's bedroom to check on Ms Cugley-Turner and then returned to his bedroom.³⁶

POLICE ATTENDANCE

22. The deceased's telephone shows he called the Kewdale police at 11.47 pm on 2 November 2013.³⁷
23. Three officers from Belmont Police Station (being Constable Bradley Tobiassen and Constable Kevin O'Shea and Acting Sergeant Rossi) attended the house at 12.20 am. The officers spoke with Mr Gilvary, Mr Mansfield, Ms Cugley-Turner and the deceased. The officers ascertained that the argument had begun over the broken garage door and there had been pushing on both sides. Mr Gilvary and Mr Mansfield indicated that the deceased had been the initial aggressor but they did not want to make a complaint in relation to the pushing against themselves and maintained that there was no punching (which is contrary to what Mr Mansfield later admitted about possibly landing a single punch).³⁸ Constable O'Shea recalled that the housemates seemed quite surprised that the deceased had called the police.³⁹ They were cooperative with police and their evidence was generally consistent with each other.⁴⁰
24. Constable O'Shea recalled that the deceased was genuinely upset and agitated at the time they spoke to him, which resulted in his

³³ Exhibit 1, Tab 8.2 [16].

³⁴ Exhibit 1, Tab 8.2 [16] – [17].

³⁵ Exhibit 1, Tab 8 [13] and Tab 9, p.4.

³⁶ Exhibit 1, Tab 9, pp. 4 – 5.

³⁷ Exhibit 1, Tab 16.1 and Tab 16.2 [9].

³⁸ T 76; Exhibit 1, Tab 23, p. 1.

³⁹ T 49.

⁴⁰ T 50, 52.

account being incoherent and not consistent.⁴¹ Constable Tobiassen recalled that the deceased said he was punched in the face during the ‘push and shove’ scuffle.⁴² Constable Tobiassen recalls seeing a tiny bit of swelling, like a puffy cheek, on the deceased’s face but the injury was very minor in nature.⁴³ Unlike his housemates, the deceased *did* wish to make a complaint of an assault in relation to the matter.⁴⁴

25. After speaking to all the parties the police officers decided not to pursue the matter given the conflicting witness accounts, which they believed made it impossible to determine who was telling the truth. The deceased was advised of their decision that they would not lay any charges. The deceased was reportedly unhappy with the outcome but he was also understanding.⁴⁵
26. Mr Mansfield recalls that prior to the police officers leaving the house they asked Mr Mansfield and the deceased to shake hands in front of them.⁴⁶ Constable O’Shea gave evidence that he could not recall asking the men to shake hands but it was not something he has ever done before, so he didn’t think it was something that he would have said. He agreed he was more likely to have told them to stay away from each other, as suggested by Mr Gilvary.⁴⁷ Acting Sergeant Rossi agreed that they simply told the housemates to stay away from each other.⁴⁸ Having told the men to stay out of each other’s way, they then left the scene at 12.45 am.
27. Acting Sergeant Rossi recalls that they offered to wait with the deceased if he wanted to collect some things and go stay the night elsewhere, but he declined their offer.⁴⁹
28. After the police left the house the deceased went to his bedroom and shut his door. None of the housemates are certain that they saw or heard the deceased after this time. His bedroom door remained locked and his car was in the garage.⁵⁰

⁴¹ T 47 – 49.

⁴² Exhibit 1, Tab 20.6.

⁴³ Exhibit 1, Tab 20.7.

⁴⁴ Exhibit 1, Tab 23, p. 1.

⁴⁵ T 76; Exhibit 1, Tab 23, p. 1.

⁴⁶ T 18, 20.

⁴⁷ T 49.

⁴⁸ T 53.

⁴⁹ T 53.

⁵⁰ Exhibit 1, Tab 8.3 [17].

29. Mr Mansfield claimed at the inquest that after the police left he knocked on the door to the deceased's bedroom and asked if he could shake the deceased's hand and say sorry, but the deceased did not open the door and told Mr Mansfield he was fine and asked him to go away.⁵¹ Mr Mansfield had not mentioned this conversation to police previously when interviewed, but maintained at the inquest that he was "pretty sure"⁵² that this conversation occurred.
30. Mr Mansfield was asked at the inquest whether he went into the deceased's bedroom again after the police had left, which he denied. He was also specifically asked if he went into the deceased's room and did any harm to him in any way, which he also denied.⁵³
31. Mr Gilvary did not see the deceased again⁵⁴ but he initially told police that he heard the deceased go into the bathroom and come and go from his room later in the morning (being the morning of Sunday, 3 November 2013).⁵⁵ However, when he provided his second statement he stated that although he thought he may have heard the deceased have a shower, he was "not 100% sure."⁵⁶ In this third statement, he clarified that he thought the deceased had a bath on the Sunday night, but Ms Cugley-Turner later told him that the two children she was caring for had a bath in his bathroom, which is what he also told the police when he participated in an electronically recorded interview on 17 July 2014.⁵⁷ It is clear from the above that Mr Gilvary was confused about what he had heard, and made assumptions about the deceased having a bath or shower that cannot be relied upon.
32. Ms Cugley-Turner did not see the deceased again after the police left, although she also recalled hearing his door slam a short while later and the shower run, which might have been the deceased.⁵⁸

⁵¹ T 27 – 28.

⁵² T 28.

⁵³ T 33.

⁵⁴ Exhibit 1, Tab 8.3 [14].

⁵⁵ Exhibit 1, Tab 8.1 [13].

⁵⁶ Exhibit 1, Tab 8.1 [20].

⁵⁷ Exhibit 1, Tab 8.3 [35] and Tab 9, pp. 5, 18.

