239. **Chris Moloney** told the Court that he left the Sly Bar and went out to the car park as soon as he had spoken to Pixie Gleeson. He did not mention having spoken to Sly Gleeson or to Mr Board.

- Mr Moloney administered first aid. He saw a bruise above Mr McLarty's right eye lid.
- Mr Moloney says that he rang 000 on his mobile phone to inform them that they were required at the car park of the Caledonian Hotel. However, he did not contact police.
- Mr Moloney also remained with Mr McLarty and the ambulance paramedics until they left the scene.
- CCTV evidence confirms that Mr Moloney was using his telephone at 5:31:42pm while he was standing close to Mr McLarty. Further, Mr Moloney's telephone records confirm that he rang 000 at 5:29pm.
- Therefore, this independent evidence is consistent with Mr Moloney's statement and evidence in Court in relation to his role in providing initial emergency first aid to Mr McLarty.
- However, Mr Moloney consistently denied any suggestion that he knew or should have known that Mr Board may have assaulted Mr McLarty when he responded to the request that he administer first aid.
- Mr Moloney insisted he first heard about the possibility of an assault when he spoke to Mr Poulton at 9:39pm.
- When confronted with the ambulance record's note that Mr McLarty's injuries followed an altercation. Mr Moloney told the Court:

  "Well, if I had have heard "altercation", then that would have alerted me once again that it was a fight. I don't know where they've got "altercation" from.

- In the face of Mr Moloney's evidence about the information he obtained from Sly Gleeson and Pixie Gleeson and the information recorded on the ambulance records, I find that Mr Moloney knew or should have known that Mr Board may have been involved in an altercation with Mr McLarty by the time the ambulance left the scene.

240. Further, at 8:23pm, Mr Krause rang Mr Moloney after completing his review of the CCTV evidence. Mr Krause had formed the opinion that Mr McLarty and Mr Board were involved in an altercation prior to leaving the Sly Bar. He also told the Court he would have discussed this event with Mr Moloney.

241. Therefore, even if I am wrong in believing that Mr Moloney already knew about this dispute between Mr McLarty and Mr Board, Mr Krause confirmed that he told him of his interpretation of the CCTV evidence during this phone conversation.

242. Further, Mr Moloney made three phone calls on his mobile phone after he spoke to Mr Krause:

- At 8:27pm, Mr Moloney called the Warrnambool Police Station. The call lasted over five minutes. However, Mr Moloney told the Court he had no recollection of who or why he called.

- At 9:18pm, Mr Moloney rang the Caledonian Hotel. The call lasted over three minutes. Again, he cannot recall who or why he called the hotel.

- At 9:34pm, Mr Moloney rang Mr Board's brother in Queensland, Terry Board, because he had been informed that Nick Board was under arrest, was in the police station and would need to engage a solicitor. He left a voice message. Terry Board subsequently rang him back.

243. Although it is possible that the 8:27pm phone call related to his planned trip to Melbourne next day, the phone call to Mr Board's brother confirms that Mr Moloney was aware that Mr Board was likely to be arrested before Mr Poulton rang him at 9:39pm.

244. Mr Moloney's telephone records show that he also made one other relevant phone call after he spoke to Mr Poulton:

- At 10:07pm, Mr Moloney rang Bruce Dixon.

245. I do not accept that Mr Moloney did not discuss the events of 5 November 2006 during his conversation with Mr Dixon.

246. **Nick Board** entered the car park of the Caledonian Hotel at 5:29 pm on 5 November 2006. At 9:55pm, Mr Porter, Detective Senior Constable Neagle and Mr Ryan approached Mr Board in

his bedroom at Room 6 of the Caledonian Hotel. Mr Ryan recorded the conversation in his diary.

247. During his conversation with Mr Ryan, Mr Board confirmed the following in relation to the car park:

- In the car park, Mr Board said to Mr McLarty "*Fuck off and stop annoying me.*"
- Mr McLarty did not say anything.
- Mr Board turned and walked away. He intended to walk to the fire escape and back into the pub and lose Mr McLarty in the car park.
- Then Mr Board saw out of the corner of his eye that Mr McClarty was coming towards him.
- Mr Board looked back and saw Mr McLarty's hand move. *"I didn't know if he was going to hit me or what so I thought I would get in first, so I went wack."*
- Mr Board hit Mr McLarty in the face, once with the right hand and once with the left:

  "I wouldn't have hit him the second time if I had of realized but I think he was gone after the first hit....

  He was out before he hit the ground, he went straight back and hit his head on the asphalt."

248. Further, in a recorded interview commencing at 1:09am on 6 November 2006, Mr Board confirmed that:

- About two metres from the back door of the hotel in the car park, Mr Board said to Mr McLarty:

  "Can you stop talking shit and just leave me alone... you're full of piss"

- He went to walk away but he noticed Mr McLarty running towards him. He stopped and Mr McLarty stopped right beside him with one hand up.

- Mr Board was not sure whether there was a punch coming or whether Mr McLarty was about to grab him. The opportunity was there so he struck Mr McClarty first with his right hand then with his left.

- Mr Board hit Mr McLarty twice in the face because he thought Mr McLarty was about to strike him.

- Mr Board believed that Mr McLarty had already lost consciousness after the first hit but he was unable to stop the second proceeding.

249. CCTV footage confirms the essential elements of Mr Board's record of interview. Therefore, I accept his interpretation of the sequence of events in the car park of the Caledonian Hotel on 5 November 2006.

Medical response to Mr McLarty's collapse in the car park of the Caledonian Hotel on 5 November 2006

250. At 5:29pm on 5 November 2006, telephone records indicate that Mr Moloney called 000 and asked for an ambulance.

251. Mr Moloney told the call taker:

"We have got a male collapsed in the back yard with blood coming from his head... he is conscious and breathing."

252. In response to the call taker's questions, Mr Moloney confirmed that Mr McLarty was not completely awake or talking normally and that he believed he had sustained a head injury when he fell. He denied he knew what caused him to fall but he said it was not attributed to his diabetes.

253. At 5:31pm, Warrnambool ambulance paramedics, John Wormald and Trevor Niklaus, were despatched to an 'unconscious male' at the rear of the Caledonian Hotel.

254. Mr Wormald told the Court that the ambulance station is close to the back entrance to the car park of the Caledonian Hotel.

255. At 5:34pm, Mr Moloney made a second call to 000. He told the Court:

"given the close proximity to the ambulance station to the backyard of the hotel, five minutes had elapsed but it seemed like 50 minutes, so I made a second call to find out where the ambulance was. As I was making that second call, I started walking around towards the ambulance station and that's when I saw the ambulance actually driving towards the backyard."

256. CCTV evidence from the car park on 5 November 2006 confirms that Mr Moloney appeared to use his phone on two occasions after he assessed Mr McLarty.

257. In evidence, Mr Wormald and Mr Niklaus confirmed that, after they had been despatched to the incident in the car park of the Caledonian Hotel, Mr Moloney met them as they were leaving the ambulance station. Mr Wormald and Mr Niklaus both knew Mr Moloney from their professional work in the region.

258. The ambulance paramedics say that Mr Moloney confirmed that there was an unconscious male in the car park of the hotel. He and Mr Wormald walked back to the car park. Mr Niklaus followed them in the ambulance.

259. However, CCTV footage does not support the evidence of Mr Moloney and the ambulance paramedics that Mr Moloney met them at the ambulance station and walked with Mr Wormald to the car park of the Caledonian Hotel.

260. Rather, the CCTV evidence indicates that, at 5:37:06pm, Ms Quinn left the car park on foot through the back entrance. At 5:37:08pm, she returned with an ambulance paramedic. Mr Moloney remained with Mr McLarty during this short period, too short for Ms Quinn to have reached the ambulance station.

261. Therefore, I presume Ms Quinn provided Mr Wormald and Mr Niklaus with some of the background information that was included in their review of Mr McLarty's circumstances in the Ambulance Patient Care Record including that Mr McLarty's medical history included non-insulin dependent diabetes mellitus and asthma, that Mr McLarty was found unconscious by a third party, that Mr McLarty had been drinking at the hotel and that he had an altercation with a "third party of unknown origin".

262. On initial examination, Mr Wormald and Mr Niklaus found Mr McLarty unconscious with a GCS of 3, a laceration to the occipital region of the head with about 50ml blood loss and no further new injuries.

263. Mr McLarty's blood sugar level was within normal limits, his airway was clear and he was cyanosed. Therefore, the paramedics excluded the differential diagnoses of diabetes and asthma causing Mr McLarty's collapse.

264. Mr Wormald told the Court that, in the absence of any contrary policy, he did not and would not usually inform Victoria Police when he treated a head injury associated with a possible assault.

265. The ambulance paramedics placed an oropharyngal airway into Mr McLarty's mouth to help to maintain his airway. Mr Wormald explained:

"With a GCS level of 3 which is extremely low, which the patient had no signs of any stimulus whatsoever, I was quite confident that, at that level, that he would be able to tolerate an OP airway, and the main issue then was airway for me, at that stage."

