CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mona Lisa and Jacinta Smith
Hearing dates:	27 November 2023 – 1 December 2023; 19 – 20 December 2023
Date of findings:	23 April 2024
Place of findings:	Coroners Court of NSW at Bourke
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Aboriginal; First Nations; Wakamurra; Muruwari; Kunya; Bourke; Enngonia; single vehicle collision; rollover; inquest resumed; s.79 Coroners Act; colonisation; racism; Police Guidelines for the review of investigations relating to deaths, Police training.
File number:	2022/0027663

Representation:	**Counsel Assisting the Coroner:** Dr P Dwyer SC and E Sullivan, Instructed by E Trovato and J Best (Crown Solicitor's Office) NSW Commissioner of Police, NSW Police Force ('NSWPF'), C Melis of Counsel instructed by NSWPF Office of the General Counsel Mr Peter Ehsman, S Russell of Counsel instructed by the Police Association of NSW Mr John Ludewig, Mr R Reitano of Counsel, instructed by McNally Jones Staff Lawyers Dawn Smith and June Smith, J Buxton of Counsel, instructed by the National Justice Project

Findings:	**Mona Lisa Smith** **Identity:** The person who died was Mona Lisa Smith (Mona). **Date of death:** Mona died on or around the early hours of Sunday, 6 December 1987. **Place of death:** Mona died on the Mitchell Highway, 34 kilometres south of Enngonia. **Cause of death:** Mona died from multiple internal injuries (including head and lung injuries) sustained in the accident, leading to extensive blood loss **Manner of death:** Mona died in a single-vehicle collision when a Toyota utility 4WD vehicle driven by Mr Alexander Grant was involved in a roll-over accident, in which contributing factors were intoxication, fatigue, road speed and the lack of lighting. **Jacinta Rose Smith** **Identity:** The person who died was Jacinta Rose Smith (Cindy). **Date of death:** Cindy died on or around the early hours of Sunday, 6 December 1987. **Place of death:** Cindy died on the Mitchell Highway, 34 kilometres south of Enngonia. **Cause of death:** Cindy died from multiple internal injuries (including pelvic and lung injuries) sustained in the accident, leading to extensive blood loss. **Manner of death:** Cindy died in a single-vehicle collision when a Toyota utility 4WD vehicle driven by Mr Alexander Grant was involved in a roll-over accident, in which contributing factors were intoxication, fatigue, road speed and the lack of lighting.

Recommendations:	**1.** That the Commissioner of the NSW Police Force develop guidelines for the review of investigations relating to deaths that are the subject of a request for advice from the NSW Attorney General to the Commissioner of the NSW Police Force, where the Attorney General is considering an application for the holding of a fresh or further inquest into the death/s. Such guidelines should include: a) the methodology of the review; b) transparency of the review process; c) the involvement of any experts (including independent experts as required); and d) consultation with the family of the deceased. In formulating the guidelines, the standard operating procedures applicable to the review of homicide investigations should be considered and applied as appropriate.

Table of Contents

A. INTRODUCTION

1. From 27 November to 1 December 2023, and 19 to 20 December 2023, I held an inquest in Bourke, New South Wales, into the deaths of Mona Lisa and Jacinta Smith.

2. Mona Lisa Smith (known as **Mona** to family and friends) was a First Nations Muruwari Kunya girl. Mona was born on 29 November 1971 to parents June Smith and Doug Shillingsworth. Mona grew up with her five brothers and sisters.

3. Jacinta Smith (known as **Cindy** to family and friends) was a First Nations Wakamurra girl. Cindy was born on 23 October 1972 to parents Iona Dawn Smith (Dawn) and Neil Smith. Cindy had six brothers and one sister and one adopted sister.

4. Mona Lisa and Jacinta were aged 16 and 15 respectively at the time of their deaths in the early hours of 6 December 1987. The girls died after sustaining non-survivable injuries following a motor vehicle accident on the Mitchell Highway between Bourke and Enngonia in circumstances which I have detailed below. A non-Aboriginal male, Mr Alexander Grant, was also in the car at the time of the crash. Mr Grant escaped the accident with only minor injuries. The evidence suggested he had plied the girls with alcohol before taking them out onto the highway in his car in the early hours of that Sunday morning. Horrifyingly, the evidence indicates that Mr Grant sexually interfered with Cindy after she had passed.

5. The initial police investigation in the days following the girls' deaths is detailed below. It was wholly and, in some respects, inexplicably deficient (for reasons amplified below). A subsequent re-investigation by a determined and dedicated senior officer from the Accident Investigation Squad of the NSW Police Force in May 1988 sought to pursue important avenues of inquiry. By this stage, however, it was simply too late. Critical evidence had been irreparably lost. Mr Grant was charged with certain criminal offences, but following a jury trial in February 1990, he was acquitted of any criminal conduct. Notwithstanding Mona and Cindy's families raising concerns about the inadequacy of the police investigation on a number of occasions over the last few decades (which

concerns I note were entirely vindicated by the evidence received in this inquest, as set out below), those concerns were repeatedly dismissed.

6. This inquest - held because of the unrelenting advocacy of Mona and Cindy's families - was their final hope to obtain answers about the circumstances of the deaths of their beloved girls. It was some form of "justice", albeit decades too late.

7. Mona and Cindy were living as part of a small and close-knit community in Bourke, New South Wales. It was obvious that they were loved dearly by their families. Both girls attended Bourke High School and were clearly popular. Inseparable since childhood, the girls were described as being like sisters.

8. At the conclusion of the inquest, Mona and Cindy's families generously shared with the Court some of their special memories of the girls. Family members paid tribute to Mona and Cindy through very personal statements and with a deeply moving song.

9. During her evidence on 30 November 2023, June Smith shared this about her beautiful daughter, Mona:

> *Well, Mona was a beautiful baby and she grew up, you know, lovely, happy-go-lucky girl and you know, as she got older, her and her cousin Cindy was always together every day.*
>
> *...*
>
> *She [Mona] was a singer as she was growing up getting into where - about 12 and 13, she wanted to sing in the talent quest because we used to have Aboriginal talent quests every year and everybody joined in, and she loved singing, so, you know, she wanted to be a singer because I used to sing.*

10. Dawn Smith told the Court that Cindy loved listening to music. Her favourite songs were Uptown Girl by Billy Joel and Venus by Bananarama. One day she was on a school excursion and came home with a picture of her playing the piano. After that, she wanted to learn how to play.

11. Dawn also said:

> *We would go down the river for swimming, fishing and crayfishing, the kids and old people would play games like rounders, skippies, high jump*

and marbles, and every Sunday we would walk up town to church. We used to take the children out to show them wild fruit and bush medicine too.

...

I used to love taking my kids to the Talent Quest, where our kids could perform for our community. Cindy was always too shy to get up and sing, but she enjoyed going and watching the others, especially her older brothers Richard and Lloyd who sang and played the guitar.

12. Mona and Cindy were young, bright girls, sparkling with life and excitement. They had big hopes and dreams, and so much to look forward to.

13. Almost 37 years after the passing of Mona and Cindy, the grief and anguish of their tragic passing remains raw for their families.

14. It is my hope that through the recent coronial investigation and inquest proceedings, Mona and Cindy's families have been provided long awaited answers.

Holding of the inquest

15. Mona and Cindy's deaths were the subject of an initial coronial investigation in 1988.

16. On 8 November 1988, the then Coroner (Mrs Rosemary Cater-Smith) made preliminary remarks regarding the girls' deaths but ultimately determined to dispense with the inquest[1] as Mr Grant had been charged with an indictable offence in connection with the deaths.[2] The inquest was not resumed following the conclusion of the criminal proceedings in February 1990 (see [165] below).

17. On 4 July 2022, the National Justice Project (**NJP**) wrote to the me as the State Coroner (on behalf of Mona and Cindy's families) requesting resumption of the inquests into the girls' deaths.

18. On 14 July 2022, I directed that the inquests be resumed pursuant to s 79 of the *Coroners Act 2009* (the **Act**).

---

[1] Under s 19 of the then *Coroners Act 1980 (NSW)*)
[2] Exhibit 1, Tab 68

19. I again acknowledge and commend the tireless advocacy of Mona and Cindy's families pressing for the holding of an inquest to obtain much-needed answers about the circumstances of their passing.

Purpose of an inquest and the role of the Coroner

20. coronial proceedings are an inquisitorial exercise in fact finding – that is, an investigation aimed at discovering the truth, to the extent possible.

21. In these proceedings, the inquest hearing is a public examination of the circumstances of Mona and Cindy's passing. My primary function – as the Coroner presiding – was to explore the circumstances in which Mona and Cindy's deaths occurred, with a view to making specific findings of fact as specified in s 81 of the Act, as to:

    a. The person's identity;
    b. The date and place of the person's death;
    c. The manner and cause of the person's death.

22. In this inquest, the identity of the persons who passed away and the date, and place of the deaths were not in issue.

23. Rather, the central issue concerned the "manner of death", including the circumstances relating to how Mona and Cindy came to be on the Mitchell Highway with Mr Grant and also the circumstances or cause of the vehicle crash.

24. Further, a Coroner has the power to make recommendations under s 82 of the Act where it is considered necessary or desirable to do so in relation to any matter connected with the person's death which is the subject of the inquest. Coroners can make recommendations directed at opportunities for systemic improvement including as to matters of public health or safety or with respect to the investigation of the deaths.

The proceedings

25. The inquest hearing into Mona and Cindy's deaths was held at Bourke Local Court over seven hearing days. The first tranche was conducted from 26 November to 1 December 2023. Significantly, Mr Grant could not be called to give evidence, as he died of natural causes on 30 July 2017.[3]

26. Prior to the proceedings commencing, a smoking ceremony, a form of cultural cleansing, was conducted.

27. The second tranche was held from 19 to 20 December 2023.

28. During the hearing, a comprehensive brief of evidence comprised of four volumes of documentary material was tendered. Oral evidence was then adduced from various witnesses.

29. After the proceedings concluded on 20 December 2023, a traditional cultural dancing ceremony was held as a tribute to Mona and Cindy, and their families.

30. I very much appreciate the contribution of the families and the community and the enthusiastic and respectful way in which parties in the inquest embraced these important cultural events.

Expert evidence

31. Given the complexity of this matter (not least because of the effluxion of almost 37 years since the deaths), a number of expert reports were obtained at my request, and received into evidence, with those experts also giving oral evidence. Specifically:

    a. Dr Peter Ellis, a forensic pathologist who conducted a review of the forensic medical evidence in 2004, prepared a report dated 25 July 2004 and gave oral evidence on 1 December 2023;

    b. Dr Andrew McIntosh, an expert in the field of biomechanics and injury causation, prepared a report dated 13 June 2023 and gave oral evidence at the inquest on 30 November 2023;

[3] Ex 1, Tab 85 – Death certificate of A Grant

c. Clinical Professor Katherine Brown, a sexual health and forensic sexual assault physician, prepared a report dated 6 June 2023 and gave evidence on 28 November 2023; and

d. Dr Lorraine du Toit-Prinsloo, the forensic pathologist who conducted a further post-mortem examination following the exhumation of the remains of Mona, prepared a report dated 26 June 2023 and gave evidence on 1 December 2023.

32. Additionally, Professor Christopher Cunneen, a Professor of Criminology at the University of Technology Sydney, prepared a comprehensive report entitled 'The Historical Relationship between the Aboriginal and non-Aboriginal Community and the NSW Police Force in the 1980s, specifically in Bourke and the Surrounding Region' (dated 11 October 2023) (the **Cunneen Report**). The Cunneen report draws upon various resources, including government and non-government reports and statistics, as well as articles and books to inform the views expressed.

33. I found the Cunneen Report to provide crucial context for the inquest, in particular to inform the long history of racial tension in that area, particularly in the period leading up to 1987; it clearly outlines the extent of the lack of trust between the Aboriginal community and the police at this time. The significance of that report is such that I have decided to annexe it to these findings (see **Annexure A**).[4]

Submissions

34. On 20 December 2023, oral submissions were made by Senior Counsel Assisting me; Ms Melis (for the Commissioner of Police); Mr Russell (on behalf of Mr Ehsman); Mr Reitano (on behalf of Mr Ludewig); Ms Buxton (on behalf of the families of Mona and Cindy).

35. Subsequently, written submissions were received from:

a. Ms Buxton on behalf of the Smith families (dated 16 February 2024).