⁵⁸ Exhibit 1, Tab 12, p. 2 and Supplementary Statement [11] – [12].

33. Ms Cugley-Turner recalled that Mr Mansfield spent some time in Mr Gilvary's room after the police left, contrary to Mr Gilvary's account.⁵⁹

THE SEARCH FOR THE DECEASED

34. At 5.30 pm on 3 November 2013 the deceased's wife contacted a friend, Masaniga Boland, who lives in Perth. The deceased's wife asked Mrs Boland to check on the deceased as she had been calling him all day and he was not answering his phone. Mrs Boland rang the deceased's telephone and left a message asking him to contact his wife. The deceased's wife sent another message to Mrs Boland indicating she had had no response from the deceased and asked if she could go and check on the deceased. Mrs Boland then went with her husband and youngest son to the deceased's home in Kewdale sometime after 7.00 pm.⁶⁰
35. When they arrived at the house they were met by a man she did not know but who was later identified as Mr Mansfield. Mrs Boland told Mr Mansfield that she was looking for the deceased as the deceased's wife needed to get in touch with him and talk to him. According to Mrs Boland, Mr Mansfield said that the deceased was not at home and must have gone out. Mrs Boland thought Mr Mansfield seemed normal and friendly during this conversation.⁶¹ She asked Mr Mansfield to tell the deceased to get in touch with his wife as she was worried about him. Mrs Boland recalls that Mr Mansfield said that he would definitely do that and indicated at that time that he had seen the deceased that day walking in and out of his room a few times, and had seen him as recently as three hours before Mrs Boland arrived. Mr Mansfield also said he had seen the deceased in his car on the road from a distance. Mrs Boland felt relieved by what Mr Mansfield told her and subsequently went home and sent a reassuring message to the deceased's wife.⁶²
36. Mr Mansfield's also gave an account of his conversation with Mrs Boland. He recalled a woman coming to the door and asking to see the deceased and agreed that he denied her access to the

⁵⁹ Exhibit 1, Tab 12, Supplementary Statement [6] – [8].

⁶⁰ Exhibit 1, Tab 14 [6] – [13].

⁶¹ T 38.

⁶² T 36 – 37; Exhibit 1, Tab 14 [15] – [31].

house. He maintained he was just following the rules of his agreement with the landlord, which stipulated that he was not to allow visitors into the house. Mr Mansfield claimed he told Mrs Boland she would have to contact the homeowner to be allowed access into the house.⁶³

37. Mr Mansfield also indicated he told her he thought he had heard the deceased's door open and shut and the sound of his car starting and then seen him drive his car down the street but acknowledged it was a common type of car and he might have been mistaken.⁶⁴
38. Ms Cugley-Turner was apparently also present during this first conversation but all she indicated in her police statement was that they tried to reassure Mrs Boland and her family that the deceased was "just keeping to himself."⁶⁵ As indicated earlier, Ms Cugley-Turner was unable to be called as a witness at the inquest, so she was unable to be questioned further about what was said at this time.
39. Mr Mansfield claimed at the inquest that he later went and knocked on the deceased's door five times, without getting a response and he found the door was locked when he tried to turn the handle. He also noticed the deceased's car was in the garage, and went to tell someone in the house but could not find any other housemates.⁶⁶ He also claimed to have gone and tried to look into the deceased's bedroom through the outside window but his view was blocked by the blinds. He then assumed the deceased may have gone for a walk or a run to cool off.⁶⁷
40. Although Mrs Boland had sent a reassuring message to the deceased's wife, Mrs Chandra was still concerned as the deceased would usually call her a few times a day. In particular, at this time it was Diwali, the Hindu festival of lights, and usually the deceased would call his family at that time.⁶⁸
41. As the deceased's wife remained concerned, she asked Mrs Boland if she could go back and see the deceased in person. Mrs

⁶³ T 21, 23.

⁶⁴ T 22.

⁶⁵ Exhibit 1, Tab 12, p. 2.

⁶⁶ T 24, 26.

⁶⁷ T 24.

⁶⁸ Exhibit 1, Tab 14 [32] – [33].

Boland agreed to go and quickly returned to the deceased's house with her eldest son at 8.00 pm. Once there she spoke again to Mr Mansfield, who was sitting with a neighbour out the front of the house.⁶⁹

42. Mr Mansfield recognised Mrs Boland and came over to speak to her. Mrs Boland explained that the deceased's family were still worried and she asked to be allowed to go into the deceased's room and also to check for the deceased's car. Mr Mansfield said that the deceased hadn't come back to the house and wouldn't allow Mrs Boland to enter the house. He told her he was not allowed to permit visitors into the house under the lease agreement, although this rule was not confirmed by the other housemates.⁷⁰ Mrs Boland asked him to open up the garage so she could check if the deceased's car was there, but he said the door was locked and that he did not have a key.⁷¹
43. Mrs Boland recalled that another person, who it seems was Mr Gilvary, joined them and she started talking to him while Mr Mansfield spoke to the deceased's daughter on Mrs Boland's telephone.⁷²
44. According to Mr Gilvary, Mr Mansfield had beckoned him to come outside at that time.⁷³ Mr Gilvary recalls that Mrs Boland told him that she knew the deceased's family and they were worried about him. According to Mrs Boland, Mr Gilvary said he had been working the Saturday night and hadn't seen the deceased, while Mr Gilvary recalls that he said that he couldn't recall exactly when he had last seen him.⁷⁴ Mrs Boland gave Mr Gilvary her contact number and asked him to get the deceased to call her or his wife.⁷⁵
45. The deceased's daughter, Ms Sylvia Chandra, recalls that when she spoke to Mr Mansfield he told her that he had last seen the deceased come out of the shower on the morning of 3 November

⁶⁹ T 25, 38.