266. At 5:43pm, telephone records indicate that Mr Moloney called an emergency telephone number for a third time. There is no indication of the content of this phone call.

267. However, at 5:44:25pm, a third paramedic arrived on foot through the back entrance to the car park.

268. At 5:51:44pm, Mr Wormald and Mr Niklaus loaded Mr McLarty into the ambulance and transported him to Warrnambool & District Base Hospital which is now part of South West Healthcare.

269. Mr Wormald inserted an intravenous cannula during the trip. Mr McLarty's condition remained unchanged.

270. At 5:55pm, Mr McLarty presented in the ambulance at the Emergency Department at Warrnambool & District Base Hospital.

271. At 5:57pm, the triage nurse assessed Mr McLarty. She recorded that he was not responding, diabetic, asthmatic and had a pre-existing prolapsed disc in the neck.

272. Mr McLarty was triaged Category 2.

273. The triage nurse also noted:

*"lac(*eration*) to back of head, unwitnessed but ? knocked to ground outside pub, head trauma".*

274. Therefore, the hospital was on notice that Mr McLarty may have been involved in an altercation. However, they did not report Mr McLarty's presentation to Victoria Police.

275. At 5:57pm on 5 November 2006, Dr Qalo Sukabula examined Mr McLarty.

276. Dr Sukabula had worked at Warrnambool & District Base Hospital for two years and was the Director of the Emergency Department.

277. At 6.05pm, Dr Sukabula confirmed that Mr McLarty was unconscious and unresponsive. He had a wound on the back of the head. He also had a developing right black eye, blood around his mouth from his teeth and smelled of alcohol. Neurological observations indicated that Mr McLarty had Glasgow Coma Scale of 3.

278. Dr Sukabula told the Court that Mr McLarty was clearly in a critical condition and that it was likely he would require transfer to a tertiary hospital. However, Dr Sukabula was not aware of the document entitled Inter-Hospital Transfer of a Critically Ill Patient and dated December 2003.

279. At 6:00pm, Dr Sukabula ordered blood for analysis. Nursing notes indicate the blood was taken 6:20pm.

280. Preliminary results of these blood analyses included serum glucose level of 7.2mM where the normal range is 3-6.9mM. This excluded the possibility of continuing hypoglycaemia.

281. Post mortem analysis of hospital samples labelled 6:00pm also indicated that the blood alcohol concentration was 0.15g/100mM and therapeutic levels of naproxen and paracetamol as well as morphine, phenytoin, midazolam and propofol used in the emergency response. No cannabis metabolites were detected.

282. Accordingly I have formed the view that Dr Sukabula seems to have labelled the blood tubes with a time of 6:00pm and the pathology report of the results indicates the blood was taken at

6:00pm. However, the nursing notes indicate the blood was taken 6:20pm and the results include phenytoin which was first administered at 8:50pm.

283. Therefore, although I have used times reported in the medical record, I have become sceptical about the relationship between these reported times and the times at which procedures were performed at Warrnambool & District Base Hospital.

284. At 6:20pm, Dr Sukabula directed no intubation due to alcohol consumption. At 6:40pm, he ordered an x-ray and a CT brain scan.

285. The Symbion Imaging report of the CT brain performed at 7:14pm on 5 November 2006 at Warrnambool indicated extensive left subdural haematoma involving the left frontoparietal region associated with severe displacement of the midline towards the right. The report of the CT brain scan did not include any measurements of the size of the haemorrhage or the mid line shift.

286. Mr McLarty vomited during the CT scan. Accordingly, at 7:40pm, he was intubated.

287. At 7:45pm, Dr Sukabula paralysed Mr McLarty with morphine, midazolam, suxamethonium and vecuronium.

288. At 7:46pm, Dr Sukabula contacted the on-call surgeon, Mr Phillip Gan.

289. At 8.00pm, Mr Gan arrived at the Emergency Department and assessed Mr McLarty.

290. Although the Symbion Imaging report did not include any measurements, Mr Gan noted the CT showed a massive left subarachnoid haemorrhage with marked cerebral oedema/contusion and 5-10mm midline shift. He also noted a blood sugar level of 7.1mM.

291. At 8:05pm, an x-ray was performed using the portable x-ray. The x-ray confirmed fracture of the right temporal bone extending into the internal auditory canal and foramen lacerum and multiple facial bone fractures.

292. At 8:14pm, Mr Gan ordered further sedation, elevation of the head and continuing special spinal precautions.

293. Mr Gan directed Dr Sukabula to arrange trauma retrieval and neurosurgery liaison. He also directed that police be informed because it was a potential homicide.

294. At 8:45pm, Mr Gan noted that Ms Mitchell told him that Mr McLarty got into:

"Some fight with a guy who lives at the Caledonian ".

295. Further, Mr McCarthy's systolic blood pressure had climbed from 62mmHg at 6:05pm to 120mmHg at 8:45pm

296. At about 8:50pm, Dr Sukabula contacted the Admitting Officer at The Alfred Hospital in Melbourne. He arranged a bed for Mr McLarty and also obtained advice about his management including administration of mannitol and phenytoin as well as more vercuronium.

297. Mannitol is used primarily to reduce intracranial pressure. Phenytoin is an anti-convulsant.

298. At 8:50pm and 9:10pm, the vercuronium and phenytoin were administered.

299. At 9:10pm on 5 November 2006, the air ambulance was despatched to transfer Mr McLarty to The Alfred.

300. At 9:10pm, Dr Sukabula also contacted Leading Senior Constable Deane Owen who was performing Watch House duties at the Warrnambool Police Station.

301. At 9:15pm, Dr Sukabula entered orders for 70 g mannitol over one hour.

302. At 10:05pm, the 70g mannitol infusion commenced.

303. At 11:05pm on 5 November 2006, the ambulance officers arrived at the Warrnambool & District Base Hospital.

304. At 11:25pm, Mr McLarty left Warrnambool & District Base Hospital for air transfer to The Alfred hospital. His GCS remained 3 throughout the trip.

305. Dr Sukabula's referral letter includes CT scans without contrast, plain film x-rays and blood results. He also told The Alfred: *"there were no witnesses to the event but his partner saw him arguing with another patron"*

306. At 12:58am on 6 November 2006, Mr McLarty presented to The Alfred Hospital.

307. At 1:00am, the Trauma Registrar at The Alfred Hospital recorded that the Warrnambool CT brain scan showed a 10mm thick subdural haemorrhage and a large subarachnoid haemorrhage associated with 15mm midline shift to the right.

308. However, at 1:15am on 6 November 2006, The Alfred hospital notes indicate that the Warrnambool CT brain scan showed a hyperacute left subdural haematoma with approximately 25mm midline shift and other haemorrhages.

309. These differences in measurements indicate the degree of uncertainty inherent in reading CT data.

310. After consultation with the Neurosurgery Registrar, these assessments of Mr McLarty's injuries were determined to be non-survivable and he was therefore not suitable for neurosurgical intervention.

311. Further, his blood alcohol concentration remained 3mM or 0.138g/100mL.

312. At 5:20am, a further CT brain scan performed at The Alfred hospital confirmed a large (7mm) left subdural haemorrhage with intraparenchymal contusions in anterior and inferior left temporal and frontal lobes involving mid brain right posterolateral pons and 25mm midline shift and subarachnoid blood.

313. In as far as can be determined on the available evidence, the degree of displacement of normal brain structures observed in the CT brain performed at The Alfred Hospital at 5:20am on 6 November 2006 was no larger than that observed at 7:14pm on the previous day Warrnambool.

314. Therefore, failure to administer mannitol in a timely fashion did not change Mr McLarty's outcome.

315. At 8:00am, Mr McLarty was transferred to the Intensive Care Unit.

316. At 12:20pm on 6 November 2006, the neurosurgery consultant, Professor Jeffrey Rosenfeld, and Dr Bittar confirmed that Mr McLarty's lower brainstem functions were intact but the brainstem haemorrhages and bilateral wide pupils prior to arrival at The Alfred indicated poor prognosis and evacuation was contraindicated.

317. At 7:00pm, it was agreed that a 24 hour period of assessment prior to decisions about on-going management.

318. However, there was no improvement overnight and active treatment was withdrawn at 12:35pm on 7 November 2006.

319. At 2:45pm on 7 November 2006, Russell McLarty died.

320. The Medical Deposition indicates that a CT brain indicated a left side subdural haemorrhage, intraparenchymal contusions in anterior and inferior left temporal and frontal lobes, fracture of the left temporal bone extending into the auditory canal and foramen lacerum and multiple facial bone fractures.

321. Autopsy determined that the cause of death was head injury. These injuries included:

- An area of bruise abrasion to the right of the midline in the occiput at the back of the head. This was associated with local bruising in the underlying subcutaneous tissue and across the right side of the head in association with deep scalp frontal bruising on the right side. As well as a linear fracture extending from the occiput on the right side for 10cm immediately deep to the injury to the back of the head.

- An irregular laceration running horizontally and bruising on the right upper eyelid and on the left upper eye lid. These injuries were associated with an angled fracture of 3cm present through the roof of the left orbit with a smaller finer 1.5cm fracture present in the roof of the medial aspect of the right orbit.