[4] One redaction was made to [12.14] of the Cunneen Report by agreement with Counsel Assisting and the legal representatives for the Commissioner of the New South Wales Police Force.

b. Mr Reitano on behalf of Mr Ludewig (dated 19 February 2024); and

c. Mr Russell on behalf of Mr Ehsman (dated 24 February 2024);

36. I have given the helpful oral and written submissions close consideration in the preparation of my findings.

The Issues

37. As is the usual practice, an issues list was disseminated to the parties in advance of the hearing.

38. The issues which were the focus of the inquest hearing were as follows:

a. The circumstances in which Mona and Cindy came to be in Mr Alexander Grant's vehicle on the night of 5 December 1987, and their movements for the remainder of the evening (*Issue 1*);

b. The manner and cause of Mona and Cindy's deaths on 5 or 6 December 1987 (including the time of death, if ascertainable) (*Issue 2*);

c. The adequacy of the initial NSWPF investigation from 6 December 1987 (including by former Detective Sergeant Peter Ehsman and crime scene officer former Senior Constable John Ludewig), including as to:

    a. evidence gathering from the scene on 6 December 1987 and whether the collision scene was treated as a crime scene;
    b. the attendance of crime scene investigators and the nature of their evidence gathering on 7 December 1987;
    c. the non-attendance of the Accident Investigation Unit;
    d. the taking of witness statements (including from first responders and family and friends);
    e. forensic examination of the subject vehicle (a Toyota Hilux utility OGQ-921);
    f. the retention and handling of exhibits (including the subject vehicle and forensic specimens) (*Issue 3*);

d. Whether there was any evidence of systemic racism or cultural bias in the conduct of the initial police investigation? If so, how did it impact the investigation? (*Issue 4*);

e. Whether any recommendations are necessary or desirable in connection with Mona and Cindy's deaths (*Issue 5*).

39. I set out the evidence relevant to these issues, and my findings in respect of each below.

B. EVENTS OF 5 AND 6 DECEMBER 1987 (ISSUE 1)

Bourke community

40. The historical background and colonisation of the Bourke area is detailed in the Cunneen Report (at [2.1]-[2.5]).

41. Mona and Cindy lived on the Reserve at Bourke, located just outside town, with their respective families. It is clear that the families living on the Reserve were close knit and that the girls were part of an extended, loving community.

42. Fiona Smith, Mona's sister, provided a statement dated 9 November 2023 about her memories of her childhood on the Reserve. She recalled living with her family "in a tin shack with a dirt floor on The Reserve, but we were a very happy loving family… We worked together and there was a lot of singing and dancing". Dawn Smith in her statement dated 9 November 2023, recounted that "the kids on the Reserve used to make up their own games. They would make little carts out of tin and wire and drag each other around. They called the carts 'rollie pollies'. They played with marbles too".

43. Mona and Cindy were very clearly good girls - they had a strict upbringing and were "taught right from wrong" (as June explained in her statement of 9 November 2023). The girls' mothers, June and Dawn (amongst others in the community), kept a watchful eye over their daughters.

Previous incident involving Mr Grant (in white 4WD utility)

44. The evidence revealed that approximately a week to a fortnight prior to the incident on 5 and 6 December 1987, Sharon Smith (then 17 years old) and her cousin, Julie Smith (also a teenager at the time) were approached by a male in

a white 4WD utility. Sharon and Julie were cousins of Mona and Cindy. The male driver spoke to Sharon through the car window and asked, "Can you tell me where the rodeo is?"

45. Sharon and Julie got into the vehicle to direct the male to the showground where the rodeo was being held. They asked him to buy them some beer, which he did. The man, Sharon and Julie drank at the showground before leaving together. As they were driving along North Bourke Road, near the levee, the male asked if Sharon wanted to drive the car. Sharon did so, driving back to the showground, and picking up Cindy. Sharon continued to drive the vehicle with Cindy, Julie and the male as passengers.

46. Sharon later reported to police that as they were driving:

> *... the man started rubbing his hand up and down my leg and when Cindy seen him doing that, she put her hand in and moved it away. The man was trying to do the same thing to Cindy and Julie but since I was driving, I couldn't see exactly what he was doing.*

47. Sharon drove the vehicle to Cottage No 12, where Cindy got out. Sharon then continued to drive to the weir. The male said to Julie and Sharon, "If you let me do sex with you, I'll give you money." Both Julie and Sharon refused. Sharon then drove back to the Reserve where she and Julie got out of the vehicle, and the man drove away.

48. The circumstances of this incident including the description of the subject vehicle, and the conduct of the male (including having regard to the events that followed a week or so later) are such that I am satisfied this person was Alexander Grant.

49. Mr Grant was 40 years of age and an itinerant worker. He worked in the cotton industry, including on the cotton gin as a contractor and excavator. The evidence received during the inquest established that the cotton gin was a cotton processing plant located on the outskirts of town. It was described by one witness (Mr Ludewig) as "just a big industrial area".

50. Mr Grant arrived in Bourke around mid-1987. He later told police that he was a partner in a business in Wee Waa, Major Metals Excavations, in 1985. It was listed as a steel fabricator and steel merchant.

51. By December 1987, Mr Grant had a record with a number of driving offences including driving under the influence; driving at excessive speed; and driving whilst disqualified.

Mr Grant's attendance at the Bourke Reserve on 5 December 1987

52. The evidence, which was essentially unchallenged, revealed the following as to the events of Saturday, 5 December 1987.

53. Mona's mother, June Smith, recalled that at around 7pm or 7.30pm, Mona was at home when she left "with some other people to go into town." This was the last time June saw Mona alive.

54. Lisa Edwards, sister of June Smith, recalled that after lunch, she, Mona and Cindy were drinking with a person named David Corn "in the little blue caravan" until just after dark. They sat out at the Convent Park before Cindy and Mona left and went up town to get smokes.

55. At 8:15pm, Lloyd Smith (Cindy's brother) recalled seeing Mona and Cindy sitting on the curb on the south-eastern corner of Adelaide Street and Yanda Street in Bourke.

56. Daniel Booth, a cousin of Mona and Cindy, stated that sometime between 8pm and 9pm that evening, Mona went to see him at "the house in Adelaide Street." He said that Mona asked him for a lift home, but he was unable to drive her because "the car was at [his] auntie's place." Mona then left and met with Cindy about halfway up the block. He next saw the girls turn around and start walking back towards the Reserve, apparently to go home.

57. At about 8:15pm, Betty-Anne Edwards was walking towards her home, away from the Reserve, along Adelaide Street, with Karen Johnson. When they got to the corner of Adelaide and Yanda Street, a man driving a white Toyota utility stopped beside them and said, "Do you want a lift home?". Karen called to him, "No, we're going home now." He said, "Do you want to come for a drive with me?" Karen said, "No, we have to go home." Ms Edwards recalled that Cindy and Mona ran over to the car from where they had been sitting on the corner of Adelaide and Yanda Street, outside Daniel Booth's place.

58. Cindy and Mona had reportedly been drinking. The pair approached Mr Grant's vehicle and asked him, "Would you run us over to the levee, to see if any boys are coming?". The man agreed, and Cindy and Mona then got into the vehicle.

59. Witnesses saw the vehicle turn right into Yanda Street, left onto Anson Street, and then out of the reserve. Ms Betty-Anne Edwards gave chilling oral evidence that the male:

> *... was supposed to take a U-turn and go over to the levy. He didn't take a U-turn. He turned right up Yanda Street to Mrs Linda Elwood way, then 25 turn left past Uncle Cliff's place, and there was no more, no more laughing. The girls laughed all the way from Adelaide corner to the corner of the showgrounds, and turned left. They still laughed until they got past Uncle Cliff's and then there was no more, no more laughing. I can still hear them laughing* (T44.4-30, 1 December 2024).

60. This was the last time that Cindy and Mona were seen alive.

61. In oral evidence, Ms Edwards was adamant that the vehicle involved in the accident was not the same one she saw Mona and Cindy get into. She told the Court the vehicle she had seen was a HiLux with a silvery tray, two door and a single cab – it was "altogether different" to the vehicle involved in the accident (having viewed photos of the vehicle owned by Mr Grant in Exhibit 2). Although I absolutely accept that Ms Edwards was doing her best to recall the evidence (many years later), I have ultimately found that she is mistaken in this regard: see [176] below.

62. As to what next occurred, at approximately 10pm, Mr Lawrence Barnett, a barman at the Riverview Hotel on the Mitchell Highway at North Bourke recalled seeing Mr Grant at the Hotel. Mr Grant purchased half a bottle of rum and a dozen stubbies of beer, and then left.

63. In a subsequent interview with police on 9 December 1987, Mr Grant later told police that he and the girls left Bourke at about 11pm or 12am, although he also said, "I don't know what time it was".

64. The timing of events after this point in time is unclear, and no evidence could elucidate matters, in particular, because Mr Grant provided conflicting and at times, patently false and self-serving accounts to police.

65. My consideration of the evidence and findings as to who was driving the vehicle at the time of the accident, and the circumstances of what occurred follow below.

The motor vehicle accident

66. In the early hours of 6 December 1987, civilian witnesses, Michael (Joe) Baty and Texter Johnston were driving together from Bourke to Quilpie. Shane Baty was following in a separate vehicle.

67. Around 4:00am or 4:30am, they observed a vehicle crashed on the side of the Mitchell Highway about 34 kilometres south of Enngonia.

68. Mr Johnston and Mr Shane Baty immediately stopped and exited their vehicles near the scene.

69. Mr Johnston observed Mona lying face down by the shoulder of the road on the gravel. He then saw what he believed was a male and a female lying on a tarpaulin some 10 yards away from the crashed vehicle. Mr Johnston believed that the male was alive but the female (now known to be Cindy) was deceased.

70. Mr Johnston saw the male lying on his left side with his right arm around Cindy's waist. He saw that Cindy's pants were down around her ankles, her legs were together and that she had a jumper on.

71. Mr Johnston could not give evidence at the inquest, as he died in 2014; he did however, provide two statements to police in January and September 1988.

72. Mr Shane Baty provided a statement to police (on 8 March 1988), and also gave evidence at the inquest on 1 December 2023. Significantly, Mr Baty had completed first aid courses in connection with his employment. His evidence was that he checked for, but could not find, a pulse on either of the girls; he was confident that the girls had both passed (and would otherwise have administered first aid).

73. Mr Baty also observed that Cindy was clothed from her neck to her waist but naked from her waist to her ankles. Mr Baty saw the male's right arm was draped across Cindy's chest, near her breast (on top of the shirt).

74. The male (Mr Grant) initially appeared to be unmoving, but then regained consciousness, appearing "very dopey". Mr Baty told Mr Grant "*you have two dead 'jins' here mate*"; Mr Grant responded, "*No, no, they're alright, they have had too much to drink*". Mr Baty recalled the male then became agitated and abusive. The male was intoxicated – Mr Baty could smell alcohol and there were bottles and cans around the area.

75. Mr Michael Baty provided a statement dated 16 February 2023 and gave evidence on 28 November 2023. Notably, Mr Baty was not approached for a statement by the initial investigating officers. Indeed, the first time he was asked to provide a statement was in 2023. Amongst other matters, Mr Baty recalled seeing the accident scene and seeing tools strewn across the road.

76. Appreciating there was little they could do, Mr Shane Baty and Mr Johnston drove to Enngonia Police Station to obtain police assistance, arriving around 5.15am. Mr Baty recalled knocking on the door and telling the officer: "There's been a very bad accident about 35ks back down the road, there's a couple of dead people there, and my brother is waiting there to - waiting for you to come ...".

77. While Mr Michael Baty initially remained at the accident scene for a short period after his brother left for Enngonia, he too left the scene after the male (Mr Grant) began acting aggressively.

Observations of the first responding police officers

78. The actions of police during the initial investigation and thereafter, was the focus of significant evidence during the hearing. I have accordingly set out the relevant evidence in some detail.

79. At approximately, 5.45am, the first officers on scene on 6 December 1987 were Constable Kenneth McKenzie and off-duty Constable Harper (then on sick leave owing to an arm injury).