⁷⁰ T 39; Exhibit 1, Tab 9, pp. 20 – 23.

⁷¹ T 39.

⁷² T 39.

⁷³ Exhibit 1, Tab 9, p. 5.

⁷⁴ Exhibit 1, Tab 9, p. 5.

⁷⁵ Exhibit 1, Tab 14 [53] – [62].

2013. He said he would tell the deceased that Ms Chandra had called when he saw the deceased again.⁷⁶

46. At some stage during the second visit Mr Mansfield told Mrs Boland that the deceased had been angry the previous evening and the police had attended. She became very concerned and suspicious on hearing this information. She immediately spoke to the deceased's wife on the telephone, while still at the Kewdale house and within the hearing of Mr Mansfield and Mr Gilvary, and told the deceased's wife that she should call the police.⁷⁷ Shortly afterwards Mrs Boland and her son left the house.
47. Ms Cugley-Turner said in her statement to police that she gave her own telephone number to Mrs Boland before she left the second time, so that Mrs Boland could call to check up later.⁷⁸ Mrs Boland did not mention this in her evidence.
48. In the meantime, Mr Gilvary took the message he had written down from Mrs Boland to the deceased's room. He knocked on the door and called out to the deceased but the deceased did not answer. Mr Gilvary told police he assumed that the deceased had gone out and slipped the message under the deceased's bedroom door for him to find.⁷⁹ Mr Gilvary recalled that Mr Mansfield tried to open the deceased's door at this time but the door was locked. Mr Gilvary thought he observed a light under the bedroom door.⁸⁰ Mr Gilvary then went to bed as he had to work the following day. Ms Cugley-Turner also thought she saw a light on in the room, but she could not hear anybody inside and the deceased did not answer the door.⁸¹
49. The deceased's wife and daughter attended the Auckland Central Police Station on 4 November 2013 to request police assistance to locate the deceased. They had last heard from him by telephone at 4.30 pm on Saturday, 2 November 2013 (some hours before his altercation with Mr Mansfield). At that time the deceased was in good spirits and looking forward to celebrating Diwali the following night. He told them he would call them the following day, and they were expecting him to telephone them first thing in

⁷⁶ Exhibit 1, Tab 16.2 [13].

⁷⁷ Exhibit 1, Tab 14 [34] – [48], [53] – [62].

⁷⁸ Exhibit 1, Tab 12, p. 2.

⁷⁹ Exhibit 1, Tab 9, p. 24.

⁸⁰ Exhibit 1, Tab 8.1 [16] – [18] and Tab 8.2 [23] and Tab 9, p. 5.

⁸¹ Exhibit 1, Tab 12, p. 3.

the morning. They told the Auckland police about Mrs Boland's unsuccessful attempts to locate the deceased. The Auckland police officers passed on the relevant information to Interpol and Interpol Canberra contacted WA police and asked them to assist in locating the deceased.⁸² In the meantime, the deceased's family made urgent arrangements to fly to Perth due to the level of their concern.⁸³

DISCOVERY OF THE DECEASED'S BODY

50. Constable Tobiassen, who was one of the officers who attended the house on 3 November 2013, was on duty on the morning of Monday, 4 November 2013. He recalled that a job came through indicating that the deceased's family had concerns about his welfare. Constable Tobiassen and First Class Constable Scragg were tasked to go to the deceased's home and check on him.⁸⁴ They attended the house just before 7.00 am.⁸⁵ Mr Gilvary let them into the house and showed them the deceased's room.⁸⁶
51. The two police officers noted the deceased's bedroom door was securely locked. They knocked loudly on the door several times but received no response. They went outside the house and found the window to the bedroom was also secure and the curtains were closed, so they couldn't see into the deceased's bedroom.⁸⁷
52. Another housemate, Mr McLaughlin, had just returned from a holiday to Bali in the early hours of Monday morning. He had only just gone to bed when police officers knocked on his door and asked him about the deceased. Mr McLaughlin suggested they could use his key to try to open the deceased's bedroom door. Mr McLaughlin was surprised when the police officers did try the key and it opened the deceased's door, as he had believed that each bedroom had its own individual lock and individual key.⁸⁸ The housemates later checked all their keys and Mr Gilvary found that his keys opened all the doors in the house

⁸² Exhibit 1, Tab 6 and Tab 16.3.

⁸³ Email to counsel assisting from Sylvia Chandra 6.2.2017.

⁸⁴ T 76 – 77.

⁸⁵ Exhibit 1, Tab 7.

⁸⁶ Exhibit 1, Tab 7.

⁸⁷ Exhibit 1, Tab 7.

⁸⁸ Exhibit 1, Tab 9, p. 6 and Tab 15 [15] – [21].

except Mr Mansfield's main bedroom door.⁸⁹ Ms Cugley-Turner told police that her key (the same as Mr Mansfield's) only opened the master suite bedroom, unlike the other housemates' keys.⁹⁰ Mr Mansfield also later gave evidence that on the day he moved in to the house he had tested his key and tried everyone else's key, to make sure no one else had a matching key.⁹¹