- Extensive subdural haemorrhage on the left side of the cerebrum but also extending over the superior surface of the tentorium and around the base of the brain on the left side and frontally.

- Patchy subarachnoid haemorrhage particularly at the base of the brain frontally associated with blood around the cervical spinal cord.

- A sizeable glide haemorrhage in the left temporal pole and on the left frontal pole.

322. There was no evidence of bruising on the forearms or the backs of the hands and fingers.

323. In his report, Professor David Ranson stated:

"The pattern of head injury was of the type often seen where the back of a moving head strikes a stationary surface.... The fracture to the back of the occiput on the right side is also in keeping with the application of force to the back of the head. The laceration of the upper right eyelid and associated bruising may have occurred in association with the blunt force application to the front of the head in this region."

324. Further, Professor Ranson told the Court that the fractures to the facial region were confined to the roofs of the eye sockets. They were probably caused by contre coup movement of the brain within the skull after Mr McLarty's head hit the ground following with some sort of accelerative force.

325. Put another way, Professor Ranson said that the movement of the head as it struck the ground may be partly the result of gravity effects and partly the result of a accelerated force because the head was pushed as part of the force to the front of the face.

326. However, Professor Ranson could not completely exclude the possibility that the roof fracture on the left, where the laceration was, occurred as a result of a blow to the front of the head.

327. Further, Professor Ranson found no evidence that there were two blows to the head as admitted by Mr Board.

328. A forensic radiologist, Dr Chris O'Donnell provided us with a review of the Alfred Radiology. However, on 9 July 2008, the Warrnambool and District Hospital informed the Coroners Court that they have no electronic or hard copy versions of the radiology performed on 5 November 2007. They said Symbion Imaging said these versions had been sent "elsewhere".

329. Dr O'Donnell says the CT brain scan performed at 5:20am on 6 November 2006 showed cerebral and subarachnoid haemorrhage including acute left cerebral convexity subdural haemorrhage measuring up to 1cm in depth.

330. Dr O'Donnell concluded that:

"i. findings indicate an impact injury to the right occipital region producing local scalp and right occipital and skull base fractures (so called coup pattern) leading to a typical contra-coup pattern of injury including fracture to the orbital plate of the left frontal bone, hemorrhagic contusion to the left temporal and left frontal lobes of brain as well

as acute left subdural and subarachnoid haemorrhage. These contra-coup changes have occurred diagonally opposite to the site of coup.

i.as a result of the brain injury there is considerable mass effect leading to displacement of normal brain structures causing the brain stem to be compressed and development of secondary brainstem haemorrhage (so called Duret haemorrhage)

ii.It is not possible to determine if the right facial bone injuries occurred at the same time as the skull fractures."

331. Dr O'Donnell's radiological findings generally confirmed Professor Ranson's interpretation of his autopsy findings.

Victoria Police response to the incident in the car park of the Caledonian Hotel on 5 November 2006

332. At 9:10pm on 5 November 2006, Dr Sukabula contacted Leading Senior Constable Deane Owen who was performing Watch House duties at the Warrnambool Police Station.

333. Dr Sukabula told Mr Owen that Mr McLarty had suffered life threatening injuries arising from an assault at the rear of the Caledonian Hotel some time before 6.00pm. He also said that Mr McLarty would be transferred to The Alfred by the air wing.

334. Other than Mr Krause's telephone call to Mr Moloney at 8:23pm and Mr Moloney's telephone call to the Warrnambool Police Station at 8:27pm on 5 November 2006, there is no evidence to suggest that anyone on duty in Victoria Police could have known about the incident before this time.

335. Mr Owen determined that the offences reported by Dr Sukabula could include a serious assault and accordingly, he commenced a major incident check list.

336. At 9:15pm on 5 November 2006, Mr Owen informed his supervisor, Acting Sergeant Stuart Poulton. Mr Poulton is a person friend of Mr Moloney.

337. Mr Poulton then contacted the on-call Criminal Investigation Unit member, Detective Senior Constable Colin Ryan.

338. At 9:16pm, Mr Poulton established a crime scene and arranged to secure video footage from the hotel CCTV cameras.

339. At 9:20pm, Mr Poulton spoke to Mr Krause and arranged to go to the Caledonian Hotel. By now it was raining and Mr Poulton was concerned about loss of evidence.

340. Mr Krause took him to the car park and Mr Poulton saw three pools of blood between parked vehicles. He also watched some of the CCTV footage of the car park at the Caledonian Hotel.

341. After watching some of the CCTV from the camera at the south-east corner of the car park of the Caledonian Hotel and forming the belief that Mr McLarty threw the first punch, Mr Poulton spoke to Mr Ryan.

342. Mr Poulton told Mr Ryan that Mr Moloney had been involved in the incident in which Mr McLarty was injured.

343. Mr Ryan told the Court that he did not know Mr Moloney well because Mr Moloney was a uniformed police officer and he was a detective. Further, even after he also became aware that Mr Moloney had known Mr Board for a long time, he was unconcerned about Mr Moloney's involvement. He explained to the Court:

"...on the night it was my impression, and it still is to this day, that the role that Chris Moloney played was that of a purely good Samaritan role in that he rushed out and went to the assistance of Mr McLarty and made - conducted initial first aid and phoned the ambulance."

344. Mr Ryan also told the Court:

"My focus was to determine if a crime had been committed and whether a crime contributed to what happened to Mr McLarty."

345. Mr Ryan had been working in Warrnambool for 16 years but this was the first time that he had led a homicide inquiry. At about 9:39pm, Mr Ryan contacted Mr Canavan.

346. At 9:55pm, Mr Canavan went to the Warrnambool & District Base Hospital and took a signed statement from Ms Mitchell. He also collected Mr McLarty's clothes as evidence.

347. At 9:39pm, Mr Poulton also rang Mr Moloney on his mobile phone.

348. In the telephone call, Mr Poulton told Mr Moloney he had recognised him in the CCTV footage from the car park of the Caledonian Hotel providing first aid to Mr McLarty.

349. Mr Moloney told Mr Poulton he was going to Melbourne early the next morning but he would come into the police station now and make a statement. Mr Moloney then went to the Warrnambool Police Station.

350. At 12:09am on 6 November 2006, Mr Moloney completed a statement for police. The Court heard that he drafted it himself and had it witnessed by Acting Sergeant Steve Parkinson at the Warrnambool Police Station.

351. In his statement, Mr Moloney said he was informed that Mr Board had assaulted Mr McLarty when he spoke to Mr Poulton.

352. I do not accept Mr Moloney's evidence in relation to this matter because:

- He was in the Sly Bar when Mr Board and Mr McLarty have argued and he had reacted to their conversation.
- He saw and spoke to Mr Board when he returned to the Sly Bar without Mr McLarty.
- Sly Gleeson and Pixie Gleeson had both told him that Mr McLarty had been injured in an altercation. Sly Gleeson said that Mr Board was involved.
- He was present when ambulance paramedics learned that Mr McLarty's injuries may have arisen from an altercation.
- He had already spoken to Mr Krause after Mr Krause had viewed the CCTV footage but before Mr Poulton rang Mr Krause. Mr Krause told the Court they would have talked about Mr Board's involvement.
- He had also spoken to Mr Board's brother and told him Mr Board was under arrest.

353. At 9:50pm, Mr Ryan, Mr Neagle and Detective Sergeant Porter arrived at the car park of the Caledonian Hotel. At that time, Mr Moloney was not at the hotel.

354. At 9:55pm, Mr Porter, Mr Neagle and Mr Ryan approached Mr Board in his bedroom at Room 6 of the Caledonian Hotel. Mr Ryan recorded the conversation in his diary.

355. Mr Ryan told the Court that Mr Board appeared to be fully coherent and understanding of everything and he was not affected by alcohol. He agreed that he could have requested a voluntary breath test but it seemed unnecessary.

356. Before questioning Mr Board, Mr Ryan told him that he wanted to ask him some questions about an incident that had occurred between him and Mr McLarty earlier that day. He also cautioned Mr Board.

357. After Mr Ryan had completed the interview with Mr Board, he and the other two police officers searched Mr Board's room. Nothing was found. There is no evidence that the police searched elsewhere in the hotel or asked further questions about Mr Board's possessions. In particular, they did not know or ask about Mr Board about the bag that he took down the fire escape after Mr McLarty was assaulted.

358. At 10:28pm, Mr Board was transferred to the Warrnambool Police Station by Mr Porter and Mr Ryan. Mr Neagle began reviewing the CCTV evidence with Mr Krause.

359. Mr Owen signed him into the Watch House. Mr Owen was never aware during that time that Mr Moloney had been at the Caledonian Hotel and had administered first aid to Mr McLarty.

360. At 10:45pm, Mr Ryan spoke to Detective Senior Sergeant Ron Iddles because it is Victoria Police protocol to contact the Homicide Squad in circumstances where a person might die.

361. In general terms, Mr Ryan told Mr Iddles that Mr McLarty was in The Alfred Hospital with serious head injuries resulting from Mr Board punching him twice in what appeared to be self defence.