80. On arrival, Constable McKenzie observed that Cindy was lying on her back and was predominately naked.

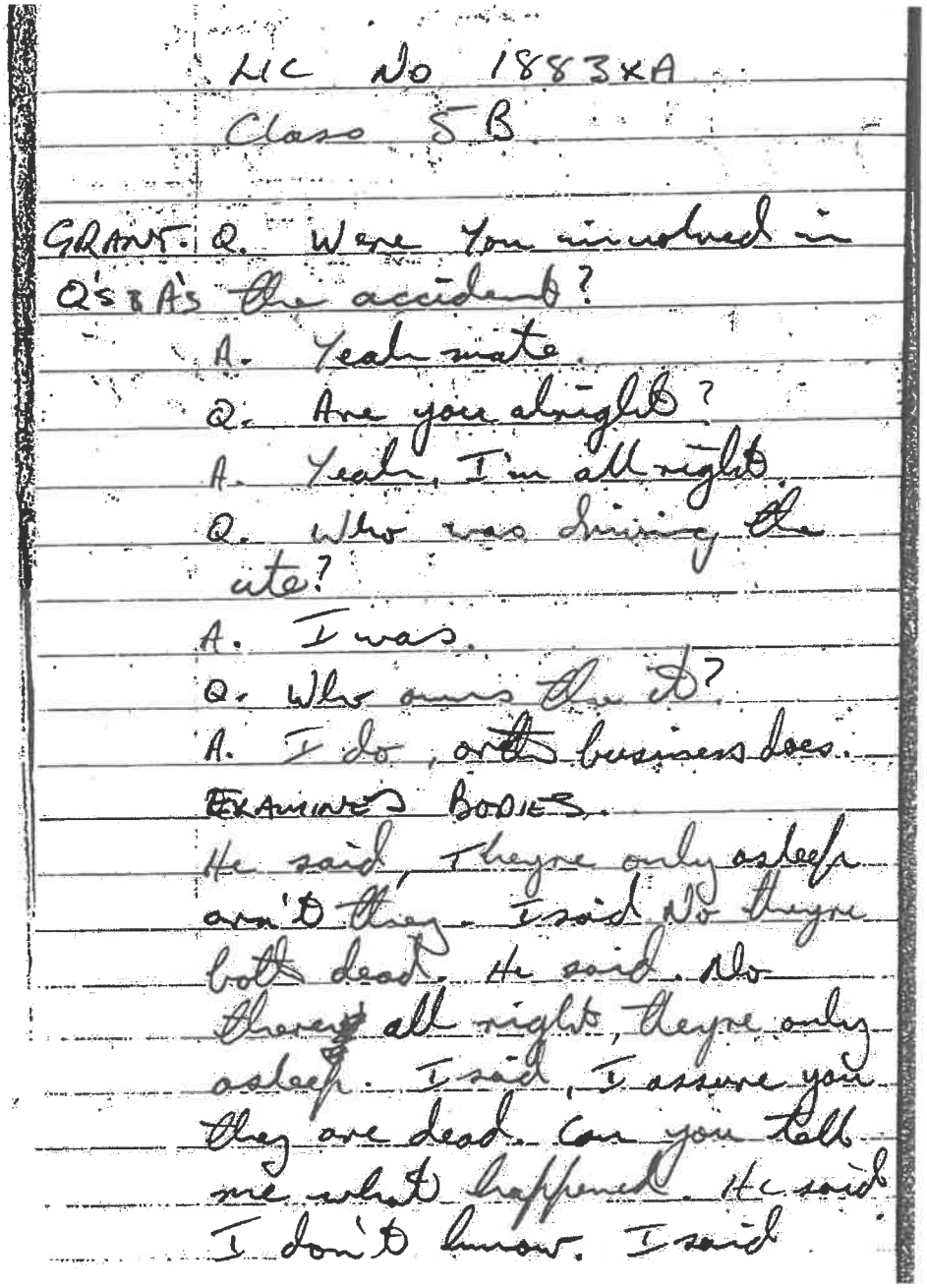
81. In a statement dated 6 May 1988, Constable McKenzie set out the following conversation he had with Mr Grant (who he observed smelt strongly of liquor, had bloodshot eyes, was incoherent and slurred his speech). after arriving on scene:

> Constable McKenzie asked: "*Were you involved in the accident?*".
> Mr Grant stated, "*Yeah mate*".
> ...
> Constable McKenzie asked, "*Who was driving the ute*?".
> Mr Grant stated, "*I was*".
> Constable McKenzie asked, "*Who owns the ute?*".
> Mr Grant stated, "*I do, or the business does*".
> ...
> Mr Grant asked, "*They're only asleep, aren't they?*", to which Constable McKenzie stated, "*No, they're both dead*".
> Mr Grant said: "*No, They're all right. They're only sleeping".*
> McKenzie said: "I assure you they are dead".
> McKenzie said: "Can you tell me what happened".
> Mr Grant said: "I don't know".

82. Mr McKenzie also outlined this subsequent exchange:

> I then said to the defendant, "Were there any other vehicles involved?" He said, "I didn't see any other cars". He then said, "Are you sure they're both dead?" I said, "Yes". He then pointed at the deceased female at the front of the vehicle and said, "Ah, she was driving".

83. This was also recorded in Mr McKenzie's spirax notebook:



Lic No 1883xA
Class 5B

GRANT. Q. Were You involved in
Q's & A's the accident?
A. Yeah mate.
Q. Are you alright?
A. Yeah, I'm all right.
Q. Who was driving the
ute?
A. I was.
Q. Who owns the ute?
A. I do, or the business does.
EXAMINER'S BODIES.
He said, Theyre only asleep
aren't they. I said No theyre
both dead. He said. No
theyre all right, theyre only
asleep. I said, I assure you
they are dead. Can you tell
me what happened. He said
I don't know. I said

Extract from Mr McKenzie's notepad (Tab 63, Ex 1)

84. Mr McKenzie gave evidence of Mr Grant's initial admission to driving the vehicle in the committal proceedings in 1988 and also in the evidence before this inquest.

85. Constable Ken Harper similarly recalled the conversation between Mr Grant and Constable McKenzie in his statement of 29 January 1990:

[5] Constable McKenzie then said to the male person, GRANT, in my presence and hearing, "Are you alright". He said "yeah". McKenzie said "Are you the driver of the ute? Grant said "I was".

[6] Constable McKenzie then walked to look at the bodies of both deceased persons. When he was next to the person lying on the tarpaulin Grant said "They are only asleep". McKenzie said "They are both dead". The defendant then said "There only sleeping". McKenzie said in a louder tone of voice "I can assure you they are both dead".

[7] Constable McKenzie had a further conversation with GRANT. During the course of this conversation GRANT indicated to Constable McKenzie that he was not driving the vehicle at the time of the accident. Grant indicated that one of the deceased females were driving the vehicle at the time of the accident.

86. Mr Harper confirmed this account in evidence before this inquest. A short time after this conversation, Officer Harper then returned to Enngonia with one of the ambulance officers (and did not return to the scene).

87. For his part, the lead investigator, then Detective Sergeant Peter Ehsman denied ever being advised by Mr McKenzie that Mr Grant had initially admitted to being the driver of the vehicle. Mr Ehsman's evidence at the inquest was as follows:

> "Q. Did you have any conversation that you remember with Constable McKenzie on that day?
>
> A. I spoke to him when I first got there, yes.
>
> Q. What did you speak to him about?
>
> A. What happened, what they saw when they got there.
>
> Q. Do you recall that he told you that Mr Grant had initially said that he was the driver?
>
> A. No. I was never told that.

88. Mr Ehsman also denied becoming aware of the initial admission by Mr Grant from other material obtained in the investigation, such as from Constable Harper or from the paramedics who attended the scene. Rather, Mr Ehsman told the Court that he accepted Mr Grant's version that Mona was the driver of the vehicle. There was this exchange with Senior Counsel Assisting during the inquest:

Q. Was it important to you, at that time, as part of your investigation, to establish who the driver had been of the vehicle before the accident?

A. Yes.

Q. Did you give any instruction to the Crime Scene Unit that it was important to you to establish who was the driver?

A. I'd already ascertained who was the driver from Grant.

Q. Right. Did you then, by the time that the Crime Scene Unit came, did you have doubts about who was the driver?

A. I didn't have any doubts, no. Grant told me one of the girls wanted to drive.

Q. You believed him? You accepted that?

A. Yes.

Q. Why?

A. He told me what happened.

89. Otherwise, Constable McKenzie made observations of the scene and damage to the vehicle; he noted that the offside towards the front and forward near side panels were damaged and that the driver's door was jammed closed. The keys were missing from the ignition and the steering wheel was locked. Constable McKenzie saw a large number of tools and equipment scattered on the road metres away from the car. He took various measurements and prepared a detailed plan of the accident scene.

90. Importantly, Constable McKenzie, Constable Harper and Detective Sergeant Peter Ehsman all noted the positioning of Cindy's legs and the state of her clothing, in particular observing her top and her bra having been pulled up. This was different to the positioning described by Mr Johnston and Mr Baty when they first saw Cindy, including in terms of the position of Cindy's legs and the state of her clothing.

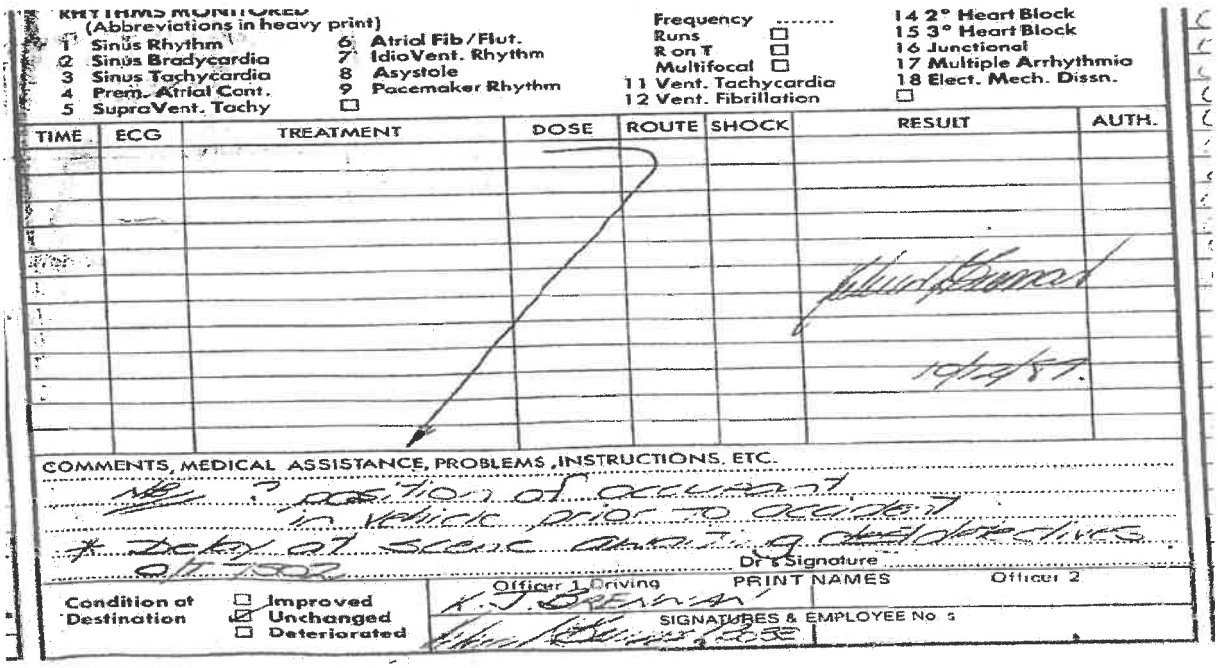
Attendance of ambulance officer (Ronald Willoughby)

91. Mr Ronald Willoughby, an ambulance officer from Bourke Ambulance Station, was called to the scene at around 5.18am, arriving around 6am. He confirmed that Cindy and Mona were deceased.

92. Mr Willoughby provided his first statement to police on 31 January 1990, and a supplementary statement the following day on 1 February 1990. In that statement, Mr Willoughby recalled the following:

> [3] Since making the statement I have been thinking about it overnight and some further things have come back to me. I now recall that I was definitely first at the scene and the ambulance that I drove out to the accident was Car 131. When I arrived I saw the same things that I described in my other statement. I also recall that when I first pulled up Constable Ken McKENZIE said to me, "You've got two female patients there that are both deceased and that fellow over there is the driver and he appears to be okay." When Constable McKENZIE said that to me he pointed to a male person I know now as Alex GRANT, who was standing nearby smoking a cigarette. Immediately that Constable McKENZIE said that the person Alex GRANT said, "No she was the driver. " At that time GRANT pointed, to the deceased female laying by the roadside. Constable McKENZIE said to GRANT, "Oh she's the driver now is she".

93. Mr Willoughby explained that because of this conversation, the Ambulance Report case slip for Mona had been marked with a query driver position by Officer Brennan (to whom Mr Willoughby had related the above conversation). The case slip recorded the following:


RHYTHMS MONITORED (Abbreviations in heavy print)
1 Sinus Rhythm
2 Sinus Bradycardia
3 Sinus Tachycardia
4 Prem. Atrial Cont.
5 SupraVent. Tachy
6 Atrial Fib/Flut.
7 IdioVent. Rhythm
8 Asystole
9 Pacemaker Rhythm
Frequency .....
Runs
R on T
Multifocal
11 Vent. Tachycardia
12 Vent. Fibrillation
14 2° Heart Block
15 3° Heart Block
16 Junctional
17 Multiple Arrhythmia
18 Elect. Mech. Dissn.
TIME | ECG | TREATMENT | DOSE | ROUTE | SHOCK | RESULT | AUTH.
COMMENTS, MEDICAL ASSISTANCE, PROBLEMS, INSTRUCTIONS, ETC.
Dr's Signature
Condition at Destination: Improved / Unchanged / Deteriorated
Officer 1 Driving — PRINT NAMES — Officer 2
SIGNATURES & EMPLOYEE No s

Extract from Ambulance Report dated 6 December 1987 (Tab 65, Ex 1)

94. Mr Willoughby gave the following consistent oral evidence on 30 November 2023:

> *A. Yeah, that was basically he told me I had two female patients that were both deceased, and the fellow that was over there is the driver and he appears to be okay. Constable McKenzie said that to me, he pointed to a male I know as Alex Grant afterwards, who was standing by smoking a cigarette. Immediately when Constable McKenzie said that, Mr Grant said, "No, she was the driver". From my memory, Constable McKenzie never said at that time that he was the driver or passenger, but Mr Grant then McKenzie said to Grant, "Oh, now she's the driver", so I'm assuming that he had told Mr McKenzie that he was the driver earlier.*

95. Mr Willoughby then took Mr Grant to hospital via ambulance. When they got to Bourke, Mr Grant asked, "Can you take me to the Mitchell Caravan Park so I can tell my wife what's happened?" Mr Willoughby declined and took Mr Grant straight to hospital.