53. On opening the door the police officers observed the deceased lying face down on his bed with his hands tucked underneath his chest. He was dressed in shorts and a t-shirt. He was cold to the touch and there were signs of rigidity to his body. The room was cluttered with objects but in a tidy state. The deceased's medication was placed on his bedside table. There was no evidence to suggest unusual amounts were missing.⁹² The deceased's wallet was found on his desk. Constable Scragg noted the main ceiling light was on, as was the heater and fan.⁹³ The note was still in the same place where Mr Gilvary had pushed it under the door the night before.⁹⁴ Constables Scragg and Tobiassen could not see any injuries or anything of a suspicious nature at the scene. The only thing that struck them as unusual was the fact that the deceased was lying on his arms.⁹⁵ Constable Tobiassen was also struck later by some inconsistencies in the statements of the housemates, that made him think something was "a little bit suspicious" although after discussing the matter with detectives he acknowledged they concluded there was "nothing to point to a suspicious cause of death."⁹⁶
54. Ambulance officers were requested at 7.17 am and arrived at the house at 7.24 am. The ambulance officers examined the deceased and noted he showed obvious signs of death, including rigor mortis and lividity in the lower limbs. One of the ambulance officers certified that he had died.⁹⁷
55. Constable Tobiassen began to take photographs of the deceased and scene while Constable Scragg contacted the 'on road'

⁸⁹ Exhibit 1, Tab 8.3 [20] and Tab 9, p. 21.

⁹⁰ Exhibit 1, Tab 12, Supplementary Statement [15] – [16].

⁹¹ T 17.

⁹² Exhibit 1, Tab 23.2.

⁹³ Exhibit 1, Tab 7.

⁹⁴ Exhibit 1, Tab 9, p. 6.

⁹⁵ T 77 – 78.

⁹⁶ T 78 – 79.

⁹⁷ Exhibit 1, Tab 3 and Tab 21.

detectives due to the earlier reported police attendance.⁹⁸ Detective Sergeant James Bradley from Major Crime Squad was then contacted by local detectives. He was told the general observations of the police officers at the scene and he reviewed the police incident report from the previous day. Based upon the information available to him, Detective Sergeant Bradley concluded the death did not appear to be suspicious and directed that the investigation into the death be conducted by the Coronial Investigation Unit.⁹⁹

POST-MORTEM EXAMINATION

56. On 6 November 2013 the Chief Forensic Pathologic, Dr Clive Cooke, made a post-mortem examination of the body of the deceased. In view of the history of police attendance prior to the death, Dr Cooke requested that police attend the post mortem examination.¹⁰⁰ Several police officers attended the mortuary, including Detective Sergeant Bradley, and a photographic record of the examination of the body of the deceased was made.¹⁰¹
57. Prior to commencing the full post-mortem examination, the deceased underwent an external examination for any suspicious injuries. Dr Cooke explained that the detection of most suspicious injuries is quite straightforward and takes only a matter of 10 seconds or so to detect them. Dr Cooke indicated that in this case, given the history of earlier police involvement, particular attention was paid to the presence or absence of any suspicious type injuries. The examination includes looking for restraint injuries and any type of marks around the neck suggesting strangulation or compression, as well as any sign of petechiae (small blood spots around the eyes), which is a tell-tale sign of asphyxia.¹⁰²
58. The examination showed a small abrasion to the skin of the left cheek with no internal injuries (consistent with the minor injury

⁹⁸ T 78; Exhibit 1, Tab 7.

⁹⁹ Exhibit 1, Tab 4.

¹⁰⁰ T 55 – 56.

¹⁰¹ Exhibit 1, Tab 4 and Tab 26.4.

¹⁰² T 56 – 57.

observed by Constable Tobiassen shortly after the altercation).¹⁰³
Dr Cooke described it as a “relatively trivial injury.”¹⁰⁴

59. The deceased’s lungs were congested, which is a non-specific finding. Dr Cooke observed possible regurgitated vomit staining of the upper airway. There was early, localised narrowing of one of the arteries on the surface of the heart (early focal coronary arteriosclerosis). The narrowing was judged to be moderate at approximately 40%.¹⁰⁵ At the conclusion of the initial examination Dr Cooke left the cause of death as undetermined, pending investigations.¹⁰⁶
60. Microscopic examination of the body tissues confirmed the presence of focal coronary arteriosclerosis and showed terminal aspiration of vomit into the small airways to the lungs. Tests for a significant viral infection were negative. Microbiology testing showed the presence of some bacteria in a lung tissue sample (Streptococcus and Staphylococcus), most likely a result of aspiration of vomit. These organisms can cause respiratory infection but, in the absence of pre-existing illness, and microscopic changes in the lungs of pneumonia, it appeared to Dr Cooke that the presence of the bacteria was a result of post mortem contamination. The deceased’s sugar (glucose) level was not raised. Toxicology analysis showed no alcohol or common drugs.¹⁰⁷
61. In the end, after all of the investigations, the only real finding was a confirmation that the deceased had coronary artery disease.¹⁰⁸
62. In the absence of further findings Dr Cooke formed the view it appeared that the deceased died as a result of a sudden disturbance in the normal beating rhythm of the heart (cardiac arrhythmia) arising on the basis of localised coronary artery disease. Dr Cooke also expressed the opinion that it was possible that physiological stress and emotional stress associated with the recent confrontation played a part in causing the likely arrhythmia.¹⁰⁹ Dr Cooke explained that about once a year they

¹⁰³ T 57.

¹⁰⁴ T 58.

¹⁰⁵ Exhibit 1, Tab 26.4.

¹⁰⁶ Exhibit 1, Tab 26.3.

¹⁰⁷ T 60 – 61; Exhibit 1, Tab 26.2.

¹⁰⁸ T 60.