362. Mr Ryan did not record and cannot remember what other specific information he told Mr Iddles. However, he remembered clearly that Mr Iddles' advice was to go ahead and interview Mr Board. Further, The Alfred Hospital records indicate that Mr Iddles was to be notified when Mr McLarty died.

363. At 11:34pm, Mr Ryan commenced a tape recorded interview with Mr Board. It was immediately suspended until 1.09am on 6 November 2006.

364. At 1:09am on 6 November 2006, Mr Ryan continued a tape recorded record of interview with Mr Board. No one else was present.

365. At 1:30am on 6 November 2006, Mr Board was released from Warrnambool Police Station without charges being laid. Mr Ryan had no further contact with Mr Board.

366. At 8:20am on 6 November 2006, Mr Iddles spoke to Mr Ryan and updated him that Mr McLarty's condition was critical.

367. Later on 6 November, Mr Ryan went to the Homicide Squad office in Melbourne and viewed the CCTV footage from the south-east corner of the car park with Mr Iddles.

368. The decision was reached to leave the investigation with Warrnambool CIU because Mr Iddles agreed with Mr Ryan that there was an issue of self defence.

369. Although Mr Iddles was open to further consultation about the investigation, Mr Ryan agreed with his interpretation and did not seek further guidance.

370. In making his decision on 6 November 2006, Mr Iddles also told the Court that he relied on his experience in *Wilson's* case[4] and some other issues.

371. In *Wilson's* case, David Wilson pleaded guilty to manslaughter causing the death of Matthew Thomas Goodwin from head injury arising out of an unwitnessed altercation outside a hostel where both men lived on 9 August 2003. Both men had been drinking. The incident occurred after prolonged provocation. Mr Wilson tried to dispose of Mr Goodwin's body.

372. I do not understand why *Wilson's* case was relevant to Mr Iddles' decision that the Homicide Squad should not investigate Mr McLarty's death. On the contrary, Mr Wilson was sentenced to seven years in prison after a Homicide Squad investigation. Further, on

[4] DPP v Wilson [2006} VSC23 handed down on 7 February 2006. .

17 June 2006, Coroner Phillip Byrne closed the coronial investigation of Mr Goodwin's death without an inquest on the basis of Mr Wilson's successful prosecution.[5]

373. On 8 November 2006, Mr Ryan returned to the Caledonian Hotel and spoke to staff who had been working on 5 November. As the result of these conversations, he also obtained CCTV footage from the camera above the fire escape and identified a number of extra witnesses.

374. Subsequently, Mr Canavan took over the police investigation of Mr McLarty's death. Mr Canavan's assistance has been important in allowing me to complete the coronial investigation.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. Russell John McLarty was 38 years old when he died. He lived with his fiancee, Kylie Mitchell, at Unit 1, 51 Donovans Road in Warrnambool.

2. Mr McLarty's medical history included non-insulin dependent diabetes, asthma, prolapsed disc and left arm pain, and intravenous and cannabis drug use.

3. Ms Mitchell told the Court that Mr McLarty used cannabis up to four times a day to assist him with his arm and back pain.

4. On the afternoon of 5 November 2006, Mr McLarty and Ms Mitchell were socialising and drinking in the Sly Bar of the Caledonian Hotel in Warrnambool.

5. The Caledonian Hotel is a social base for many people in the local community. It provides food and beverages, accommodation, a TAB facility and weekend entertainment in the lounge.

6. Regular patrons, residents, hotel licensees and staff at the Caledonian Hotel all know each other. They work together. They drink together. They gamble on horses and dogs at the TAB. They use the hotel as a meeting place before they go out to or after they return from other venues.

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[5] Coroners case 2630/03.

7. Nick Board had lived upstairs at the Caledonian Hotel for 10 years. Although Mr McLarty now lived elsewhere in Warrnambool, he had also lived at the Caledonian Hotel until 2004 and he continued to use it as his social base.

8. Mr Board and Mr McLarty knew each other through the coincidence of living and socialising at the Caledonian Hotel over a number of years. They also knew hotel staff.

9. Chris Moloney was an off-duty Acting Sergeant of Police who was in the Sly Bar of the Caledonian Hotel on the afternoon of 5 November 2006.

10. Mr Moloney had known Mr Board and his family for 30 years. He told the Court that Mr Board also had a history of illicit drug use and probably still used cannabis.

11. During the afternoon of 5 November 2006, Mr Board was also drinking and gambling in the Sly Bar and associated venues in the Caledonian Hotel when he became involved in an argument with Mr McLarty.

12. At 5:28:43pm, Mr Board directed Mr McLarty to the car park at the back of the hotel.

13. At 5:29:11pm, Mr Board hit Mr McLarty in the head. Mr McLarty immediately collapsed. His head hit the back of a parked car and then the surface of the car park.

14. At 2:45pm on 7 November 2006, Mr McLarty died at The Alfred Hospital from the head injury he sustained when Mr Board hit him and his head hit the ground.

15. No one has been charged with any offences associated with Mr McLarty's death.

16. Deaths caused by assaults in hotel premises are not unusual in Victoria. For example:

    - In 2004, David Hookes died in The Alfred Hospital from head injury sustained in an altercation with a security staff member after hitting his head on the ground following a punch in the mouth.[6] He had a blood alcohol concentration of 0.14g/100mL. Mr Hookes' death was investigated by the Homicide Squad of Victoria Police.

      Coroner Phillip Byrne did not hold an Inquest because the security staff member was charged with and found not guilty of manslaughter.

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[6] Coroners Case No. 232/2004.

- In 2006, Craig Wayne Taylor died in the Bendigo Hospital after hitting his head on the ground following a punch in the mouth.[7] He had a blood alcohol concentration of 0.21g/100mL. Mr Taylor's death was investigated by the Homicide Squad of Victoria Police.

  Coroner Paresa Spanos was unable to say whether Mr Taylor collapsed as a result of the blow, the fall, his high blood alcohol concentration or a combination of these factors.

  Coroner Spanos recommended that consideration be given to legislation requiring licensed premises to keep a comprehensive first aid kit, including safe resuscitative equipment in particular, and a regime for enforcing this requirement.

17. Adrian Krause, Tasma Quin and Michelle Romaniszyn were all working in the Caledonian Hotel on 5 November 2006. They gave consistent evidence that there was no known history of hostility between Mr McLarty and Mr Board.

18. Further, there is no evidence before me to suggest that the Caledonian Hotel has a general reputation for alcohol-related violence.

19. However, Mr McLarty was seen to purchase and drink four stubbies of full strength beer between 4:44pm, and 5:28pm on 5 November 2006. A blood sample taken later in the evening showed that he had a blood alcohol concentration of 0.15g/100mL.

20. Mr Board was also drinking beer in the Sly Bar and he told police he had had a big weekend drinking so he drank less on the afternoon of 5 November 2006. After 4:44pm, Mr Board purchased two stubbies of beer. There is no independent analysis of his blood alcohol concentration.

21. Therefore, as with the previous deaths of Mr Taylor and Mr Hookes after assaults on hotel premises, alcohol was probably a factor in precipitating the argument that developed between Mr McLarty and Mr Board.

22. My comments in relation to Mr McLarty's death will review the evidence before me in the context of these two previous deaths to determine:

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[7] Coroners case No 1986/2006.

- The sequence of events that led to Mr Board and Mr McLarty leaving the Sly Bar of the Caledonian Hotel;
- How Mr McLarty's injuries occurred;
- The medical response to Mr McLarty's injuries; and
- The police investigation of Mr McLarty's death.

23. I will then make recommendations intended to prevent further deaths occurring for the reasons Mr McLarty died.

The most likely sequence of events in the Sly Bar of the Caledonian Hotel

24. The CCTV and personal evidence available to me about the behaviour of Mr McLarty and Mr Board in the Sly Bar of the Caledonian Hotel on 5 November 2006 indicates that:

- At about 1:45pm on 5 November 2006, Mr McLarty went to the Caledonian Hotel with Ms Mitchell.
- Mr Board and Mr McLarty were both in the Sly Bar or its surrounds for most of the afternoon.

25. After 4:44pm, Mr McLarty spoke to Mr Board on at least eight occasions: each man initiated the conversation on four of these occasions.

- At 5:22:38pm, Ms Mitchell also spoke to Mr Board after consulting with Mr McLarty. Ms Mitchell told the Court that Mr McLarty asked her to ask Mr Board why he had not responded to Mr McLarty's request to buy cannabis from him.
- Mr Krause identified this conversation as the first indication in the CCTV evidence that there was any trouble between Mr McLarty and Mr Board. In particular, Mr Krause said he formed this opinion because:

  "It appeared that Nick walked past Kylie and sort of knocked her jumper off her waist or knocked something out of her hand, I believe...

*That's all, yeah, just look back through the cameras and see if there's anything that might have started something outside, yes. Only sort of appears from then on that sort of Russell got, maybe a little bit (*touchy*).*"

26. This means that, by 8:20pm, Mr Krause was in the position to contact police and initiate investigation of the incident in which Mr McLarty was injured.