Attendance of Detective Sergeant Peter Ehsman

96. Around 6:30am, Detective Sergeant Ehsman (**DS Ehsman**) attended the scene. As the most senior officer, DS Ehsman took over the investigation and became the officer in charge. He observed Cindy lying on her back, partially naked. DS Eshman took some photographs of the scene. He also spoke to Constable McKenzie and Constable Harper. He later arranged to have the vehicle towed from the scene (a point of some contention as detailed below).

97. As noted at [87]-[90] above, conflicting evidence was received about DS Ehsman's conversation with Constable McKenzie at the scene: in short, there was a denial by Mr Ehsman that Mr McKenzie ever told him of Mr Grant's initial admission to being the driver of the vehicle. Mr McKenzie was adamant this information was conveyed.

98. The evidence on this issue, together with my consideration of the evidence concerning the driver of the vehicle follows below (from [222]).

99. By statement dated 19 October 1988, DS Ehsman made observations of the scene, which included his observations of Cindy's position (and the position of her legs, and state of her undress, which included her top having been pulled up and bra having been pulled down, exposing her breasts).

100. Mr Ehsman said the following of his examination of the accident scene:

> ... I saw that the vehicle had extensive damage to the roof offside panels towards the front, the front of the vehicle and the front nearside panels. I saw that the tyres were in a roadworthy condition, and I was unable to open the doors as they were jammed shut. I saw a large quantity of tools, toolboxes and a spare tyre and a large metal fuel tank scattered over the side of the road ... I saw a skid mark on the roadway about 200 m south of the utility going from the eastern side of the centreline to the western side onto the dirt shoulder. I saw heavy skid marks in the dirt for a short distance then deep gauge marks facing east, there was broken glass in this area. I then took a number of photographs of the area.

101. It is not known what happened to the various items strewn around the scene, including the tarpaulin (which potentially contained relevant evidence as to the potential sexual assault of Cindy) and the tools sprawled across the road.

Towing of subject vehicle to Enngonia Police Station

102. At an unknown time that day, at the direction of DS Ehsman, it seems that Mr Grant's vehicle was towed to Enngonia Police Station where it was left unsecured in front of the building.

103. From Enngonia Police Station, the vehicle was then towed to another unsecure location, the Bourke Cotton Gin. As noted, the Bourke Cotton Gin was an industrial cotton processing plant. It was certainly not set up as a secure location to hold police exhibits.

104. There are no records that elucidate how the vehicle was towed, nor any chain of custody or possession of it by police as an exhibit, nor the eventual disposal of the vehicle.

105. DS Ehsman gave evidence on 29 November 2023 that he had the vehicle towed from the Mitchell Highway and taken to Bourke, but he could not recall any details of those arrangements. He did recall that the vehicle ended up being taken to the Cotton Gin.

106. Mr McKenzie's evidence on 28 November 2023 was that he saw the vehicle parked in the driveway next to Enngonia Police Station later on 6 December 1987.

107. By the time that Senior Constable Ludewig from the Crime Scene Unit at Dubbo arrived to inspect the vehicle the following day (7 December 1987), it had been moved to the Bourke Cotton Gin. As detailed further at [135] below, Mr Ludewig recalled on 1 December 2023 that the "ute was parked alongside a big shed". The shed had not been secured.

108. On 14 January 2024, Frederick Harvey and Mervyn Galway provided statements indicating that they were employees of the Bourke Cotton Gin in 1987. They recalled being tasked by their boss, Mr Phillip Hams, with towing Mr Grant's vehicle from Enngonia Police Station to the Cotton Gin. They complied with this request.

Mr Grant's interactions with Constable Christopher Clarke

109. Just before 7.10am on 6 December 1987, Constable Christopher Clarke (**Constable Clarke**) had a conversation with Mr Grant at the Bourke Hospital. Of note, Mr Grant told Constable Clarke that prior to the crash, he had "grabbed the wheel" and told Mona to slow down, "but then she went off the road and that was that." He then said that he had been sitting on the left-hand side of the vehicle, with Cindy in the middle and Mona driving. Mr Grant told Constable Clarke that after the incident, one of the girls had gotten out of the car, taken her clothes off and said, "Ya want me" to which Mr Grant apparently replied, "No, we've got a problem here."

110. Constable Clarke also noted that Mr Grant told him that the vehicle had been travelling at about 70-80km/h, but that when Mona got to 100km/h "I jumped on her."

111. Constable Clarke gave oral evidence at the inquest on 29 November 2023.

Blood alcohol testing

112. At around 9:10am at the Bourke District Hospital, a sample of Mr Grant's blood was taken pursuant to 4F of the *Motor Traffic Act 1909* (NSW). Mr Grant's blood alcohol concentration was found to be 0.159 (noting that this was some five hours after he had been located on the side of the road).

113. Judith Perl, NSWPF Consultant Pharmacologist, considered those results. She opined as follows:

> Based on the above information, the blood alcohol concentration of the defendant at the time of the collision would have been within a range, the lower limit being not less than (highly unlikely) 0.205 grams in 100 millilitres and the upper limit being 0.345 grams in 100 millilitres with the most likely level being 0.260 grams in 100 millilitres blood. At a blood alcohol concentration of 0.205 grams in 100 millilitres or above, all people would be under the influence of alcohol to the extent that driving ability would be very significantly impaired.

114. The blood alcohol concentration for Mona and Cindy was later determined. Cindy's concentration was 0.220, while Mona's was 0.060.

Interview with Mr Grant – 6 December 1987 (10.30am)

115. At 10.30am on 6 December 1987, DS Ehsman interviewed Mr Grant at Bourke Police Station. The following matters are noteworthy:

    a. When questioned about the location of the incident (34km south of Enngonia), Mr Grant said that he had "let the bigger one drive she drove a fair way…30 or 40 kilometres;"
    b. As to events after the crash, Mr Grant said "the smaller one of the two said, do you really want me and then just pulled her clothes down and sat down on the green cover that was on the ground. I said that would be bloody right, give us a hand to get the gear back in the truck, she wanted a beer so I had a stubbie with her and then I went to sleep;
    c. Mr Grant also said that immediately after the incident, he "got out the passenger door" and "the smaller one was out;"
    d. When asked whether he had made sexual advances towards either of the girls, Mr Grant said, "I had my arm around her, she was cuddling up to me, I didn't touch her or no sexual advances, all she wanted to do was drive my Toyota".

Attendance of crime scene investigator – 7 December 1987

116. The following day, on Monday 7 December 1987, Senior Constable John Ludewig from Dubbo Police Station and a member of the 'Crime Scene Unit – Physical Evidence Section' (for three years, having first joined the NSW Police Force in 1978) attended Bourke Police Station at the request of DS Ehsman. Senior Constable Ludewig spoke to DS Ehsman and DS Vaughan Reid upon arrival.

117. Former Officer Ludewig gave evidence at the inquest. By way of background, he told the Court he had attended many fatalities, and was trained in taking evidence at a scene involving a car collision or accident. Steps to be taken included securing the scene; trying to identify the point of impact and undertaking an analysis of how the accident occurred. Detailed photographs would be taken, but Mr Ludewig said "we relied on detectives and the scientific investigation section back in those days" to take photograph of the vehicle involved. However, photographs would be taken of skids marks, yaw marks, gouge marks and any kind of physical evidence on the road (including any debris around the accident scene), as well the bodies of persons involved *in situ* (depending on the timeframe for arrival on scene, or whether someone else could take the photographs). The local detectives were the liaison point for taking physical photographs if the crime scene officers could not attend immediately.

118. Mr Ludewig confirmed (as had a previous witness, Mr Patrick Moss) that the Crime Scene Unit was on call 24 hours, seven days a week and that the unit was "spread thin on the ground" as there were so many jobs in those days. He said it would be "nothing to do a thousand kilometres a day while doing jobs".

119. As to the circumstances of attending the job on 7 December 1987, Mr Ludewig explained:

> *It was my - Monday was our changeover day at Dubbo, so my boss would hand me the reins sort of thing and I would take on whatever jobs were left over, and I can remember getting a phone call early hours, I'd say probably 7.30/8 o'clock at Dubbo, and saying that I had a job at Bourke, and that's how I got there.*

120. Mr Ludewig confirmed that the call he received was on the Monday morning (he had received no calls over the weekend, but nor was he in fact on call).

121. Mr Ludewig's evidence was to the effect that no one was called from the Crime Scene Unit to attend the job on Sunday, 6 December 1987. As to whether he would have expected to receive such a call, Mr Ludewig stated:

> *First and foremost we should have been advised and, like I say, if I had have got that call on the day of the - on the morning of the accident, I could have been there within about five hours.*

122. Mr Ludewig agreed that this would have enabled photographs to have been taken of the vehicle at the scene; it could also have been "secured properly", and seized after photographing as "there was a lot of aspects of the vehicle that needed to be looked at", including damage to the roof, where people were sitting in the car – "... if we could work that out, how the accident actually happened, so a lot of dynamics to work out the nuts and bolts of the accident".

123. However, Mr Ludewig would not have expected the deceased girls to have remained on scene (given the heat); he would have hoped they would have been photographed and then removed.

124. Mr Ludewig recalled that on arriving at Bourke, the first place he went was the detectives' office to discuss what they needed to be done. Mr Ludewig spoke with DS Reid and Ehsman (a "lengthy conversation", according to his statement of 3 February 1988). Of that conversation, Mr Ludewig told the Court:

> *I can remember getting instructions about what they wanted done, for me to attend and go out and where the job was, what it was, and I do remember making - asking a couple of questions, who had been advised, motor vehicle examiners, photogrammetry and the Crash Investigation Squad, and they told me the Crash Investigation Squad was on the way and the other two had been notified of the accident.*

125. Mr Ludewig confirmed his understanding that one of the detectives referred to the Crash Investigation Squad being advised and that they were attending. He told the Court that the crash investigators would "purely examine the crash", whilst the motor vehicle examiners were trained forensic mechanics who look for the cause of the accident. Both the crash investigators and motor vehicle examiners were based in Sydney.

126. Mr Ludewig also gave evidence that:

> *The officer-in-charge, when I was in Bourke, I was told that the motor vehicle examination section had been informed, so I assumed that the motor vehicle examiners would eventually get to Bourke and have a good look at the car about its mechanical ability, what caused the action if there was any broken parts underneath that caused the truck to roll...*

127. He subsequently again confirmed that Officers Reid and Ehsman had told him that "the accident squad were on the way and the photogrammetry and, yeah, the motor vehicle examiners had been advised."

128. Additionally, Mr Ludewig recalled being told by detectives that Mr Grant had said that he was the driver of the car and in relation to the two girls, one had been thrown out and the other one was still in the car. This was denied by Mr Ehsman.

129. From a discussion with Constable McKenzie, Mr Ludewig became aware that Officer McKenzie had already prepared a sketch plan with all the measurements (which Mr Ludewig reviewed). He thought Constable McKenzie had done a "very good job" and was "pretty methodical with the way he approached the scene", other than the fact it was not sealed up or closed off to the public.

130. As to the steps Mr Ludewig took upon arriving on scene, he gave evidence as follows:

> *I drove out to Enngonia Road. When I got out there, I was expecting to see maybe a point of impact where the vehicle was marked on the road by paint. The yaw marks on the road were what they call - some people call them skid marks, but they looked like yaw marks, where the car's under acceleration and the tyres leave marks on the road. I expected those to lead-up to where the car left the roadway. There was none of that at all, and, in fact, it was part of the road when I got there was covered with dust and vehicles and cars driving over it anyway.*

131. Mr Ludewig subsequently confirmed that from memory, there were no markings from police to indicate where the accident had occurred, and that he would have expected to see "a paint mark on [the] side of the road where it left, maybe a point of impact, where the first roll started .... I don't think there was anything there. I'm pretty sure of that".