¹⁰⁹ T 61.

have a known death where a person dies suddenly and unexpectedly during some sort of confrontation, and all they have is coronary artery disease, so it is not an uncommon or unknown phenomenon.¹¹⁰

63. Terminally, the deceased appears to have aspirated (“choked”) on regurgitated stomach contents (vomit). Dr Cooke explained that this is a common thing in anyone who is dying.¹¹¹ On the basis of those findings, on 7 February 2014, Dr Cooke formed the opinion that the cause of death was aspiration of vomit in a man with focal artery arteriosclerosis.¹¹²
64. Dr Cooke was asked whether it is unusual that the deceased had no previous documented cardiac history. He agreed that it would be unusual, but also noted that it can happen. Dr Cooke also agreed that you would expect a person to display symptoms of arteriosclerosis, such as chest pains, but again it is not uncommon for people to have no symptoms.¹¹³
65. Dr Cooke described the deceased’s level of coronary artery disease as “at least moderate”¹¹⁴ and acknowledged that at an estimated 40 per cent it was not a huge amount of coronary artery disease. Dr Cooke explained that he would normally want to see 60 per cent to feel really comfortable that someone has died as a result of coronary disease, but in the absence of any other finding, and in the context of the police information about an acutely stressful event prior to his death, that was all he could identify.¹¹⁵
66. However, further police investigation identified the possibility of neck compression (“sleeper hold”) as a possible factor in the death (coming from information provided by a witness). This prompted Dr Cooke to review his earlier findings and conclusion and change the cause of death to “unascertained.”¹¹⁶
67. Dr Cooke explained at the inquest that if the deceased had been placed in a neck hold, there are signs that you would hope to see,

¹¹⁰ T 62.

¹¹¹ T 60 – 61.

¹¹² Exhibit 1, Tab 26.2.

¹¹³ T 62.

¹¹⁴ T 62.

¹¹⁵ T 62 – 63.

¹¹⁶ T 62 – 63; Exhibit 1, Tab 26.1.

although any or all of them may not be present in a particular case. Dr Cooke described the signs he would look for as:

- i. some marking to the skin of the neck;
 - ii. some internal neck injury;
 - iii. petechiae, around the eyes but also inside the lips and larynx; and
 - iv. signs of some struggle or combat such as self-defence or fighting type injuries.¹¹⁷
68. As noted earlier, the post mortem examination had found no obvious marks to the neck, no petechiae and no apparent injuries indicative of restraint or a struggle.¹¹⁸
69. However, one additional finding of possible significance was the presence of damage to the tip of the main throat cartilage (the right superior horn of the thyroid cartilage). Dr Cooke's interpretation at the time of the examination was that it had been cut as part of the post-mortem dissection. Dr Cooke explained in his evidence that, due to the known circumstances of the death, a careful examination of the deceased's neck was undertaken, where the neck was dissected in layers, starting at the skin and going through the muscles one at a time all the way down to the throat cartilage (larynx). The process is done to look for internal injuries. During that layered neck dissection process Dr Cooke thought that he or his assistant cut the tip of the thyroid cartilage and made a note to that effect.
70. However, after the information about the possible sleeper hold was raised, Dr Cooke reconsidered this finding again as neck compression can cause similar damage. Dr Cooke noted that if the injury came from significant neck compression it would be as a result of a fracture and it would be expected that there would be some bleeding at the site of the fracture of the thyroid cartilage, but there was no line of haemorrhage visible in this case.¹¹⁹ Dr Cooke acknowledged in his evidence that he could have been mistaken that the injury he observed was part of the dissection, but the lack of any obvious haemorrhage was a significant factor weighing against that conclusion.¹²⁰

¹¹⁷ T 64.

¹¹⁸ T 64; Exhibit 1, Tab 26.4.

¹¹⁹ T 65 – 66; Exhibit 1, Tab 26.4.

¹²⁰ T 66.

71. Dr Cooke also indicated if a neck hold had been applied that caused the death, he would also expect to see some marking to the skin of the neck (which may be minimal or absent if there is broad application of force as may occur with a sleeper hold) and petechiae around the eyes or larynx or lips. These changes were not observed. Further, you might see muscle bruising internally, but none was present here.¹²¹
72. Dr Cooke also suggested that you would expect to see disturbance at the scene, unless the person was semi-conscious and unable to defend themselves prior to the neck restraint being applied.
73. However, despite any obvious signs¹²² consistent with neck compression, Dr Cooke explained that if neck compression is very effectively applied and a person falls unconscious very quickly, then those constellation of features may be absent. Essentially, that is why Dr Cooke changed the cause of death to unascertained, as the possibility of neck compression (if suggested by the factual scenario) needs to be looked at very carefully, even though the absence of any post mortem findings makes the likelihood of it having occurred more remote.¹²³
74. Dr Cooke was asked to review the photographs of the deceased taken in situ in his bedroom. Dr Cooke, who has considerable experience attending scenes where the cause of death is considered to be suspicious, gave evidence that there was nothing about the way in which the body was positioned that would make him reconsider his original opinion that the deceased died as a result of a cardiac event.¹²⁴ Dr Cooke expressed the view that the only unusual feature was the way the deceased had his face down into the pillow, although he acknowledged that it is possible that the deceased could have moved into that position shortly prior to his death if it was as a result of a cardiac event.¹²⁵

¹²¹ T 66 – 67; Exhibit 1, Tab 26.4.

¹²² T 68.

¹²³ T 67.

¹²⁴ T 68.

¹²⁵ T 69.