27. However, Mr Krause did not inform police about the incident because he presumed they already knew. Rather, he rang Mr Moloney. In circumstances where Mr Krause acknowledges that he discussed the incident with Mr Moloney, I find it difficult to understand how he could continue to believe police already knew about it.

28. Accordingly, I have formed the view that licensees of hotels should be encouraged to always contact police when they become aware that a serious assault has occurred on licensed premises. **Recommendation 1**

29. Mr Moloney was sitting near Ms Mitchell during her interaction with Mr Board at 5:22:38pm and must have heard at least some of their short conversation. However, Mr Moloney denied hearing anything.

30. Ms Mitchell told the Court that Mr McLarty was seeking to obtain cannabis from Mr Board and this was the reason that Mr McLarty was annoying Mr Board.

- This explanation of the behaviour of the two men is consistent with Mr McLarty's expressed pain on the day, observations that he looked unwell, Ms Mitchell's evidence that two people told her that Mr McLarty had asked Mr Board for cannabis while she was still in the lounge and that Mr McLarty asked her to ask Mr Board why he was not providing him with the cannabis and Mr Moloney's opinion that it was likely that Mr Board still used cannabis.

- However, it is inconsistent with evidence from hotel staff, Pixie Gleeson and Sly Gleeson that they were not aware that either Mr McLarty or Mr Board used cannabis.

- Police investigators did not ask Mr Board about the reason Mr McLarty was annoying him.

31. In the absence of any alternative explanation of the altercation between Mr McLarty and Mr Board on 5 November 2006, I find it more likely than not that the argument between Mr McLarty and Mr Board arose in relation to Mr McLarty's seeking to obtain cannabis from Mr Board.

32. By 5:28:33 pm, Mr Board had become frustrated with Mr McLarty approaching him and perceived that he was becoming louder and more persistent.

- At this time, Francis Gleeson heard Mr Board say to Mr McLarty:

  "*Fuck you, you have been hassling me all afternoon, outside.*"

- CCTV evidence suggests that Mr Moloney, Mr O'Malley and Mr Dixon also heard these comments or at least they were attracted by their tone.

- At 5:28:43pm, Mr Board left the Sly Bar. At Mr Board's insistence, Mr McLarty followed him.

33. Therefore, I find that Mr Board initiated escalation of the argument between himself and Mr McLarty so that they left the Sly Bar and entered the car park of the Caledonian Hotel.

34. Mr Board returned to the Sly Bar about one minute after leaving with Mr McLarty.

- Mr Board spoke to Mr Moloney, Mr O'Malley and Mr Dixon and looked at the television.

- Mr Board then turned to watch the television with his hands behind his back. Mr Moloney said something further particularly directed at Mr Board. Francis Gleeson remained on the phone. Ms Mitchell remained sitting at the table.

- There is no evidence that Mr Board alerted anyone in the Sly Bar to Mr McLarty's circumstances in the car park.

- CCTV evidence from the Sly Bar stopped at 5:30:00pm.

35. Sly Gleeson followed Mr Board into the Sly Bar and saw that Mr Board was already leaving in the direction of his room upstairs.

- Sly Gleeson asked Mr Moloney to come out to the car park because Mr Board had pushed someone and they had been injured.

- Mr Moloney immediately left the Sly Bar.

36. In his statement made on the night of 5/6 November 2006, Mr Moloney said that Brian Gleeson told him that Mr McLarty was injured in the car park. He later confirmed that he was referring to Brian (Pixie) Gleeson.

37. In his statement made on 15 November 2006, Pixie Gleeson also said that he went straight inside after Mr McLarty collapsed and told Mr Moloney that Mr McLarty was injured. However:

- Mr Moloney and Pixie Gleeson's evidence on this point is inconsistent with CCTV evidence which shows that Pixie Gleeson stayed in the car park until after Mr Moloney left the back door of the hotel to tend to Mr McLarty.

- CCTV evidence shows that Sly Gleeson went inside immediately behind Mr Board.

- Further, Sly Gleeson's evidence is that he went inside and told Mr Moloney that Mr McLarty was injured. Pixie Gleeson was not in the Sly Bar at that time.

38. Therefore, Mr Moloney and Pixie Gleeson provided police investigators with similarly incorrect evidence about their movements and the people who spoke to them at about 5:29pm on 5 November 2006.

39. Accordingly, in the absence of CCTV footage in the Sly Bar before 4:44:01pm and after 5:30:00pm on 5 November 2006, I remain uncertain about the reliability of other evidence provided by Mr Moloney and Pixie Gleeson to police investigators and the Court.

40. Sly Gleeson also insisted that he told Mr Moloney that Mr McLarty had been injured by Mr Board in the car park. He told the Court:

"I think I said someone better get an ambulance, Nicky's just pushed a bloke and then he's hit his head and he might be in a spot of bother."

41. Therefore, Mr Moloney knew or should have known from his conversation with Sly Gleeson that Mr McLarty had been injured by Mr Board before he left the Sly Bar to tend to him.

42. Further, CCTV evidence shows that Pixie Gleeson met Mr Moloney at the door to the car park of the Caledonian Hotel at 5:30:44pm on 5 November 2006.

43. Pixie Gleeson also says that he told Mr Moloney that Mr McLarty had been injured in a fight.

- Pixie Gleeson said he used words like:

"there's been a blue."

"Moses, there's been an incident out the back, could you ring the ambulance and the police."

"Moses could you come please? There's been an incident and there's been a fight".

44. Therefore, if I presume that Pixie Gleeson used these words in car park rather than in the Sly Bar, Mr Moloney knew or should have known from both Sly Gleeson and Pixie Gleeson that Mr McLarty had been injured in a fight before he administered first aid to Mr McLarty and before he rang 000.

45. However, Mr Moloney has consistently denied that he knew or suspected that there had been an argument associated with Mr McLarty's collapse when he was administering first aid in the car park of the Caledonian Hotel:

"There was certainly no mention of a blue to me"

46. Further, when confronted with the ambulance record's note that Mr McLarty's injuries followed an altercation. Mr Moloney told the Court:

"Well, if I had have heard "altercation", then that would have alerted me once again that it was a fight. I don't know where they've got "altercation" from."

30 Despite Mr Moloney's denials, I find that Mr Moloney knew or should have known that Mr McLarty had been involved in an altercation with Mr Board when he administered first aid to Mr McLarty and contacted 000 in the car park of the Caledonian Hotel at 5:29pm on 5 November 2006. In making this determination I have relied on the following evidence:

- Mr Moloney's visible reaction to Mr McLarty and Mr Board's dispute in the Sly Bar immediately before they went outside,

- The short time between this dispute and Mr Board's return to the Sly Bar without Mr McLarty,

- Sly Gleeson's evidence about the information he provided to Mr Moloney when he asked him to assist Mr McLarty in the car park,

- Pixie Gleeson's evidence that he also told Mr Moloney that Mr McLarty had been involved in an altercation, and

- The information recorded in the ambulance records.

31 Accordingly, the evidence suggests that Mr Moloney misled investigators and this Court in relation to his knowledge about the dispute between Mr McLarty and Mr Board and the possible causes of Mr McLarty's injuries at the time he was providing first aid to Mr McLarty and contacted 000.

32 However, in the context of information given to ambulance paramedics by other witnesses, there is no reason to suggest that Mr Moloney's failure to acknowledge that Mr McLarty may have been injured in a fight when he was administering first aid and calling 000 influenced his death.

How Mr McLarty's injuries occurred

33 The evidence available to me about the behaviour of Mr McLarty and Mr Board in the car park of the Caledonian Hotel on 5 November 2006 indicates that:

- At 5:28:45pm, Mr Board walked out the back door of the Caledonian Hotel. He was closely followed by Mr McLarty.

- At 5:28:52pm, Mr Board turned to face Mr McLarty under the roof over the back door. Mr Board says he said to Mr McLarty:

  "*Fuck off and stop annoying me.*"

- Mr Board also said to Mr McLarty:

  "Can you stop talking shit and just leave me alone... you're full of piss."

- Mr McLarty did not say anything in response.

- At 5:29:08pm, Mr McLarty followed Mr Board into the car park from between parked cars outside the back door of the hotel.

- Mr Board then started to walk towards the fire escape entrance to the upstairs of the hotel. Mr McLarty followed.

- By this time, Pixie Gleeson had exited the front passenger door of a taxi driven by Michael Finn. Sly Gleeson remained the back seat passenger in the taxi.

- Pixie Gleeson was concerned about what he heard and started to follow Mr Board and Mr McLarty. However, he denies hearing the content of their conversation.

- Pixie Gleeson was less than three metres from Mr McLarty at this time.

47. Accordingly, I do not accept that Pixie Gleeson could respond as he did without hearing some or all of what Mr McLarty and Mr Board said to each other.

48. At 5:29:10pm, Mr McLarty ran up behind Mr Board.

- Mr Board turned to face Mr McLarty and took a 'boxing-like' stance with clenched fist and bent right arm. Mr McLarty had his arms at his sides.

- Mr McLarty moved quickly towards Mr Board before he extended his right arm with a closed fist in a move that seemed intended to hit or push Mr Board in the left shoulder.