132. On scene, Mr Ludewig took eight colour photographs; he did not do a map as the sketch plan Constable McKenzie had prepared was "excellent".

133. Mr Ludewig also gave evidence of the "pecking order" within the police, and that if a "sergeant told you to do something, you did it ... you didn't question it".

134. Mr Ludewig was aware of the potential sexual interference with Cindy; however, he gave evidence that he did not find out about the tarpaulin for some weeks later; he then asked the detectives for it (believing this was DS Ehsman), "but I never saw it. They had their own exhibits there and I think sometime later that

might have gone down to Sydney for analysis, but I didn't see the tarp when I was there".

Attendance at the Cotton Gin, Bourke

135. After returning to Bourke, Mr Ludewig then attended the Cotton Gin to view the damaged vehicle. Mr Ludewig did not speak with anyone there stating: " ... I didn't see anybody there. I drove in, I saw the ute parked alongside a big shed. I parked my car and took a couple of photographs like I was asked to do and that was it." He explained that he just saw the vehicle parked near the shed, and went over to do what he had to - there was no need for "access", as it was just open, and no one else was around.

136. As to whether he was concerned by the storage of the vehicle, as an important exhibit, Mr Ludewig stated: "Yeah, I felt that it should have been, like I said before, locked in ... a secure shed for further examination by whoever." Mr Ludewig told the Court that he "would have" surely brought up the storage of the vehicle in a secure location, "not at the Cotton Gin or parked in the backyard of the police station". He also said: "I would have been concerned the fact that it's out in the weather, and if there was any further examinations to be done, I would have mentioned to them that it needs to be under cover and locked up." He later noted that "if we got any rainfall up there", it would have destroyed any evidence in the vehicle, so he thought it was prudent to get it out of the weather and locked up somewhere secure.

137. At the time of taking the three photographs, Mr Ludewig thought the steering wheel was there; he did not take possession of it, nor seek to take any fingerprints. Mr Ludewig referred to a "conundrum" as to whether he should try and lift fingerprints off the steering wheel (noting he was not an expert in fingerprinting) or use Hemastix to try and get a bloodstain; there was a risk with the destruction of evidence for each procedure – and he ultimately thought "it would be better if we could secure the car and maybe somewhere down the track get an expert up". No swabs or fingerprints were taken from the vehicle (nor was Mr Ludewig requested to take any).

138. After this, Mr Ludewig referred to calling his boss (Ian Hobson) to let him know about the job; he otherwise did not speak with the detectives in the afternoon.

Failings in crime scene examination

139. In giving evidence, Mr Ludewig agreed with the numerous criticisms of the officer in charge, Detective Inspector Paul Quigg, including as to the failure to keep a record of who entered the scene; the status of exhibits; the failure to take detailed photographs of the bodies and the vehicle in situ; the failure to seize and examine the tarpaulin; and the failure to photograph the debris, motor vehicle (amongst other matters).

Reports of death to the Coroner

140. On 7 December 1987, Constable McKenzie completed the reports of deaths to the Coroner. Those reports noted that the driver was Mona. There was no indication suggesting that Mr Grant had made an initial admission to being the driver at the scene.

141. On that date, Constable McKenzie also completed an Occurrence Pad entry at Enngonia Police Station at 1.50pm (Exhibit 1, Tab 91B). The entry again suggested that Mona was the driver.

142. Mr McKenzie's evidence was that the reports and the Occurrence Pad entry were drafted in that way on the instruction of then DS Ehsman. For his part, Mr Ehsman gave evidence denying that position.

Further interview with Mr Grant – 9 December 1987

143. Subsequently, on 9 December 1987, Mr Grant was again interviewed by Officers Ehsman and Reid at Nyngan Police Station.

144. On this date, Mr Grant described being drunk; he referred to Cindy being "on her feet", drinking some of a bottle of rum, and also asking for beer. Amongst other things, Mr Grant said:

    a. that the green tarpaulin "fell" so that it was laid out on the ground, and Cindy was "wandering around" and had "walked there herself";

    b. he had not interfered with Cindy's clothes – she had pulled her pants down herself, and then pulled her top up and lay back and said: "Do you want me?"; and

c. that Mona had been driving.

145. Following this interview, Mr Grant was charged with the following offences:

- By misconduct or wilful neglect cause bodily harm (2 counts);
- Aid and abet unlicensed driver counts of 'wilful neglect or misconduct grievous bodily harm' and 'owner permit unlicensed driver'; and
- Drive with high range prescribed content of alcohol (PCA).

Involvement of Accident Investigation Squad – May 1988

146. Some months later, around May 1998, then Senior Sergeant Raymond Godkin (**S/Sgt Godkin**) was at Enngonia Police Station at the time of the Brewarrina floods. He was the Officer in Charge of the Accident Investigation Unit based in Parramatta. To pass the time, S/Sgt Godkin started reading the Station Occurrence Pad. This triggered his memory about the double fatality which he had initially seen in December 1987 (given that due to his role in the Accident Squad, he received notification of all motor vehicle fatalities). S/Sgt Godkin discussed the matter with Constable McKenzie, and his suspicions about it. Constable McKenzie also had misgivings, stating "it was not right in his mind".

147. When S/Sgt Godkin returned to Sydney shortly after that conversation, he spoke to his superior officer. They agreed that the accident should be investigated further.

148. Some weeks later to pursue the re-investigation, S/Sgt Godkin returned to Bourke Police Station and spoke to Inspector Bassett, who was then in charge of the station. Of that conversation, Mr Godkin recalled the following:

> *I explained to him why - why I was there, and - and he said to me, and I'll use the words he used…*
>
> *He said to - "Well, as far as I'm concerned, you can hop in your car and piss off back to Sydney, because my detectives did - did this job and I'm content with what they did". And I got a - pardon me - I - on the phone, and I asked him, could I use his phone, and I rang and luckily I was able to make contact with Mr Fleming, and Mr Fleming asked me to give the phone to the inspector, which I did, and - and of course, I didn't hear the conversation, but I later on learned what it was. It wasn't very pleasant. But then the inspector told me, "Okay, get on and do what you've got to do"* …

Q. So what did you do after that?

A. Well, that's when I took over the inquiry, and I spent some time then at Enngonia, and with McKenzie. We were back out the scene, and did all sorts of things, and then eventually - and I'm bit rusty on this - when I came - but when I went back and when I didn't - but then I found the vehicle hadn't been examined. Nothing had been done like that. There was so much wasn't done, and so then it was time to chase up the vehicle, have a look at the vehicle and see what we would - could find out about that.

149. In the context of this re-investigation, on 11 May 1988, S/Sgt Godkin and Constable Richard Le-Merton interviewed Mr Grant at Hurstville Police Station.

150. Significantly, Mr Grant told police: "Well I've thought about it a lot and a lot of the stuff I told the Detectives is not right and some things I said is really bullshit." He also said he was "rotten drunk", worse than he told the detectives.

151. Mr Grant told the officers that they (he and the girls) went across to North Bourke and bought Mona and Cindy a bottle of rum. He maintained that Mona was driving at the time of the accident. Mr Grant said:

> *After we left North Bourke the older one said to me, "Can I have a drive?". After a while I said, "Alright" and she got into the driver's seat and I sat on the left hand side… she drove for a while, and I said "That's it, pull up and turn around now but instead of turning around she just pulled off the road and stopped. One of the girls then poured the rum into the bottle of coke. They drank the rum and coke, and I had a stubbie. I didn't drink the rum. Then she started driving again and the next thing we flipped… the bigger one (Mona), that's the one that was driving, she was the older one who went through the windscreen…I'm not sure if I was knocked out or not, I know I had a good hit on the top of the head, there was a big lump there and I was still sitting in the seat next to the left hand door, the smaller girl she was still in the Ute with me… I opened the passenger door, got out, and then I pulled the other girl out of the vehicle.*

152. When asked whether Mr Grant could recall if he had interfered with or removed any of Cindy's clothing after the accident, Mr Grant replied, *"I don't think so, I have to say no."*

153. As to how the tarpaulin got into the position it was found in, beside the car, Mr Grant said, "that's where it fell out of the back of the Ute." As to whether Mr Grant recalled lying on the tarpaulin with Cindy, he replied, "like I said, I was right out of it. I remember opening the door and dragging her out, that's how her clothes got pulled down."

Examination of the vehicle (and the missing steering wheel)

154. On 13 May 1988, S/Sgt Godkin spoke with Detective Sergeant Patrick Moss (**DS Moss**), an officer at Inverell involved with the physical evidence section.

155. On 14 or 15 May 1988, DS Moss attended Wee Waa Electrics, in Wee Waa, where the Toyota utility was located. He spoke with the owner of the premises, Mr Hurle. Mr Hurle confirmed that he had purchased the vehicle from 'Major Metals' on 21 January 1988, and collected it about a week later. It will be recalled that Major Metals Excavations was Mr Grant's own excavation business. The vehicle was registered to his company.

156. The evidence is unclear as to how the vehicle came to be at Major Metals by 21 January 1987 (noting of course, that criminal proceedings were on foot by that time, and the vehicle ought to have been an exhibit in the possession and custody of police).

157. When DS Moss examined the vehicle, all the component parts had been removed by Mr Hurle. However, he was able to make some observations, undertake certain testing and take some 32 photographs. Significantly, DS Moss could not examine the steering wheel as it was not in the vehicle, nor otherwise on the premises when he attended.

158. In this regard, Mr Hurle's statement dated 8 September 1988 noted the following (emphasis added):

> *Prior to the attendance of Detective Moss I sent the steering wheel to Alex Grant, at Alex's request.* ***I sent the steering wheel to Alex the day before Detective Moss attended my workshop****. On 14 May 1988, I gave Detective Moss a number of items, including the roof liner and the two sun visors. I have since received the steering wheel from Alex Grant.*

159. Mr Hurle passed away before the inquest and was therefore unavailable to give evidence.

Criminal charges

160. As noted, on 9 December 1987, Mr Grant was charged with the following offences by Detective Ehsman:

    a. By misconduct or wilful neglect cause bodily harm (2 counts); and

b. Aid and abet unlicensed driver.

161. Mr Grant was then charged with an offence of drive with high range prescribed content of alcohol (PCA).

162. On 12 May 1988, Mr Grant was charged with further offences by Sergeant Godkin, namely, two counts of culpable driving by driving under the influence causing death.

163. On 24 May 1988, Mr Grant was charged with one offence of indecently interfere with a dead human body, contrary to s 81C of the *Crimes Act 1900* (NSW).

Criminal proceedings

164. On 8 November 1988, the indictable offences, namely, the two charges of culpable driving causing death and the charge of indecently interfere with a dead human body were committed for trial to Bourke District Court. The charges of aid and abet unlicensed driver and by misconduct or wilful neglect cause bodily harm (2 counts) were discharged.

165. Shortly prior to the trial commencing, the offence of indecently interfere with a dead human body was no billed by the NSW Director of Public Prosecutions. This was due to difficulties on the evidence obtained, with establishing the timing of Cindy's death.

166. On 1 February 1990, the trial then proceeded in relation to the two charges of culpable driving causing death.

167. On 8 February 1990, Mr Grant was acquitted of both counts by a jury. Notwithstanding very extensive efforts to locate the trial transcript of these proceedings, it could not be found.

168. Needless to say, the acquittal of Mr Grant was devastating for the families of Mona and Cindy, and for the broader Aboriginal community. As June Smith explained (in her statement of 9 November 2023):

> *The trial wasn't explained. We didn't even know why he got acquitted. Nothing was explained. It didn't feel fair or right. It felt like the police were the judge, the jury and the prosecutor. We couldn't do anything about it. That's just how it was. It was terrible. We weren't offered any support.*

Nothing during the trial and nothing after the trial. They never came anywhere near us.

169. As noted at [16] the inquest into Mona and Cindy's deaths was not resumed at this time. Questions as to the events that lead to the crash and to the tragic deaths of the girls has tormented their families ever since; distressing rumours and harmful speculation also circulated in the Bourke community, in the absence of answers and information (as noted at [213] below).

170. Significantly, shortly after Mr Grant's acquittal, on 19 February 1990, a complaint from the Aboriginal Legal Aid Western District Unit was made to the Attorney General expressing dissatisfaction with the initial investigation. The particular issues raised included the following:

    a. That there was no proper forensic test of the motor vehicle;

    b. There was a failure to interview key witnesses; and

    c. There was no proper investigation of the scene of the alleged motor vehicle accident.[5]

171. The relevant evidence and my findings as to the adequacy of the initial police investigation are detailed in Section D below. Suffice to say, the concerns raised in this complaint have been entirely vindicated by these coronial proceedings.

FINDINGS – SECTION B

172. I have set out above the relevant evidence as to the events of 5 and 6 December 1987, which was essentially unchallenged.