75. If the deceased had been smothered or suffocated, by having his head pushed into the pillow, then Dr Cooke explained that you would not expect to see any marks on his face as the surface was soft, but you might expect to see signs of a struggle, of which none were present.¹²⁶ As to the evidence of some blood or fluid on the deceased's pillow, Dr Cooke described that as something that was a seepage of fluid occurring post-mortem, and was not as a result of bleeding from the deceased's face.¹²⁷
76. At the conclusion of Dr Cooke's evidence, he indicated that if the police investigation had been able to exclude the possibility of suffocation by way of a sleeper hold or smothering, his fallback position would again be his original cause of death, namely aspiration of vomit in a man with focal coronary arteriosclerosis. This would be so even though he would be more comfortable if there was a bit more narrowing of a coronary artery.¹²⁸
77. In terms of excluding the possibility of neck compression or smothering, Dr Cooke confirmed that the event would have to have occurred at the time of death.¹²⁹ Therefore, any suggestion of neck compression prior to the police speaking to the police could be ruled out as being the cause of death.¹³⁰ For a sleeper hold or choke hold to have been the cause of death, the evidence would have to support the conclusion that the neck compression occurred sometime after the deceased spoke to the police.¹³¹

POLICE INVESTIGATION INTO THE DEATH

78. Police officers took statements from Mr Gilvary, Mr Mansfield, Ms Cugley-Turner and Mr McLaughlin on 4 November 2013.
79. Shortly after Mr Gilvary contacted police and indicated that he had some additional information that he thought the police should know. He was followed up by detectives and spoken to by telephone on 6 November 2013. During that telephone call Mr Gilvary told Detective Peters that he had been told by Mr Mansfield that there had been a further altercation between

¹²⁶ T 70; Exhibit 1, Tab 26.5.

¹²⁷ T 70

¹²⁸ T 71.

¹²⁹ T 71 – 72.

¹³⁰ T 71 – 72.

¹³¹ T 71 – 72.

Mr Mansfield and the deceased after police left the house, during which Mr Mansfield alleged he had placed the deceased in a headlock and put him down on the bed. Mr Gilvary did qualify the information with the comment that he didn't know if Mr Mansfield "told him this to big note himself or not."¹³²

80. Arrangements were then made for a supplementary statement to be taken from Mr Gilvary the following day. In that statement Mr Gilvary stated that on the evening that the deceased's death was discovered Mr Gilvary and Mr Mansfield had a conversation about the events surrounding the death. According to Mr Gilvary, Mr Mansfield told Mr Gilvary that during his fight with the deceased he had "punched [the deceased] in the head and got him in a head lock and pushed him down to his bed."¹³³ It was after that occurred that the deceased got up and said he was calling the police.¹³⁴ Mr Gilvary indicated in his statement that he believed Mr Mansfield often boasted and made "stuff up to big note himself."¹³⁵ The important difference between this statement and the information provided in the telephone call was that Mr Gilvary indicated the admission about the headlock related to the altercation that prompted police attendance, rather than a second altercation after the police had left.
81. Mr Mansfield and Ms Cugley-Turner moved out of the house in President Street a week after the deceased's death.¹³⁶
82. Senior Constable Fiona Thorp from the Coronial Investigation Squad took carriage of the investigation into the death of the deceased sometime in November 2013, although she was not involved in the first few days of the investigation and did not attend the scene.¹³⁷ After reviewing the file, looking at photographs of the scene and speaking to family members of the deceased Senior Constable Thorp became concerned that the death was not a result of natural causes. As a result, Senior Constable Thorp went about obtaining further statements from witnesses and obtaining other information such as telephone records. She also spoke with Dr Cooke, which prompted him to

¹³² Exhibit 1, Tab 25, p. 21.

¹³³ Exhibit 1, Tab 8.2 [29].

¹³⁴ Exhibit 1, Tab 8.2 [29] and Tab 9, pp. 27 – 28, 40.

¹³⁵ Exhibit 1, Tab 8.2 [31].

¹³⁶ Exhibit 1, Tab 12 [22].

¹³⁷ T 4.

change the cause of death to unascertained, as described above.¹³⁸

83. Mr Gilvary signed a third statement on 23 March 2014, during which he provided additional information about ongoing arguments between the deceased and Mr Mansfield.¹³⁹
84. Mr Gilvary told the police in March 2014 that sometime before they moved out Mr Mansfield was boasting that he took the deceased onto the deceased's bed and hit him a few times. He said he had the deceased around the neck and was punching him. Mr Mansfield allegedly described having the deceased in a headlock and the deceased "flopping around."¹⁴⁰ Mr Gilvary understood that Mr Mansfield was referring to the incident that occurred shortly after midnight on 3 November 2013, and it ended when Mr Mansfield left the deceased's room and the police attended. Mr Gilvary was not aware of any other physical fight between the deceased and Mr Mansfield.¹⁴¹
85. Mr Gilvary also told police that he had found out a day or two after the deceased's death that there were jet lighter burns on the deceased's indicators on his car and the car tyres had been let down. Mr Gilvary asserted that Mr Mansfield told him that he thought the police had let down the air in the tyres so nobody could take the car. Mr Gilvary believed that the damage had been done by Mr Mansfield, as he had seen Mr Mansfield with a jet lighter previously, although Mr Mansfield denied that he had done anything to the deceased's car.¹⁴² The deceased's family confirmed that the deceased's car was found to have flat tyres and there were burns on the lights.¹⁴³
86. In his third statement taken in March 2014 Mr Gilvary still maintained that he was only aware of one fight between the deceased and Mr Mansfield, which occurred prior to police attending.¹⁴⁴

¹³⁸ T 4.

¹³⁹ Exhibit 1, Tab 8.3.

¹⁴⁰ Exhibit 1, Tab 8.3 [37].

¹⁴¹ Exhibit 1, Tab 8.3 [27].

¹⁴² Exhibit 1, Tab 8.3 [21] – [23] and Tab 9, pp. 16 – 17.

¹⁴³ Exhibit 1, Tab 16.3 [17].