- Mr Board raised his left arm in a defensive motion and seemed to lose his balance slightly so that he was leaning backwards standing on his left leg with his right leg extended forward.

- At 5:29:11pm, Mr Board and Mr McLarty separated facing each other with Mr McLarty in a submissive position backed up against Mr Moloney's car.

49. Mr Board then punched Mr McLarty on the right side of his head with his left closed fist. This caused Mr McLarty's head to flex to the left. At 5:29:12pm, a second punch seemed to hit Mr McLarty in the shoulder.

50. In explaining the reasons for his admitted assault on Mr McLarty, Mr Board told police investigators:

"I didn't know if he was going to hit me or what so I thought I would get in first, so I went wack."

51. Mr Board also told police:

"I wouldn't have hit him the second time I had of realized but I think he was gone after the first hit....

He was out before he hit the ground, he went straight back and hit his head on the asphalt."

52. At 5:29:13pm, Mr McLarty fell backwards on to the ground behind Mr Moloney's car. Mr Board said that he hit his head on Mr Moloney's car during his fall.

53. Pixie Gleeson was almost beside Mr Board by this time. Although he continued to deny hearing their conversation, Pixie Gleeson must have seen and heard what occurred in the three seconds between the time Mr McLarty approached Mr Board and the time he fell.

54. Neither Pixie Gleeson nor Mr Board made any attempt to check Mr McLarty.

55. Instead, Pixie Gleeson spoke to Mr Board and then walked away towards the back entrance to the car park with his stubby. Mr Board walked towards the back door of the hotel.

56. Accordingly, I have formed the view that Pixie Gleeson may have withheld information from investigators and this Court about the circumstances in which Mr Board hit Mr McLarty in the car park at the Caledonian Hotel on 5 November 2006. However, I note that Mr Gleeson's presentation in Court suggests to me that his failure to hear what Mr McLarty and Mr Board said to each other may have been influenced by language that he did not want to repeat in public.

57. At 5:29:22pm, Sly Gleeson approached Mr Board as he walked towards the back door.

- In response to their communication with each other, Mr Board turned towards Mr McLarty and raised his hands in the air in what looked like a dismissive gesture about the situation.

- Sly Gleeson did not approach Mr McLarty. He and Mr Board went into the Caledonian Hotel through the back door.

58. Mr McLarty remained lying on the ground. He was not moving and no one made any attempt to check him.

59. At 5:30:42pm, Mr Moloney entered the car park from the side door. He met Pixie Gleeson and they both approached Mr McLarty and began to administer first aid.

60. At 5:47:12pm, while the ambulance remained in the car park, Mr Board exited the top floor of the Caledonian Hotel using the fire escape and carrying a bag. He took the bag towards the back entrance of the car park.

61. At 5.47.54pm, Mr Board re-entered the car park from the same direction as he left. He no longer carried the bag.

62. I am unable to say what was in Mr Board's bag or what he did with it. However, his movements determined that this bag was not in his room when police investigators searched it later in the evening.

63. Mr Board walked south past the waiting ambulance and in the back door of the hotel.

64. Sly Gleeson spoke to Mr Board when he entered the Sly Bar. He said to Mr Board:

"I hope that guy's all right".

Mr Board responded:

"So do I."

65. In so doing, Mr Board and Sly Gleeson seemed to acknowledge to each other that they knew that Mr Board had been a factor in causing Mr McLarty's injuries.

Medical Response to Mr McLarty's Injuries

66. Ninety seconds after Mr McLarty collapsed in the car park of the Caledonian Hotel, Mr Moloney was the first person to render any assistance to him.

67. At 5:30:50pm, Mr Moloney bent down to tend to Mr McLarty. At 5:31:23pm, he called 000 to report an injured male in the car park at the Caledonian Hotel.

68. Mr Moloney told the 000 call taker:

"We have got a male collapsed in the back yard with blood coming from his head... he is conscious and breathing."

69. Mr Moloney did not tell the 000 call taker that Mr McLarty was or may have been injured in an altercation and he did not contact police to report the incident in which Mr McLarty was injured.

70. Mr Moloney told the Court that he was not aware that the incident involved a possible assault until Acting Sergeant Stuart Poulton rang him at 9:39 pm on 5 November 2006.

71. For the reasons stated elsewhere in this Finding, I do not accept that Mr Moloney was not aware that Mr McLarty may have been injured in a fight when he contacted 000.

72. Mr Moloney also told the Court that he believed that the emergency call taker would have alerted police. However, this was not the way in which the 000 service operated at that time and it was not the evidence of another less experienced police witness:

- The Court heard that, in 2006, 000 calls requesting an ambulance were specifically directed to that service.

- Leading Senior Constable Deane Owen also told the Court that ambulance and police emergency calls operated on different systems in 2006 and there was no expectation that ambulance paramedics would contact police in relation to an assault unless they were in fear for their safety. For example:

  "We've even had car accidents, that people have been taken to hospital, and the police haven't been notified so, yeah. The first we know about it is that a blood sample turns up."

- In his 13 years experience in Warrnambool, Mr Owen could not remember the emergency call takers notifying him of an incident. Usually witnesses and bystanders would contact police separately to ensure that they were despatched.

73. Accordingly, I find it difficult to accept that a policeman with Mr Moloney's experience in Warrnambool did not call police because he thought they would have been contacted through 000.

74. Communication between emergency services has been improved since 2006 with the introduction of the state-wide Emergency Services Telecommunications Authority ("ESTA") and amalgamation of the Metropolitan Ambulance Service and the Rural Ambulance Service under Ambulance Victoria. Therefore, I make no recommendations in relation to sharing of information between emergency services.

75. At 5:31pm, Warrnambool ambulance paramedics, John Wormald and Trevor Niklaus, were despatched to an 'unconscious male' at the rear of the Caledonian Hotel.

- At 5:37:08pm, Mr Wormald and Tasma Quinn walked through the back entrance to the car park of the Caledonian Hotel. They were closely followed by Mr Niklaus in the ambulance.

- Mr Wormald and Mr Niklaus assessed Mr McLarty as unconscious with a laceration to the occipital region of the head with about 50ml blood loss and no further new injuries. His blood sugar level was within normal limits.

- Mr Wormald and Mr Niklaus were aware that Mr McLarty's medical history included non-insulin dependent diabetes mellitus and asthma, that Mr McLarty was found unconscious by a third party, that Mr McLarty had been drinking at the hotel and that he had an altercation with a "third party of unknown origin".

- Therefore, by the time ambulance paramedics had reviewed Mr McLarty they knew that his injuries probably arose from an assault. However, they also said they would not usually notify police of an assault unless they felt personally at risk.

76. At 5:51:44pm, Mr Wormald and Mr Niklaus transported Mr McLarty to Warrnambool & District Base Hospital.

77. At 5:55pm, Mr McLarty presented in the ambulance at the Emergency Department at Warrnambool & District Base Hospital.

- At 5:57pm, Mr McLarty was triaged Category 2. The triage nurse also noted:

  *"lac(*eration*) to back of head, unwitnessed but ? knocked to ground outside pub, head trauma".*

- Accordingly, I find that the triage nurse at the Emergency Department at Warrnambool & District Base Hospital was already aware that Mr McLarty had sustained his injuries in an altercation.

78. Despite this knowledge that Mr McLarty had been seriously injured in a fight, no one from Warrnambool & District Base Hospital contacted police at this stage. **Recommendation 2**

79. At 6:05pm of 5 November 2006, Dr Sukabula confirmed that Mr McLarty still had a Glasgow Coma Scale of 3. He had a wound on the back of the head. He also had a developing right black eye, blood around his mouth from his teeth and smelled of alcohol.

- Dr Sukabula ordered an x-ray and a CT brain scan but he was concerned about intubation because of his alcohol use.

- At 7:14pm, the CT brain scan indicated extensive left subdural haematoma involving the left frontoparietal region associated with severe displacement of the midline towards the right.

- The x-ray also confirmed fracture of the right temporal bone extending into the internal auditory canal and foramen lacerum and multiple facial bone fractures.

80. At 6:05pm, Dr Sukabula ordered blood tests. It is unclear when the blood was taken for these tests but it seems to have been delayed until after 8:50pm because it contained medication administered at that time.

81. This incorrect labelling of the times of taking of pathology specimens has implications for patient management, record keeping at Warrnambool & District Base Hospital and on-going understanding of the events preceding an inter-hospital transfer. **Recommendation 3**

82. At 7:46pm, Dr Sukabula contacted the on-call surgeon, Mr Phillip Gan.

- At about 8:45pm, Mr Gan directed Dr Sukabula to arrange Mr McLarty's trauma retrieval and neurosurgery liaison. He also directed that police be informed because the case was a potential homicide.

- At 8:50pm and 9:10pm, vercuronium and phenytoin were administered. Dr Sukabula also ordered a mannitol infusion but this did not commence until 10:05pm.

- Dr Sukabula told the Court that the mannitol could have been given earlier and that it is possible that this could have changed the outcome for Mr McLarty. He also explained that he did not reinforce his written orders with a verbal direction that the mannitol was urgent. He says he should have done that.