173. Given the timing and details related by the witnesses, I have no hesitation in finding that it was Mr Grant who was the male driver in the white 4WD utility who, in the weeks prior to the accident, permitted Sharon Smith to drive his vehicle. Mr Grant behaved in a predatory and sexually inappropriate manner

[5] The complete list of issues raised at that time is set out in this document tendered as part of Exhibit 1, Tab 92:

towards Sharon Smith and the other girls in the vehicle (including Cindy), including propositioning them for sex.

174. Consistent with this conduct, I find that on Saturday, 5 December 1987, Mr Grant was again scoping the Bourke township for young girls to ply with alcohol and to sexually proposition. I find that Mona and Cindy entered the vehicle sometime after 8.15pm, expecting that Mr Grant would give them a lift the short distance to the levee, near the Reserve. They did not normally accept lifts from strangers, but it is likely that they did on this occasion because they met him on that previous occasion. Instead of giving them a lift home as he should have, Mr Grant took off with them, attending the Riverview Hotel on the Mitchell Highway at around 10pm to purchase alcohol.

175. I note that I have closely considered the evidence of Ms Edwards as to the vehicle the girls entered on 5 December 1987 (as set out at [61] above). Ms Edwards was very clearly doing her best to assist the Court and noted emphatically that she had "looked for that car since I was 14 and I'm 50". However, given the totality of the evidence, and as it is clear that Mona and Cindy ultimately found themselves in Mr Grant's vehicle at some point that night in the night, I find that Ms Edwards was mistaken as to her identification of the vehicle. This is certainly understandable given the effluxion of time and the traumatic nature of the events that followed.

176. Although it scarcely needs to be said, the conduct of Mr Grant was predatory and disgraceful.

C. MANNER AND CAUSE OF DEATHS (ISSUE 2)

177. In this section of my findings, I address the evidence of relevance to the manner and cause of the deaths of Mona and Cindy.

178. I turn first to the evidence concerning the motor vehicle accident on 6 December 1987, and then set out the relevant evidence relating to the injuries sustained by the girls (but only to the extent necessary for the purpose of ascertaining the *manner* and *cause* of their deaths).

179. For completeness, I also note certain evidence regarding rumours or alternate theories as to the death of Mona and Cindy.

180. My findings on the relevant issues concerning manner and cause of death are set out at [251] below.

Single vehicle accident on Mitchell Highway in the early hours of 6 December 1987

181. During the inquest, a compelling body of essentially unchallenged evidence was received as to the circumstances (or manner) of the girls' death. That evidence unequivocally supports that the girls died in a single vehicle accident on the Mitchell Highway in the early hours of 6 December 1987.

182. The particular evidence supporting this thesis includes:

a. the evidence of the civilian witnesses, as set out at [66] above as to their observations on attending the accident scene around 4.30 am, on Sunday, 6 December 1987;

b. the evidence collated during the initial police investigation, as set out above (such as it was), supporting the theory of a single vehicle collision;

c. the evidence of Sergeant Robin Burlin, as set out in his statement of 27 February 2023 (detailed below); and

d. the evidence of Dr Andrew McIntosh, biomechanical engineer (noted below) as detailed in his report of 13 June 2023 (and confirmed in oral evidence during the hearing).

183. In particular, Sergeant Burlin formed the view that the key features of the accident were that:

a. a white coloured 1983 Toyota Hilux utility (OCQ-921) (NSW) was travelling in a generally northerly direction on the Mitchell Highway;

b. about 34 km south of Enngonia, for unknown reasons the vehicle lost control and departed the northbound lane via the western kerb alignment; it then crossed the western kerb alignment fog line, travelling along the western kerb alignment dirt/grass verge for some distance before returning to the northbound lane;

c. the vehicle then continued in a north/east direction across the northbound lane and into the southbound lane;

d. through driver input the vehicle has changed directions again, and ultimately rolled over, driver side leading and eventually come to rest on the wheels facing in a south/east direction over the western table drain;

e. there was no rain on 5 or 6 December 1987 nor any suggestion as to the issues with the surface of the roadway; and

f. the area of the collision on the Mitchell Highway is a straight section of bitumen; there is no street lighting and the speed limit is 100km per hour in the relevant zone.

184. Sergeant Burlin confirmed these views when giving oral evidence on 19 December 2023.

185. Dr McIntosh summarised all relevant evidence and the circumstances of the accident in this succinct overview (at p 46 of his report):

> In summary, in my opinion, the cause of and circumstances surrounding the motor vehicle collision on 6 December 1987 are:
>
> 1. The Toyota utility was headed north on the Mitchell Highway.
>
> 2. The speed of the Toyota is unknown, but likely at or near the posted speed limit.
>
> 3. The Toyota driver applied an inappropriate steering input that caused the vehicle to veer to the left (west) and depart the paved road. The

driver's subsequent steering inputs were also inappropriate and the vehicle veered northeast onto the southbound lane and then northwest again. The Toyota departed the highway and entered the dirt embankment on the western side of the highway.

4. The Toyota driver oversteered again and the Toyota entered into a clockwise yaw along the dirt embankment as it headed north.

5. A trip-over occurred and the vehicle commenced rolling laterally with the nearside leading.

6. The vehicle speed when the trip-over occurred was likely in the range of 40 to 50 km/h.

7. The nearside roof contacted the ground first.

8. The offside roof contacted the ground leading to substantial roof crushing involving the offside roof, and, A- and B-pillars.

9. The vehicle came to rest facing east on its wheels.

10. The vehicle rolled once fully.

11. The vehicle then rolled backwards or was reversed a short distance west before coming to a complete stop.

12. All vehicle occupants were unrestrained prior to the loss of control and rollover.

13. During the rollover both Jacinta Smith and Mona Smith were ejected. During or after ejection the Toyota rolled onto both Jacinta Smith and Mona Smith resulting in critical injuries.

14. Alexander Grant likely remained within the Toyota during the rollover.

Based on the brief of evidence, intoxication, fatigue, road speed and lighting are highly likely contributing factors to the loss of control.

186. Dr McIntosh subsequently noted his conclusions in these terms (at p 51 of his report):

1. The crash occurred because the Toyota driver applied a series of inappropriate steering inputs that resulted in the Toyota departing the highway and entering the dirt embankment on the western side of the highway. The Toyota driver oversteered again and the Toyota entered into a clockwise yaw along the dirt embankment as it headed north.

2. A trip-over occurred and the vehicle commenced rolling laterally with the nearside leading. The vehicle came to rest facing east on its wheels. The vehicle rolled once fully. The vehicle then rolled backwards or was reversed a short distance west before coming to a complete stop.

3. All vehicle occupants were unrestrained prior to the loss of control and rollover.

4. During the rollover both Jacinta Smith and Mona Smith were ejected. During or after ejection the Toyota rolled onto Jacinta Smith resulting in critical injuries. During the rollover Mona Smith was ejected and was likely exposed to a sharp force impact to her head resulting in critical scalp injuries.

5. Alexander Grant likely remained within the Toyota during the rollover.

6. Based on the brief of evidence, intoxication, fatigue, road speed and lighting are highly likely contributing factors to the loss of control.

7. The injuries are not consistent with any of the occupants of the vehicle having been the driver at the time of the collision.

8. The vehicle damage and injuries do not provide strong evidence regarding who was driving the Toyota.

9. Mona Smith and Jacinta Smith suffered injuries that were caused by the rollover crash.

10. Mr Grant survived the crash with minor injuries because the rollover occurred at a relative low speed with only one full roll and he was not ejected.

187. There was no substantive challenge to any of the foregoing evidence as to the circumstances of the vehicle crash on 6 December 1987.

Post-mortem investigation

188. On 8 December 1987 at Bourke District Hospital, Dr Clive Pringle conducted post-mortem examinations on both Mona and Cindy. It is understood that Dr Sutherland (who was known to the girls' families) was away at the relevant time, However, even had Dr Sutherland been available, he is unlikely to have conducted the procedure, given his position as family doctor for the girls.

Autopsy report for Mona

189. In the report concerning Mona, Dr Pringle noted a massive scalp wound, which would have caused considerable blood loss.

190. He found an extensive abrasion on the opposite side of Mona's head and face. This suggested that the head was subjected to considerable traumatic violence

and that the deceased would very likely have been semiconscious or unconscious as a result.

191. Dr Pringle opined that the combination of these circumstances would have been sufficient to bring about the death in a short time but there were also other injuries and complications which would have accelerated death through the production of severe hypoxia (including haemorrhages into the lungs associated with lacerations in the right lung, the presence of blood and aspirated vomitus in the air passages in the lungs and fractured ribs which would have restricted breathing).

192. Dr Pringle concluded that Mona, "died as a consequence of injuries she had received in a Motor Vehicle Accident in which she is reported to have been the driver".

193. Of particular concern, Mona was also found to be missing an ear which was never recovered.

Autopsy report for Cindy

194. In the report concerning Cindy, Dr Pringle noted the following injuries:

a. fracture of the pelvis, disarticulation of the right sacro iliac joint and rupture of the urinary bladder;
b. rupture of the right psoas major muscle;
c. rupture of the liver; and
d. haemorrhages into the lung.

195. These injuries were complicated by aspiration of gastric contents into the major air passages and the lungs and were accompanied by considerable internal bleeding. Dr Pringle thought that although the death may not have occurred immediately, it would have occurred rapidly; he thought it was most unlikely that Cindy was even semi-conscious shortly after the accident. The injuries sustained would have prevented Cindy walking; nor could she have arranged her clothing in the fashion observed at the post-mortem examination.

196. Dr Pringle concluded that Cindy "died as a result of multiple internal injuries sustained in a motor vehicle accident in which she was reported to be one of two passengers in the vehicle".

197. Noting the evidence as to potential sexual interference, several specimens were taken from the genital area and from dried material on the left thigh, some of which had a "glistening surface" when viewed in good light. The results of that testing are noted at [247] below.

Community rumours as to alternate theories of death

198. Mona and Cindy's families continued their desperate search for answers in relation to the events of December 1987, understandably distressed and deeply dissatisfied with the outcome of the criminal proceedings in 1990.

199. In March 2004, information was provided by Ms Lisa Edwards, an aunt of Mona, raising an alternate theory as to the manner and cause of the deaths of Mona and Cindy.

200. Detective Senior Constable Duncan Butcher (**DSC Butcher**) of the Darling River Criminal Investigation Unit at the Bourke Police Station was tasked with investigating this new information.

201. On 28 March 2004, Lisa Edwards, provided a statement to police alleging that she had been picked up in a four-wheel drive with Mona and Cindy. The vehicle was being driven by a white man, near Adelaide Road in Bourke. Ms Edwards told police that the man drove out towards Enngonia Road and stopped the car in, "the middle of nowhere". Ms Edwards then gave an account of seeing a male hit Mona on the head with the metal object about three times, asking for money; she told police that white man then undid Mona's bra, tied it around Cindy's neck and pulled it tight. Cindy tried to get it away but was not able to. The man let go and Cindy fell on the ground. Ms Edwards then ran from the scene. As I set out below, Ms Edwards later recanted this story and said that she had not in fact seen anything like that happen, but once such a serious allegation had been made, it needed to be investigated.

Forensic pathology review – Dr Peter Ellis

202. As part of the further investigations undertaken by DSC Butcher, on 18 July 2004 police retained forensic pathologist, Dr Peter Ellis to consider the allegations by Ms Edwards (in her statement of 28 March 2004), and to opine on whether the allegations that the girls died in the car accident on 6 December 1987 were possible.

203. By report dated 25 July 2004, Dr Ellis relevantly opined:

a. the injuries sustained by both girls were consistent with having occurred in a roll-over crash (especially if neither were restrained by a seat belt);

b. both girls had essentially died from internal bleeding; the presence of the severe bleeding confirmed that they were alive at the time of the injuries;

c. there was no suggestion from the evidence that supported that the girls were deceased prior to the crash; and

d. Cindy's injuries would have precluded her walking after the crash, and the severe abdominal injury with its associated bleeding would have rendered her unconscious quickly.

204. Police investigations otherwise found no evidence corroborating the account of Ms Edwards.

Retraction of allegations by Ms Edwards

205. In August 2004, Ms Edwards admitted to police that her statement may, in fact, have been a drug induced hallucination.

206. Ms Edwards also gave evidence at the inquest and confirmed in effect, that she did not know or have any memory of what had happened to the girls.

Other rumours surrounding the deaths

207. In the absence of clear facts regarding the circumstances of the girls' passing, rumours have abounded in the Bourke community.