¹⁴⁴ Exhibit 1, Tab 8.3 [28].

87. As a result of these various allegations and further investigation, Mr Gilvary was interviewed by police on 17 July 2014 and the interview was electronically recorded. Mr Gilvary again indicated that he had been told by Mr Mansfield after the deceased's death that he had put the deceased in a headlock during what he assumed was the known altercation that led to the police attendance, as he let go when he heard Ms Cugley-Turner scream.¹⁴⁵ He wasn't sure if Mr Mansfield was telling the truth about what he did as he believed Mr Mansfield was a compulsive liar.¹⁴⁶ Mr Gilvary also noted that Mr Mansfield "seemed overly pleased with himself"¹⁴⁷ during this conversation, although he admitted that he had never really liked Mr Mansfield and had complained about him to the landlord.¹⁴⁸ Mr Gilvary also reiterated his belief that Mr Mansfield had damaged the deceased's car with a jet lighter.¹⁴⁹
88. Mr Gilvary was asked during the interview about what contact he had had with Mr Mansfield and Ms Cugley-Turner about the deceased's death. Mr Gilvary indicated he had received an unexpected call from Ms Cugley-Turner after he contacted police but he denied being threatened or unduly influenced by them in any way, although he agreed that they had questioned him about what he had said to police.¹⁵⁰ He denied maintaining any contact with them on social media or having any other regular contact with them.¹⁵¹ It was put to Mr Gilvary that his telephone records show that he made a call to Ms Cugley-Turner's phone after he spoke to Detective Peters on 6 November 2013. Mr Gilvary was asked about the telephone call and he indicated that he didn't think it would have been about anything important and maintained that "there was no way I'm going to mention that I'm going to go give the extra bit of information against them"¹⁵² during the call.
89. Mr Gilvary was asked in the interview why he approached the police a few days after the death and he responded,¹⁵³

¹⁴⁵ Exhibit 1, Tab 9, pp. 28, 40.

¹⁴⁶ Exhibit 1, Tab 9, p. 17.

¹⁴⁷ Exhibit 1, Tab 9, p. 6.

¹⁴⁸ Exhibit 1, Tab 9, p. 6.

¹⁴⁹ Exhibit 1, Tab 8.3 [21] – [23] and Tab 9, pp. 16 – 17.

¹⁵⁰ Exhibit 1, Tab 9, p. 32.

¹⁵¹ Exhibit 1, Tab 9, p. 33.

¹⁵² Exhibit 1, Tab 9, p. 35.

¹⁵³ Exhibit 1, Tab 9, p. 36.

Because I don't want to hold anything back that I find out about the situation, because I was friends with Bez, didn't like Dylan. He told me he did something else that I ... hadn't known or told police at the time, so I thought I would call up and give you all the information you can have.

90. A friend of Mr Gilvary, Corey Schimpf, also spoke to Mr Mansfield sometime after the deceased had died. He provided a statement to police in August 2014 in which he detailed the conversation. Mr Schimpf stated he had been told about the death by Mr Gilvary previously, who had appeared upset about it. On this occasion, which was sometime in November or December 2013, Mr Schimpf was at the house in President Street, Kewdale and recalls that both Mr Gilvary and Mr Mansfield were making jokes about Mr Mansfield causing the death. Later that evening Mr Mansfield told Mr Schimpf that he had fought with the deceased over the garage door and Mr Mansfield said he had punched the deceased in the head. Mr Schimpf did not get the impression that Mr Mansfield had gone into the deceased's room again after the initial fight and Mr Mansfield did not say anything to him about using a choke hold. Mr Schimpf had heard mention of a choke hold, but was told that by Mr Gilvary, not by Mr Mansfield.¹⁵⁴
91. Mr Mansfield was spoken to by police a number of times about the various allegations. He voluntarily provided two statements to police and participated in an electronically recorded interview with police.¹⁵⁵ Mr Mansfield was also the only one of the housemates who attended the inquest and gave evidence. As noted earlier in this finding, Mr Mansfield denied at all times having put the deceased in a headlock or chokehold at any time. He maintained that after the altercation Mr Gilvary asked him why he hadn't put the deceased in a chokehold to drag him into his room and Mr Mansfield responded that if he had tried that, the deceased would have overpowered him as he was bigger than Mr Mansfield. He also stated that he didn't want to do it as in extreme cases you can damage or possibly kill someone.¹⁵⁶
92. Mr Mansfield was asked at the inquest about the damage done to the deceased's car. Contrary to his earlier denial to police,¹⁵⁷ Mr

¹⁵⁴ Exhibit 1, Tab 13.

¹⁵⁵ Exhibit 1, Tab 10.1 and Tab 10.2 and Tab 11.

¹⁵⁶ T 18 – 20.

¹⁵⁷ Exhibit 1, Tab 11, p. 32.

