IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2001 2245

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**DAVID LAY**
Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Hearing date:	8 December 2016
Delivered on:	8 December 2016
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Counsel assisting the Coroner:	Ms Jodie Burns, Senior Legal Counsel
Representation	Nil
Catchwords	Homicide, no person charged with indictable offence in respect of a reportable death, mandatory inquest

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HER HONOUR:

BACKGROUND

1 David Lay (**Mr Lay**) was born on 19 July 1979, in Dili, East Timor to [redacted]. Mr Lay was the third eldest child and grew up with his older sister [redacted], older brother [redacted], younger brothers [redacted] and [redacted] and younger sisters [redacted] and [redacted].

2 In 1989, aged 10, Mr Lay immigrated with his family to Australia where they initially resided in Flemington. Mr Lay was educated at Debney Meadows Primary School and later at Debney Park Secondary College, both being public schools in Flemington. Mr Lay left school after completing Year 11 and commenced employment as a factory worker in the western suburbs.

3 Mr Lay enjoyed playing cricket, football and basketball.

4 In February 2001, Mr Lay became engaged to [redacted], his girlfriend of 18 months. Mr Lay, aged 22 years, was killed two days before the wedding was to take place on 23 July 2001.

THE PURPOSE OF A CORONIAL INVESTIGATION

5 At the time of Mr Lay's death, the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the *Coroners Act 2008* (**the Act**) has applied to the finalisation of investigations into deaths that occurred prior to the commencement of the Act.[1] Mr Lay's death constituted a '*reportable death*' under the *Coroners Act 1985* (Vic), as his death occurred in Victoria, and was both unnatural and violent.[2]

6 The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

7 It is not the role of the Coroner to lay or apportion blame, but to establish the facts.[4] It is not a coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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[1] Coroners Act 2008, section 119 and Schedule 1. All references which follow are to the provisions of this Act, unless otherwise stipulated.
[2] Section 3, definition of 'Reportable death', *Coroners Act 1985.*
[3] Section 89(4) *Coroners Act 2008.*
[4] *Keown v Khan* (1999) 1 VR 69.

8 The term "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

9 For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all of the circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

10 The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

11 Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

12 All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[5] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

13 Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

14 While Mr Lay's identity was not in dispute and he was not a person placed in "*custody or care*" as defined by section 3 of the Act, his death is considered to be a homicide. The Act provides

[5] (1938) 60 CLR 336.

that an inquest must be conducted into the circumstances of all deaths suspected to be a homicide, if no person has been charged with an indictable offence in respect of the death.

VICTORIA POLICE HOMICIDE INVESTIGATION

15 Immediately after Mr Lay's death, Victoria Police commenced a criminal investigation because the death was considered to be a homicide.

16 Mr Lay's death was investigated by members of the Homicide Squad. Despite this investigation, no person or persons have been charged with indictable offences in connection with Mr Lay's death.

17 I note the observations of the Victorian Court of Appeal in *Priest v West*,[6] where it was stated:

> "*If, in the course of the investigation of a death it appears that a person may have caused the death, then the Coroner must undertake such investigations as may lead to the identification of that person. Otherwise the required investigation into the cause of the death and the circumstances in which it occurred will be incomplete; and the obligation to find, if possible, that cause and those circumstances will not have been discharged."*

18 Consistent with this judgment, and mindful that the Act mandates that I must conduct an inquest, one of the purposes of the inquest is to investigate any evidence that may lead to the identification of the person (or persons) who may have caused the death, bearing in mind that I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.[7]

19 Section 7 of the Act specifically states that a coroner should avoid unnecessary duplication of inquiries and investigations, by liaising with other investigative authorities, official bodies or statutory officers. The rationale behind this provision is to allow for consideration of public interest principles that weigh against the potential benefits of any further investigation, such as further cost to the community. It also acknowledges that although a number of authorities or organisations may have the mandate to investigate, some are more appropriately placed than others to do so in any given circumstance.

20 In this case, I acknowledge that the Victoria Police through the Homicide Squad, has conducted an extremely thorough investigation in this matter.

21 In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Lay's death is an unsolved homicide case which Victoria Police continues to investigate.