208. On 7 April 2004, Michael Knight (a cousin of Jacinta and Mona Smith) provided a statement to police concerning events in Dubbo shortly after the deaths of

Jacinta and Mona. Mr Knight could not recall the date but remembers it occurred around 2:30pm at the Dubbo Hotel. He described observing a man called Athol Gillon in the pub. Mr Knight asked Mr Gillon if he was in Bourke when the incident happened; Mr Gillon replied "I fucked them two girls, and I bit one of their ears off". Mr Knight wrote this information on a piece of paper, which he later gave to a relative to give Dawn Smith. That piece of paper could not be later found.

209. Mr Knight and Mr Gillon both gave evidence at the hearing. Mr Knight told the Court that there was a lot of "talk, hearsay talk and all of this" and a lot of rumours. Mr Knight gave evidence of a conversation with Mr Gillon to the effect of the above. However, Mr Knight agreed that Mr Gillon was really drunk and intoxicated at the time.

210. Mr Gillon gave evidence at the inquest. He denied any involvement in the deaths of Mona and Cindy, only finding out from his sister that the girls had died the following morning. Mr Gillon confirmed that he was drunk when he spoke with Mr Knight in Dubbo. He denied any conversation in the terms alleged by Mr Knight, saying said "I would never say something like that. I don't recall having that conversation with, with Michael Knight. I don't recall any of that sort of ... I refute what he said ...."

211. There was certainly no further evidence in support of Mr Gillon's involvement in the girls' death.

212. Unquestionably, the rumours and suspicions that spread amongst the community in the absence of clear information and answers were extremely distressing for the families of Mona and Cindy. Mr Knight gave some poignant evidence in this regard:

> *... you hear a story here, hear a story there, and there are different stories floating around the town at the time, which would have hurt my cousins' mothers at the time, of people talking like this here and it would have been upsetting for them, and even those early stories around about my cousins, two little cousins, yeah.*
>
> *Q. Did the stories start straightaway, like, that same day that you heard the girls passed or the next day or can't you remember? It's just within the first couple of weeks?*

A. In the first week or so, yeah. It went from there was a car and the two girls, the two girls were killed and whatever, you know, and then after a time when a little bit of time went on, then it's just people in general talking and talking out of school and stuff like that there, and I imagine what my two cousins, yeah, the two parents of the two girls, what they would have been going through at the time to struggle with rumours and talk about their children, so, yeah, it hurts - it hurts the community where everyone talks, a small community, and everyone knows one another and very well, and just general, all different stories in general surrounding at the time and the parents were going through this stuff and..(not transcribable)..happened, which made it a lot harder for the two parents at the time and so I can imagine what they would have been going through with all the rumours getting around at the time of the deaths of their daughters, and that's, as I'm saying, like, it hurts the community where everyone talks and there's different opinions and different stories and in general about where they don't know the truth, they don't know the truth and they're just stories are stories, and it's my two cousins' two parents, they would have suffered very severely and still do today, and, yeah, my sympathy goes out to the mothers of these two girls.

213. It will be clear from my findings below that I did not consider the evidence to support either of these rumoured accounts.

214. However, the distressing rumours and unfounded suspicion – which has swirled in the community for decades in the absence of clear facts – has caused great distress and uncertainty for the Smith families, and also fractured the broader community. It is my great hope that this inquest will finally bring this harmful speculation to an end.

Exhumation of Mona – 27 July 2023

215. Against the backdrop of decades of speculation about the deaths of the girls, and in particular, given specific concerns raised on behalf of Mona's family, 26 June 2023, I granted their application for an exhumation pursuant to s 91 of the Act.

216. On 27 July 2023, Mona's remains were carefully exhumed from Bourke Cemetery.

217. A second post-mortem examination was then expeditiously conducted by Dr du Toit-Prinsloo. The remains were also examined by a specialist anthropologist, Dr Denise Donlon.

218. Dr du Toit-Prinsloo's findings were set out in her detailed report of 26 June 2023.

219. In short, post-mortem imaging was performed. Examination of the skeletal remains showed no features of any gunshot wound, defect or blunt force injuries sustained by an axe or machete observed on the bones examined (which were of particular concern to Mona's family).

220. Dr du Toit-Prinsloo ultimately concluded as follows:

> *In conclusion, based on the reported circumstances and on the above findings, the cause of death will be recommended to be recorded as unascertained. Having reviewed the previous available material which included the previous post-mortem examination report and photographs, I am of the opinion that there is no additional information to indicate that the cause of death is other than the result of injuries sustained in a motor vehicle accident.*

Who was driving the vehicle?

221. Central to the question of the *manner* or circumstances of the vehicle accident was who was driving the car at the time of the crash.

222. There has been conflicting opinion and speculation about who was driving the vehicle for decades now.

223. As set out above, Mr Grant was initially charged on the basis he was a passenger in the vehicle.

224. The charges were subsequently amended to allege that Mr Grant was the driver of the vehicle, following then S/Sgt Godkin's investigation. At trial, that charge could not be proven beyond reasonable doubt.

225. I had the benefit of hearing evidence from the witnesses who investigated the matter from 1987-1990. I also received fresh evidence, including evidence from Dr Andrew McIntosh, a biomechanical engineer with expertise in injury causation. Dr McIntosh provided a comprehensive report dated 13 June 2023 which was received into evidence, unchallenged.

Admissions by Mr Grant as to driving

226. I have outlined at [81], the conversation reported by Mr McKenzie. In short, Mr McKenzie's evidence was that Mr Grant initially told him that he (Mr Grant) was the driver of the vehicle. Mr Grant's position quickly changed, however, once he realised that Mona and Cindy were deceased. The conversation as related by Mr McKenzie was corroborated by both Officer Harper, and also ambulance officer Willoughby.

227. In all subsequent interviews with police, Mr Grant denied being the driver. He maintained that Mona was driving the vehicle. Plainly, this was an entirely self-serving statement. Mr Grant also readily told S/Sgt Godkin in the interview in May 1988 that a lot of what he told detectives previously was "not right and some of the things I said is really bullshit". This statement may ultimately be one of the few truths related by Mr Grant.

Mona's ability to drive a manual utility vehicle

228. Of note, Mr Grant's vehicle was a manual utility vehicle. An obvious issue was whether Mona had ever driven such a vehicle.

229. In connection with S/Sgt Godkin's re-investigation, both Dawn and June provided statements in May 1988 confirming that Mona had no such experience. Whilst Mona had once driven a short distance in an automatic, she had not been taught how to drive a manual vehicle.

230. During the inquest, June Smith gave evidence in these emphatic terms:

> *Q. What you've just said, I think, is that in your village community, you never saw in your community someone owning or driving a four-wheel-drive of the type that Grant had, that being a Toyota Hilux?*
>
> *A. No, no one.*
>
> *Q. To your knowledge - and I know you've said it in your statement - was that the only occasion you saw or heard that Mona had driven a motor vehicle, the blue automatic?*
>
> *A. Yes, yes.*
>
> *Q. Were you aware whether anyone had taught her how to drive a manual car of any sort?*

A. No way, nobody.

Q. Why do you say, "No way"?

A. No way because there was no one who had them kind of vehicles and I don't think a lot of them knew how to drive them anyway if someone did because, you know, that's only the car I ever known was on the village was that old automatic blue one.

231. Similarly, Mona's brother, Douglas Smith, provided a statement that "if someone told me that Mona drove a manual car I wouldn't believe them because she just doesn't know how to drive."

232. Evidence from expert witnesses also confirmed that it would have been difficult for a person unfamiliar with manual vehicles to drive one. Mr Godkin explained that:

... Well, at that - at the time, I had a - a very similar vehicle myself, actually, but they're not an easy vehicle to drive, and they're a very heavy vehicle, and you're constantly - particularly if you're loaded, as that one was - you'll be constantly using the gears, with a manual shift, and for a person who's never driven a manual vehicle, it was - to me it was impossible.

233. Dr McIntosh also gave evidence as to the difficulties of driving a manual utility:

Q. Do you know much about this type of car that was owned by Mr Grant?

A. I do in fact. Not the 4x4, but I think my father owned something similar back at that time, so I've driven quite a few single cab utilities, manual utilities with a bench seat, yes.

Q. The evidence is that Mona had never driven a manual vehicle at all, she had driven an automatic vehicle for a very short distance. Can you tell us how challenging or not it would've been to drive this type of manual vehicle for the first time?

A. I think you would just continually stall the car. You wouldn't be able to get it up to a highway speed at all, you would just keep stalling it.

Q. Why is that, what about the car makes it so difficult?

A. Because it's a manual, because it requires coordination between your foot operating the clutch, the vehicle engine revolutions and then being able to actually place the gearstick into the right position, and coordinate the operation of the clutch, the release of the clutch, the engine revs, the road speed and all of that together. It requires a bit of skill to do it. It's fun driving a manual, but it does require some learning to do it."

234. In stark contrast, Mr Ehsman told the court the following:

> *Q. But, sir, you were a detective. You were a Detective Senior Constable, who had been in the police force for over a decade. It's part of your role to investigate who was driving, isn't it?*
>
> *A. Yes.*
>
> *Q. You wouldn't just accept, as a detective, at face value, Mr Grant's story about it, would you?*
>
> *A. It wouldn't be unusual for young kids, unlicensed drivers to be driving cars. There's nothing unusual about that.*
>
> *Q. But in in case, the allegation was that it was an unlicensed teenage girl, driving a manual utility. Do you think you should have made some inquiries, at that time, about whether or not either of these girls could drive a manual utility?*
>
> *A. No.*
>
> *Q. You don't think that that was a legitimate line of inquiry?"*
>
> *A. No.*

235. I was troubled by this evidence from Mr Ehsman, as noted below.

Evidence of Mr Vaughan Reid (as to examination of Mr Grant on 9 December 1987)

236. In his initial statement of 18 October 1988, former Detective Sergeant Vaughn Reid (**DS Reid**) stated the following of his interview with Mr Grant on 9 December 1987 at Nyngan Police Station:

> *[3] … I had a short conversation with the defendant, during which I asked him to show me any injuries he sustained in the motor vehicle incident … I recorded in my official notebook … that he informed me that he had struck his head and sustained a small amount of swelling to the rear left of his scull. I recall that he indicated that area to me and invited me to feel the swelling for myself. I was unable to locate any obvious area of swelling and recorded in my notebook that "swelling has now gone down". He informed me that he also suffered a "knock" to the inside of his left knee. He removed his shirt and I saw what appeared to be grazing to his left lower arm, right elbow area, left shoulder area and along the lower spine area.*

237. Mr Reid also gave evidence at the inquest. Of the injuries he observed on Mr Grant, Mr Reid stated:

> *At some stage, we were told by the police officer from Nyngan that he'd handle the - what's his name ... Grant, that Grant had had a bruise across his chest from right down to the left that was indicative of him wearing a seatbelt and that he was the driver of the vehicle. At that stage, we had no evidence of a driver. I think that's the main reason why we went down to talk to Grant, to look at that - just to look at that bruising, but we didn't find any bruising—*
> ...
>
> *WITNESS: That was my error. It wasn't from Nyngan, it was the officer from Enngonia. Apparently, he had attended the scene of the accident on the night and apparently he saw Grant on that night. I can't recall whether he said that he actually saw the - it's coming back to me, sorry. I can't recall whether he said he actually saw the bruising but he did tell me that a doctor at the hospital who examined Grant that night had told him about this bruising, and so that's why we went down - I'm sure, that's why we went down to Nyngan to look at him, to sort of see for ourselves. When we didn't see that bruising, I've gone back to Bourke and I just didn't remember going and seeing the doctor and asking him did he see any bruising on this fellow's chest that looked as if it may've been caused by a seatbelt, and the doctor told me, "No", and then I told him that the police officer from Enngonia had been told - allegedly by that doctor - that this bruising existed, and the doctor denied that. He said, "No, I never. I did not see that bruising and I didn't tell anybody about a bruising that didn't exist".*

Expert evidence of Dr McIntosh

238. Based on the available evidence, Dr McIntosh opined as follows as to the injury pattern and thus, the likely driver of the vehicle (emphasis added):

> 1. The injuries suffered by the three occupants are not specific to the seated positions pre-rollover because seatbelts were not worn and both Jacinta Smith and Mona Smith were most likely ejected.
>
> **2. The injuries suffered by Mona Smith and Alexander Grant do not indicate who was driving the vehicle at the time of the crash.**
>
> 3. As a result of the pre-roll movement of the vehicle, the three occupants would have been out-of-position, although a person was steering the vehicle and seated in the driver position up until the vehicle rolled. There is clear evidence of driver steering inputs until the trip-over.
>
> **4. There is weak evidence that Alexander Grant was not the driver.** Assuming that he was the driver and remained in the driver seat area, the roll dynamics would have placed his head and upper body near the roof when the offside landed on the ground. The extent of roof crush is

not consistent with his injuries. His position in the vehicle at the time the roof crush occurred, because he was unrestrained, may have placed his head and neck away from the point of maximal roof crush.