83. This delay in administration of medications ordered by medical practitioners in the Emergency Department at Warrnambool & District Base Hospital has important implications for patient management and outcomes.

84. A review of files of patients presenting to the Emergency Department would demonstrate the degree to which delay in administration of ordered medication is a more general issue at Warrnambool & District Base Hospital and enable appropriate remediation. **Recommendation 4**

85. Dr Peter O'Brien was the Director of Medical Services at South West Healthcare in Warrnambool. He had no direct involvement with Mr McLarty's clinical care.

86. Dr O'Brien told the Court that transfer to a tertiary hospital required preliminary diagnosis of a condition that could not be managed locally. In Mr McLarty's situation, Dr Sukabula appropriately sought advice from Mr Gan when he saw the extent of the haemorrhage in the CT brain scan.

87. Further, the retrieval team and the receiving hospital would normally need to know sufficient information to demonstrate that that patient needs retrieval so it would be hard with a head injury to make a decision without a CT result.

88. Further, in December 2003 South West Healthcare Clinical Emergency Department issued a document entitled Inter-Hospital Transfer of a Critically Ill Patient 2003. This document was reviewed on 13 September 2006.

89. Inter-Hospital Transfer of a Critically Ill Patient 2003 should have influenced Dr Sukabula's clinical response to Mr McLarty's presentation. In particular, this document requires:

- Contact with the 1800 Trauma Advice and Referral Line within 15 minutes when a patient presents with major trauma and a GCS less than 13.

- The Trauma Advice and Referral Line routinely advises medical officers to administer anti-convulsants and mannitol to patients who present with head injury and subdural haemorrhage.

- No retrieval can commence without a positive decision from the retrieval team and an appropriate bed in the receiving hospital.

90. However, Dr Sukabula was not aware of the document entitled Inter-Hospital Transfer of a Critically Ill Patient. He did not contact the 1800 Trauma Advice and Referral Line or administer phenytoin, midazolam and mannitol or make arrangements for transfer of Mr McLarty to a tertiary trauma centre until after Mr Gan reviewed Mr McLarty at 9:10pm

- By 2009, retrieval arrangements from Warrnambool had changed. There was a helicopter based at Warrnambool and the hospital had recruited more emergency physicians and local expertise was increasing.

- Dr O'Brien also told the Court that there are still restrictions on the way in which this facility operated. However,

  *"It's sometimes more important to have a patient stable rather than to rush somewhere but it gives another option. I mean, this (*Mr McLarty*) is perhaps the sort of patient that that option may have been seriously considered had a helicopter been available....*

  Well, this type of case was the sort of case used in an argument for the need for it (the helicopter)*."*

- If there had been more senior emergency physicians at Warrnambool, Dr Sukabula could have accompanied Mr McLarty to The Alfred Hospital. Dr O'Brien also raised this issue:

  "we are actually finding it a little difficult to determine what is a reasonable senior mix in a regional hospital ED."

- Although this availability would not have changed the outcome for Mr McLarty, the communication and experience that would have arisen would have enriched Dr

Sukabula's professional capacity to manage future emergencies and made him aware of the requirements in protocols for transfer of trauma patients. **Recommendation 5**

91. At 11:25pm, Mr McLarty left Warrnambool & District Base Hospital for air transfer to The Alfred hospital. At 12:58am on 6 November 2006, he presented at The Alfred hospital.

- Relying on the CT brain scan performed at Warrnambool, The Alfred medical team quickly assessed Mr McLarty as having a poor prognosis and surgery was not initiated.

- At 5:20am, a further CT brain scan confirmed that Mr McLarty remained unrecoverable. The dimensions of his subdural haemorrhage and mid line shift remained similar to those found at 7.14pm on the previous day at Warrnambool.

- Therefore, failure to contact the tertiary trauma centre within 15 minutes of presentation and failure to administer mannitol in a timely fashion did not change Mr McLarty's outcome.

92. Mr McLarty was transferred to the Intensive Care Unit and active treatment was withdrawn at 12:35pm on 6 November 2006.

93. At 2:45pm on 7 November 2006, Russell McLarty died.

94. The forensic pathologist who performed the autopsy formed the opinion that the cause of death was head injury.

95. The pattern of injury was consistent with that which is often seen when the back of a moving head strikes a stationary surface. Lacerations to the upper right eye lid and associated bruising may have occurred in association with blunt force application to the front of the head in this region.

96. There was no evidence of subcutaneous bruising on the knuckles hands and forearms that would have occurred if Mr McLarty had also hit Mr Board.

97. In summary:

i. The laceration and bruising above the left eye was probably caused when Mr Board hit Mr McLarty with sufficient applied force to cause Mr McLarty to fall backwards under the combined energy of gravity and the applied force.

ii. Mr McLarty's blood alcohol level would have impaired his physical motor functions and coordination functions so it may have contributed to the way in which he fell if he was not already unconscious.

iii. The fractures to the back of Mr McLarty's head occurred when the back of his head hit the ground.

iv. The fractures in Mr McLarty's eye sockets were probably a secondary injury caused by the force of the brain moving within the skull after it had hit the ground. Although a second applied force could have contributed to these injuries.

v. Mr McLarty's subdural haemorrhage and brain swelling was caused by trauma to the blood vessels in the brain caused when his head hit the ground and the associated brain movement within the skull.

vi. Mr McLarty's death was caused by a combination of the subdural haemorrhage and the brain swelling.

vii. Mr McLarty's head injury was serious and his prognosis was always poor.

98. There was no evidence that Mr McLarty sustained a second blow to the head as admitted by Mr Board.

99. Accordingly, I find that Mr McLarty died from head injuries suffered when his head struck a stationary surface after Mr Board hit him once on the head near the upper right eye lid.

Police investigation

100. Warrnambool is a regional centre in southern Victoria. It has one police station which houses both uniform police officers and detectives.

101. As I understand it, most Warrnambool police officers live in or near the town. Many grew up in the region. They know each other. They know other community and emergency service workers. They know other people in and are part of Warrnambool.

102. From my perspective as a City dweller, it seems that, most of the time, this integration of police into the local community carries benefits that City dwellers and City police do not enjoy.

103. However, as with other officials who live and work in regional towns, it can be difficult for local police to avoid the real or perceived conflicts of interest when an associate or a friend is involved in an incident which requires police involvement and/or investigation. Victoria Police management of this issue in regional centres like Warrnambool will always be a challenge.

104. Victoria Police investigation of Mr McLarty's assault and death is a good example of the issues that face regional police on a daily basis. Mr McLarty's family has complained to me and to Victoria Police about their perception of the influence of conflict of interest involved in the investigation of Mr McLarty's death.

105. The police investigation of Mr McLarty's death was influenced by a number of factors including:

- Delay of over three hours in reporting his assault;
- Emphasis on evidence required for prosecution rather than coronial investigation with associated selective retention of CCTV footage from the Caledonian Hotel;
- Early decision that the assault was administered in self defence; and
- Real or perceived conflict of interest.

106. Warrnambool Police were not formally aware of Mr McLarty's injuries or the possibility that they related to an assault by Mr Board until 9:11pm on 5 November 2006 when Dr Sukabula contacted the watch house at the direction of Mr Gan.

107. The investigating officer for this incident, Detective Senior Constable Colin Ryan, told the Court he would have expected an off duty policeman to inform police when they were confronted with the situation that faced Mr Moloney when he was off duty on 5 November 2006.

108. However, in denying responsibility for failing to contact police, Mr Moloney said he was not aware that Mr McLarty had been assaulted until Mr Poulton contacted him at 9:39pm.

109. I do not accept Mr Moloney's evidence on this point because:

- Sly Gleeson spoke to Mr Moloney in the Sly Bar at about 5:30pm on 5 November 2006:

  "I think I said someone better get an ambulance, Nicky's just pushed a bloke and then he's hit his head and he might be in a spot of bother."

- The ambulance paramedics' Patient Care Record completed by about 6:00pm indicates that Mr McLarty had been drinking at the hotel and that he had an altercation with a "third party of unknown origin".

- Telephone records indicate that Mr Krause rang Mr Moloney at 8:23pm after he viewed the CCTV footage. Mr Krause confirmed he would have discussed the incident with Mr Moloney.

- At 8:27pm, Mr Moloney called the Warrnambool Police Station. The call lasted over five minutes. However, Mr Moloney told the Court he had no recollection of who or why he called.

- At 9:18pm, Mr Moloney rang the Caledonian Hotel. The call lasted over three minutes. Again, he cannot recall who or why he called the Caledonian Hotel.

- At 9:34pm, Mr Moloney rang Mr Board's brother in Queensland and told him Mr Board was in custody.

110. Earlier notification of Victoria Police about his assault in the car park of the Caledonian Hotel on 5 November 2006 would not have changed the outcome for Mr McLarty. However, it would have reduced the loss of and mistaken memory experienced by a number of witnesses and the likelihood that the evidence provided to the Coroner would be limited by operational decisions.