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[6] (2012) VSCA 327.
[7] *Perre v Chivell* (2000) 77 SASR 282.

22 The Coroner's Investigator, Detective Sergeant Mark Hatt, has provided to the Court a statement in relation to this matter.

23 The confidential nature of the Victoria Police's ongoing investigation prevents me from reciting each and every matter which has been established by the Homicide Squad. However, Detective Sergeant Hatt's statement indicates that the following important matters have been established and are able to be disclosed:

(a) as a result of the incident involving Mr Lay, police officers attended the Salt Nightclub at 14 Claremont Street, South Yarra (**the Nightclub**) at 4.00 am and established a crime scene;

(b) police officers secured the Nightclub and obtained the names of 988 patrons still inside the Nightclub;

(c) police officers established that a number of unknown persons had been allowed to leave the Nightclub prior to their attendance;

(d) police officers reviewed the relevant security cameras in the Nightclub and noted that the video footage was of poor quality. Despite this, police officers identified that an altercation took place on the dance floor involving a number of persons;

(e) police officers also identified on the video footage that a male dressed in a white t-shirt was escorted from the premises by security personnel;

(f) that the Nightclub no longer operates;

(g) that despite the extensive homicide investigation conducted, the person or persons responsible for Mr Lay's death have to date, not been identified; and

(h) that the homicide investigation into Mr Lay's death is ongoing and the file remains open.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

24 On 21 July 2001, the Deceased was visually identified by, [redacted], to be David Lay, born 19 July 2001. It appears that [redacted] made an error in the date of birth on the 'Statement of Identification' form. Having reviewed the file, I am satisfied that Mr Lay's date of birth is 19 July 1979.

25 Identity was not disputed and therefore required no investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

26 On 22 July 2001, Professor Stephen Cordner (**Professor Cordner**), Forensic Pathologist with the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Lay's body and provided a written report, dated 11 January 2002, which concluded that a reasonable cause of death was *"Stab wound to chest and abdomen (Operation)."*

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

27 On 21 July 2001, between 1.00 am and 1.30 am, Mr Lay attended the Night Club with his fiancé and a number of other friends and family.

28 At approximately 3.45 am, as he was dancing in the 'Techno' room of the Nightclub, Mr Lay was attacked by an unknown number of males. As Mr Lay was lying on the dance floor he was observed to be kicked by two male persons.

29 The Nightclub security personnel intervened and removed a male in a white t-shirt, who had been observed throwing punches.

30 The security personnel assisted Mr Lay to get up from the floor and escorted him from the Nightclub. Mr Lay was observed to have a large amount of blood on his t-shirt and informed the security personnel that he had been stabbed.

31 Mr Lay was conveyed by ambulance, to the Alfred Hospital where he received treatment in the Intensive Care Unit. Despite emergency medical treatment, Mr Lay died from his injuries at 9.00 pm on 21 July 2001.

FINDINGS AND CONCLUSION

32 Having investigated the death of David Lay and having held an Inquest in relation to his death on 8 December 2016, at Melbourne, make the following findings, pursuant to section 67(1) of the Act:

(a) that the identity of the deceased was David Lay, born 19 July 1979;

(b) that Mr Lay died on 21 July 2001, at the Alfred Hospital, 55 Commercial Road, Melbourne from multiple stab wounds;

(c) that the death occurred in the circumstances set out above; and

(d) that despite an extensive criminal investigation conducted by Victoria Police, no person or persons have been identified, to date, as being responsible for causing Mr Lay's death. On that basis, I am satisfied that no investigation which I am empowered to undertake, would be likely to result in the identification of the person or persons who caused Mr Lay's death.

33 I note that in the future, if new facts and circumstances become available, section 77 of the Act allows any person to apply to the Court for an order that some or all of these findings be set aside. Any such application would be assessed on its merits at that time.

34 I convey my sincerest sympathy to Mr Lay's family and friends.

35 Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

36 I direct that a copy of this finding be provided to the following:

(a) Mr Lay's family.

(b) [redacted].

(c) Detective Sergeant Mark Hatt, Coroner's Investigator.

(d) Detective Inspector Michael Hughes, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 8 December 2016