Mansfield admitted he had a jet lighter on his person at the time but claimed it was for his personal use and denied he had used it to damage the deceased's car. He also denied that he had let down the air in the car's tyres and denied saying that the police might have done this to Mr Gilvary.¹⁵⁸

93. As noted earlier, Major Crime detectives had been consulted early in the investigation and concluded at that time that there was no evidence of criminality in relation to the death. At some stage during her investigation Senior Constable Thorp spoke to her supervisor about her concerns that there were some suspicious circumstances surrounding the death of the deceased arising from the new evidence. As a result, a meeting was conducted with detectives from Major Crime to discuss those concerns. At the conclusion of that meeting the Major Crime Squad detectives deemed there was insufficient evidence of criminality to prompt them to take over the investigation.¹⁵⁹
94. Nevertheless, Senior Constable Thorp continued to have some concerns about the circumstances surrounding the death. In her final report to the State Coroner, Senior Constable Thorp outlined four possible explanations for the deceased's unexpected death:
- i. the death was due to a natural event – this is consistent with Dr Cooke's original cause of death;
 - ii. the altercation with Mr Mansfield contributed to the death by causing the deceased physiological stress, which resulted in an arrhythmia – this is also consistent with Dr Cooke's original cause of death;
 - iii. Mr Mansfield's assault on the deceased, prior to the police attending, which may have included a sleeper hold, contributed to the death of the deceased – I note the evidence of Dr Cooke at the inquest in this regard, which does not support this conclusion;¹⁶⁰ and
 - iv. another altercation occurred between Mr Mansfield and the deceased after the police left the house, during which the deceased was placed in a sleeper hold or subject to some other act that caused his death.¹⁶¹

¹⁵⁸ T 23.

¹⁵⁹ T 15.

¹⁶⁰ T 71 – 73.

¹⁶¹ Exhibit 1, Tab 6, p. 11.

95. Focussing upon the last possibility, I note that other than during the initial telephone conversation with Detective Peters, Mr Gilvary never stated that Mr Mansfield had admitted a second altercation with the deceased after the police had attended. Any suggestion of a sleeper hold being applied was confined to the known altercation that prompted police attendance. Mr Gilvary's friend, Mr Schimpf, also did not assert that there was a second altercation, and his only knowledge of a sleeper hold came from Mr Gilvary. The only evidence before me of the initial account by Mr Gilvary in the telephone call is an entry in a police running sheet, as opposed to the signed and witnessed statements of Mr Gilvary and an electronic record of his interview with police. I must give much greater weight to those latter items than the running sheet entry. On that basis, even if I was to prefer the evidence of Mr Gilvary over Mr Mansfield and find that Mr Mansfield admitted to Mr Gilvary that he put the deceased in a neck hold of some kind, the weight of the evidence before me supports the conclusion that the admission related to the altercation that occurred prior to police attending in the early hours of the morning.
96. Putting that information into the context of the expert evidence of Dr Cooke, if some type of neck compression was applied to the deceased at that time, it could not be said to have played any greater role in the death of the deceased than contributing to the overall physiological stress of the incident.¹⁶²
97. I accept that there are some aspects of Mr Mansfield's conduct that raise suspicion, particularly his behaviour when approached by Mrs Boland, by both denying her access to the house and garage and misleading her as to possible sightings of the deceased that day. However, given what I have outlined above, the evidence before me is insufficient to reach any adverse conclusion about his involvement in the death of the deceased other than in the sense of some contribution to the stress that the deceased experienced.
98. I put to Senior Constable Thorp at the inquest the possibility that Mr Mansfield's evasive conduct at that time might be explained by a concern by him about his involvement in the initial assault on the deceased or the damage done to the deceased's car. She

¹⁶² T 72.

conceded that this was one possibility.¹⁶³ Mr Mansfield acknowledged at the inquest that he initially had some concerns that his punch may have played a role in the death of the deceased, which he said he raised with the police who were investigating the death.¹⁶⁴

99. At the inquest Mr Mansfield was asked whether he was surprised when the deceased was found by police. He responded that “it did break my heart a bit knowing that he had passed”¹⁶⁵ noting that he was aware the deceased was trying to get work and a house so he could move his family here from New Zealand. It is difficult for me to gauge his level of sincerity after taking into account other evidence about his behaviour after the deceased’s death, which raises some doubt as to how sincerely he regretted his behaviour towards the deceased early on. However, it is at least appropriate that by the time of the inquest Mr Mansfield expressed some sadness at the deceased’s unexpected death.
100. In conclusion, I am satisfied that the police conducted a thorough investigation into the death of the deceased. While it raised some questions about the conduct of the deceased’s housemates both prior to and after the discovery of his death, the evidence before me does not support the conclusion that they had any direct involvement in his death.
101. Putting the findings of Dr Cooke into the factual context of the other evidence before me, I am satisfied that the deceased died as a result of aspiration of vomit in a man with focal coronary arteriosclerosis. It follows from my conclusion as to the cause of death that the manner of death was by way of natural causes.

CONCLUSION

102. The deceased was a much loved family man. Even when separated by vast distance from his family geographically, the deceased remained intimately involved in the lives of his wife and children, speaking to them several times a day. At the time of his death the deceased was making plans to reunite in Australia with his family. Sadly, his untimely death prevented their reunion.

¹⁶³ T 13.

¹⁶⁴ T 28 – 29.

¹⁶⁵ T 28.

103. It was because of his steadfast devotion to his family that the deceased's family were immediately aware that something had gone wrong on the 3 November 2013. Their increasingly desperate attempts to speak to him were met with a distinct lack of cooperation by his housemates. I have no doubt that this has exacerbated the pain and confusion of the deceased's family, and it has also added weight to their concerns about the sudden nature of their beloved husband and father's death.
104. Having spoken to the deceased's family and understood their concerns, Senior Constable Thorp investigated the death thoroughly. She then properly identified a number of possibilities raised by the evidence, which could be addressed at the inquest. The deceased's family travelled to Perth to attend the inquest, and I hope that at least some of their concerns were addressed by hearing oral evidence from some of the key witnesses.
105. Having had an opportunity to consider all of the available evidence obtained as a result of the coronial investigation, I am satisfied that the deceased died unexpectedly of natural causes. I do not suggest that this means that all the questions raised by the investigation have been answered, but I am satisfied that there is no evidence that another person had direct involvement in the death of the deceased.

S H Linton
Coroner
23 March 2017