111. For example, after 9:12pm on 5 November 2006:

- Detective Senior Constable Colin Ryan was allocated to lead the investigation of the circumstances surrounding Mr McLarty's injuries and death. This was his first homicide investigation. He admits that he focussed on the evidence required to prove

the offences of murder or manslaughter. He did not even consider the requirements of the Coroner to investigate the death and find the circumstances surrounding the death.

- Mr Ryan's priorities led him to direct Mr Neagle to restrict the CCTV footage he retained to that in which Mr McLarty and Mr Board interacted. Mr Ryan waited for this information before he formally interviewed Mr Board.

- Mr Neagle confirmed that he already knew Mr McLarty was seriously injured and that the investigation could become a homicide investigation.

- Mr Neagle also explained:

  "I'd already interacted with Board... I'd been up to his room and interacted with him, taken him back to the police station and seated him in an interview room and returned to watch that and, no, I didn't consider that his reaction or response after the incident were worth sitting interviewing further."

- In the context of these pre-existing understandings and beliefs about the incident, Mr Neagle took less than two hours to review all the CCTV footage from 13 cameras from 1:30pm to 6:00pm on 5 November 2006.

- Mr Krause had already reviewed the CCTV evidence from all 13 cameras at the Caledonian Hotel and formed a view about the interaction between Mr McLarty and Mr Board of 5 November 2006.

- Mr Neagle understood that Mr McLarty had arrived at the Caledonian Hotel at about 1:30pm so he looked at CCTV records from about that time. He also told the Court that he did not consider the events that occurred in the Sly Bar after 5:30pm to be relevant to the investigation of Mr McLarty's assault.

- Subsequent conversations between Mr Ryan and hotel staff identified a further camera with important evidence of the incident in the hotel car park so it is clear that Mr Neagle did not identify all the relevant CCTV footage when he undertook his review with Mr Krause on 5 November 2006.

112. This limited and selective scope of the CCTV evidence seized on 5 November 2006 was a factor in determining that the CCTV footage from the fire escape camera was not viewed by

Mr Iddles or included in the original brief, witnesses who later denied any memory of the events in the Sly Bar did not provide immediate statements, Mr Moloney and Pixie Gleeson similarly distorted the facts in their statements and other witnesses were not even approached until many months after the event occurred.

113. These factors have also informed my doubts about Mr Neagle's evidence that there was no interaction between Mr Board and Mr McLarty in the Caledonian Hotel between 1:30pm and 4:44pm on 5 November 2006.

114. Further, from a coronial perspective, information about the movements of and interactions between Mr Board, Mr McLarty and other witnesses during the afternoon and evening of 5 November 2006 would also have assisted me in interpreting the evidence, particularly that of Mr Board, Mr Moloney and Pixie Gleeson.

115. Mr Ryan told the Court that he was not aware that the CCTV images would not remain available until several months later. He conceded that it would have been better to seize more records of the CCTV cameras. Mr Ryan told the Court:

"Yes, it would have been better to get all of it and if it happened again I'd just get the whole day and keep it."

116. Senior Sergeant Ron Iddles from the Homicide Squad also told the Court that it could have been important for me as Coroner to have a recording of the Sly Bar after 5.30pm:

"In your role, yes because you would see witnesses maybe talking to each other, see what actually happens. There may be an inference that the policeman who was off duty was doing something he shouldn't, I don't know but yes I can see why that would be important....

Our detectives across the state are trained by Victoria Police to a standard and I can't say much more than it should have been collected and all I can do is apologise it was not collected. I probably should have given the advice, I didn't give the advice....

If there's CCTV footage, collect the whole lot. You're better to have it than not have it at all."

117. Further, the Homicide Squad declined to accept responsibility for investigating Mr McLarty's death. In making this decision, Mr Iddles said that he relied on his experience in

Wilson's case[8] and his interpretation of the CCTV evidence from the camera in the south-east corner of the car park that included the likelihood of self defence. I do not understand the relevance of *Wilson's* case to the circumstances of Mr McLarty's death.

118. Although Mr Iddles was open to further consultation about the investigation, Mr Ryan agreed with his interpretation and did not seek further guidance.

119. Mr Iddles told the Court that the Homicide Squad arrangements have changed since Mr McLarty died. Now, even when the Homicide Squad is not involved in an investigation, the prosecution and coronial briefs must be reviewed at their office before transfer to the Director of Public Prosecutions and the Coroners Court.

120. Mr Iddles undertook to prepare a written policy about the preparation of an inquest brief and place it before a policy committee in the Crime Department of Victoria Police. He also said that the distinction between a prosecution brief and a coronial brief needed to be reinforced in detective training and recruit education of Victoria Police officers.

121. In circumstances where a hotel patron dies after an assault in a hotel car park in regional Victoria, this policy is welcome but it is not enough.

122. The deaths of Mr Hookes and Mr Taylor were both investigated by the Homicide Squad. The Director of Public Prosecutions made the decision about whether there was sufficient likelihood of a successful prosecution after this Homicide Squad investigation was complete. There is no justification for Victoria Police to treat other similar deaths differently or to pre-determine the Director's decision about available defences. **Recommendation 6**

123. To some extent the McLarty family is justified in complaining that the investigation of Mr McLarty's death was influenced by conflict of interest. For example, I have already found that Mr Moloney appears to have misled investigators and this Court on a number of crucial issues. Although it is unlikely that any of them would have changed the outcome for Mr McLarty, all of them have complicated the coronial investigation of Mr McLarty's death and the degree to which I am able to rely on the evidence before me.

124. Mr Moloney was an important witness in this coronial investigation. He was also:

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[8] DPP v Wilson [2006} VSC23 handed down on 7 February 2006.

- Acting Sergeant of Police in Warrnambool.
- A well established long term friend of Mr Board's family.
- He knew the Caledonian Hotel staff including Adrian Krause sufficiently well for them to have his phone number.
- He knew Pixie Gleeson and Sly Gleeson and other patrons in the Sly Bar on 5 November 2006.
- He was a personal friend of Mr Poulton who was the first police responder to Mr McLarty's death and the first person to determine that Mr McLarty threw the first punch. Mr Poulton spoke to Mr Ryan.

125. Senior Sergeant Ron Iddles from the Homicide Squad acknowledged that Mr Moloney's relationships made it difficult for Victoria Police to avoid a perceived conflict of interest. When asked what his advice would have been if he had known about these issues, he said

"Would it have changed my advice about who should do this investigation? Maybe. It may have been more appropriate for Colac CI or another unit independent of Warrnambool to do it."

126. However, Mr Iddles also said that, having determined that the investigation should not be accepted by the Homicide Squad, he would raise it with the local area manager to determine whether the investigation should be transferred out of the region.

127. I am unable to say whether or to what degree these relationships influenced Mr Moloney's failure to hear the conversations between Mr Board and Mr McLarty in the Sly Bar, denial of knowledge that Mr McLarty may have been assaulted, delay in reporting of Mr McLarty's injuries to police, communications with Mr Poulton which set the scene for limiting seizure of the CCTV evidence from the Sly Bar and incorrect assertion that he had not discussed the incident with anyone else including Pixie Gleeson and Brian Dixon.

128. However, in circumstances where an important witness in a death investigation is an off-duty police officer who has a long-term relationship with many of the other witnesses, the perception of conflict of interest can be better managed if the coronial investigation was

routinely transferred out of the region, preferably to the Homicide Squad. **Recommendation 7.**

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That the Australian Hotels Association inform its members of the circumstances of Mr McLarty's death and encourage licensees of hotels to always contact police when they become aware that a serious assault has occurred on licensed premises.

2. That the Medical Director of South West Healthcare direct the Director of the Emergency Department at Warrnambool & District Base Hospital to contact Warrnambool Police Station when a patient presents with life-threatening head injuries that are consistent with an assault.

3. That the Medical Director of South West Healthcare review the system for ordering, taking and labelling of pathology specimens at Warrnambool & District Base Hospital to ensure accurate times are recorded at each step in the procedure.

4. That the Medical Director of South West Healthcare investigate the frequency with which there is delay in administration of medications ordered by medical practitioners in the Emergency Department at Warrnambool & District Base Hospital.

5. That the Secretary for the Department of Health ensure that Emergency Departments in regional hospitals have sufficient senior medical officers to allow the medical officer responsible for a trauma patient to accompany the patient to the tertiary hospital so that they better understand the importance of implementing trauma protocols.

6. That the Chief Commissioner of Victoria Police direct the Homicide Squad to investigate all Victorian deaths following an assault in licensed premises to the level of detail required for both prosecution and coronial purposes.

7. That the Chief Commissioner of Police direct the Homicide Squad or the local area managers to accept responsibility for transferring the coronial investigation of deaths out of the region when an important witness in the death is an off-duty police officer who has a long-term relationship with many of the other witnesses.

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

Mr Robert McLarty

Detective Senior Constable Colin Ryan

Acting Sergeant Chris Moloney

Detective Senior Sergeant Ron Iddles

Chief Executive Officer, Australian Hotels Association (Victoria)

Chief Commissioner of Victoria Police

Secretary for the Department of Health

Medical Director Warrnambool & District Base Hospital

Signature:

DR JANE HENDTLASS
CORONER
Date: 26 June 2013