Evidence of Sergeant Burlin

239. Sergeant Burlin concluded as follows in his report dated 3 October 2022:

> From the available images, statements, interviews, witnesses, evidence, brief of evidence, determining who was the driver is unable to be proven beyond reasonable doubt.
>
> The only person not seriously injured was Grant.
>
> From the limited observations made of his body on the 09/12/1987, it would appear he was wearing the front seat passenger belt (over his left shoulder).

240. However, in oral evidence, Sergeant Burlin accepted that from the evidence of DS Reid regarding his examination of Mr Grant on 9 December 1987 and reference to grazing, including on the left shoulder, the position and nature of that grazing was not known. Sergeant Burlin agreed this was not sufficient evidence to confirm that a seatbelt was worn over the left shoulder.

Evidence of sexual interference with Cindy

241. As set out at [245], certain evidence from the scene suggested that Cindy had been subjected to some form of sexual interference or touching after the accident.

242. Eminent sexual health and forensic physician, Professor Katherine Brown, was retained to review the relevant evidence.

243. Professor Brown prepared a comprehensive report dated 6 June 2023; she also gave oral evidence during the inquest on 28 November 2023.

244. Professor Brown distilled the following matters as suggesting that Cindy may have been sexually assaulted after the accident (also confirming that circumstantial evidence is considered in assessing whether or not there were indicators of sexual assault):

    a. The severe nature of the injuries sustained by Cindy indicate that she would have shortly lost consciousness and would not have been in a position to participate in sexual activity or to remove her clothing.

b. The fact that Mr Grant was seen to be "cuddling up" with Cindy at the scene of the incident with his arm around her waist, whilst her pants were "down around her ankles". Further, there was the position of Cindy (including her placement on the tarpaulin) and the disarrangement of her clothing when found by Shane Baty and Texter Johnston.

c. The position of Cindy when police first attended (and took photographs, showing her legs slightly parted, and not 'straight' as found by Mr Baty and Mr Johnson); further, the fact that Cindy's top appeared to have since been pulled up above her breasts and her bra pulled down below her breasts.

d. The obvious lie told to police by Mr Grant when he was interviewed on 6 December 1987 that immediately after the accident: "The smaller one, I don't know if she was stunned or not, that's when she came on to me, do you want me now, that sort of thing, she was lying back there on the cover pulling her clothes up and just wanted a beer". At that time, both girls would have been close to death.

e. The unlikelihood of the clothing disarrangement/removal arising from Cindy's ejection from the vehicle, as noted by Dr Ellis.

f. Evidence suggesting that a man (likely Mr Grant) had previously displayed some sexual indecency towards Sharon and Julie Smith (in the presence of Cindy) whilst they were in his white four-wheel drive.

245. As stated at [198], given the circumstances in which Cindy was found, specimens (namely vaginal and vulval swabs, and swabs from the left thigh) were collected at autopsy to further investigate the potential for sexual interference.

246. By report dated 28 January 1988, Ms Virginia Friedman, Forensic Biologist, noted that no semen was detected on the high vaginal swab, low vaginal swab or the two swabs from the left thigh. However, the test for the presence of semen on the vulval swab was inconclusive.

247. Professor Brown reviewed those findings, and confirmed that given the results, she could not "guarantee that there was no semen present".

248. Ultimately, Professor Brown agreed that the evidence strongly suggested that some form of sexual touching of Cindy's breast and genital area occurred after she had passed away.

249. Professor Brown's evidence was not challenged in any respect.

FINDINGS – SECTION C

Manner of death

250. Having regard to the evidence set out above, I find that Cindy and Mona died from injuries caused when the manual Toyota utility 4WD owned by Mr Grant was travelling north on the Mitchell Highway and was involved in a single-vehicle accident. The accident was caused by the driver making steering errors for an unknown reason, leading to the vehicle veering, ultimately leaving the road, and then rolling over.

251. None of the occupants of the vehicle were wearing seatbelts at the time of the accident.

252. I accept the evidence of Dr McIntosh that during the rollover, both Cindy and Mona Smith were ejected from the vehicle, and that during or after ejection, vehicle rolled onto them, resulting in critical injuries. In contrast, Mr Grant likely remained within the vehicle during roll over.

Driver of the vehicle

253. I am well satisfied that the driver of the vehicle was Mr Grant. I make that finding having regard to the combined force of the following evidence:

    a. the initial admission by Mr Grant to Constable McKenzie that he was the driver of the vehicle;

    b. the cogent evidence from Mona's family she could not drive a manual vehicle;

c. relatedly, the difficulties of driving a manual utility vehicle (including one laden with tools in the tray, noting the evidence of Mr Godkin);

d. Mr Grant's efforts to obtain the steering wheel of the vehicle the day prior to the arrival of DS Moss (Mr Grant clearly having been tipped off by someone as to this re-investigation).

254. I also accept that contributing causes to the accident (which resulted from Mr Grant losing control) were intoxication, fatigue, road speed and the lack of lighting.

Cause of death

255. I find that Mona died from multiple internal injuries (including head and lung injuries) sustained in the accident, leading to extensive blood loss.

256. I find that Cindy died from multiple internal injuries (including pelvic and lung injuries) sustained in the accident, leading to extensive blood loss.

257. Such injuries are entirely consistent with the injury pattern in a roll-over crash, especially as the girls were not restrained by a seat-belt.

Time of death

258. As to the specific time of the girls' passing, the evidence simply does not permit me to say, beyond noting that:

a. given the extent of the injuries suffered by both Mona and Cindy, their deaths would likely have followed very soon after the accident from the severe internal bleeding; and

b. I accept both Cindy and Mona were deceased by the time that Shane Baty attended the scene, around 4.00am on 6 December 1987 (noting his first aid experience which enabled him to form the view there was no pulse at this time).

Sexual interference with Cindy after her passing

259. Based on the totality of the evidence, and in particular the views of the civilian witnesses upon seeing the positioning of Cindy, relative to the subsequent

observations of the attending police, together with the compelling evidence of Professor Brown, I am satisfied that there was some form of sexual interference. This was in the nature of the touching of Cindy's breast or genital area *after* she had passed (noting the clear evidence of Mr Shane Baty, as noted above).

D. ADEQUACY OF INITIAL POLICE INVESTIGATION (ISSUE 3)

260. I have detailed at [78] – [138] above, the evidence as to the steps taken in particular, by then Constable McKenzie, DS Ehsman and SC Ludewig in the initial police investigation from 6 to 9 December 1987.

Deficiencies in the initial police investigation

261. I had the benefit of a detailed review of the investigation from both DCI Quigg, the officer in charge of the coronial investigation, together with a statement from Sergeant Robert Burlin, an experienced investigator with the Southern Region Crash Investigation Unit.

262. That evidence highlighted numerous, significant failings with the initial police investigation, prior to the involvement of S/Sgt Godkin in May 1988, some of which concerned very basic police practice.

263. In summary, those failings included:

a. Inadequate crime scene management and failings in the evidence gathered from the scene on 6 and 7 December 1987, in particular:

i. limited photographs were taken at the scene on the day of the incident;

ii. no detailed measurements or recordings were made to capture the details of relevant items, such as tyre marks, (which may have assisted with calculating speed). For example, images of the Mitchell Highway taken on the day do not give a "closer image of the actual [swerve] mark" to define what type of mark it is; additional relevant tyre marks were not photographed or recorded;

iii. there was a limited canvassing of the scene for relevant evidence, most importantly, for Mona's missing ear;

iv. the location of where Jacinta Smith was found (on the tarpaulin on her back, facing in a northerly direction, apparently moved to this point) has never been established;

v. there were no images taken from inside the vehicle at either the scene or the Police holding yard;

vi. the debris field consisting of items thrown from the vehicle including the toolbox and fuel tank was not photographed or mapped out clearly nor secured and collected;

vii. there was a failure to seize and secure the tarpaulin Cindy was found lying on;

b. There was a failure to seize the subject vehicle for mechanical and forensic examination;

c. There was a failure to undertake a mechanical examination of the subject vehicle (which should have occurred under the relevant NSW Police Force policy at the time);

d. There was a failure to retain the subject the vehicle as an exhibit pursuant to the applicable police policy;

e. There was a failure to examine the vehicle at the holding yard;

f. The Accident Investigation Squad did not attend, noting that the collision would have met the criterion for attendance at the time; according to the OIC, this unit should in fact have *led* the investigation;

g. The delayed attendance of crime-scene on 7 December 1987 impacted on the quality of evidence then available;

h. There was a failure to interview vital civilian witnesses who were first on scene at the accident site;

i. There was a failure to obtain ambulance statements or speak to the paramedics who attended the scene at an early stage (indeed these statements were not obtained until January 1990);

j. There was a failure to obtain statements from Mona and Cindy's family at an early stage in the investigation to confirm movements and establish a timeline prior to the incident; relatedly, there was a failure to investigate whether Mona was even capable of driving a manual vehicle (this only occurred subsequently, once S/Sgt Godkin became involved in the investigation).

264. Mr Patrick Moss, a former Detective Sergeant who gave oral evidence at the inquest on 29 November 2023, emphasized that the vehicle should have been seized to preserve the evidence; he also emphasized that continuity of police possession was "probably the most important thing of any exhibit". Mr Moss noted that as the vehicle was not comprehensively documented, "there was a lot of information that could've been gained from inspecting the vehicle and photographing it properly, including whether the seatbelts had been worn or not."

265. Mr Godkin agreed with numerous concerns raised by DCI Quigg as to the failure to secure and preserve the scene at Enngonia for specialist forensic examination; the failure to interview vital civilian witnesses at an early stage; the failure to obtain the specialist resources of the accident investigation squad early to attend the scene and lead the investigation ("I couldn't … understand why that happened"); inadequate photographs of the scene ("when people are thrown from vehicles … their locations are in relation to the vehicle, … very, very important … we couldn't ascertain … particularly in relation to where Mona was … It was – just didn't add up that she could possibly have been the driver"); inadequate photographs of the external and interior of the vehicle; a significant failure to properly record and measure the tyre marks at the scene ("I don't think they were examined at all, in my knowledge); failure to photograph the debris and items left on scene and to seize the vehicle for mechanical and forensic examination (being "a very critical aspect of the inquiry that wasn't done"); failure to seize and retain the clothing of Cindy and Mona for forensic examination; and also the clothing of Mr Grant. Mr Godkin also agreed that a

vital aspect was to ensure that the steering wheel and gearstick were fingerprinted.

266. Mr Godkin was initially very suspicious about Mr Grant's contention that Mona was the driver, stating:

> It was a Toyota utility, and it was - it was loaded very heavily with 40 excavation equipment in the back of it, and it was manual driver - driven vehicle, and the enquiries I made, I had absolutely no doubt in my mind that that girl - Mona - could not drive that vehicle. There was absolutely no question in my mind about it.

267. After speaking to Mona's family about whether it was possible she was the driver, Mr Godkin was "further convinced" she was not:

> ... Because they - they were very close-knit group of people, as you - you are aware, and they - everyone seemed to know each other, and they always seemed to know what each other was doing in all sorts of aspects. Drinking, or doing - driving, whatever. And I didn't find one person that gave me any indication or possibility that Mona Smith could drive a manual vehicle, and I did ascertain that she did drive a - a vehicle on the reserve, which was an automatic vehicle, which a ten year old kid - you know, an eight year old kid can drive - anybody can drive. But that - so that didn't help at all.

268. Notably, Mr Raymond Godkin told the Court he regretted that he had not been involved at an earlier stage in the investigation, stating:

> I give evidence in courts, and I spend so much time in courts, that I have personally attended five - more than five hundred fatal accidents, and I've never, ever dealt with one as bad as this investigation.

269. Further, the circumstances in which Mona and Cindy's family came to learn of the girls' passing was also extremely distressing and poorly managed by police. In a statement dated 9 November 2023, June Smith recalled:

> No police ever came near me or explained anything to me when the girls died. We had to find everything out ourselves. My eldest brother told me that they had died. We had heard that a couple of girls got hurt but I didn't know they got killed until my brother came home and said, 'sis you've gotta come to the hospital straight away' I said, 'what for?' and he said 'just get dressed you gotta come up now. You gotta identify a couple of girls. No police spoke to us when we got to the hospital. It was just me, my brother and Lyiatta Gillon.

270. Similarly, Dawn Smith provided the following account in her statement dated 9 November 2023:

> The police should have come to us themselves and informed us about the girls' deaths, but they never came anywhere near us after the girls died. They never explained to me what had happened, never offered me support. They could have easily found me to talk to me, but they never came anywhere near me or the Aboriginal community. My cousin had to come and tell me at the church that they had died and then took me up to hospital to identify her. I couldn't believe it when I saw her.

271. There followed was a general failure by investigators to keep Mona and Cindy's family apprised of the status of the investigation during the court process and the District Court trial. Nor were the appropriate welfare or support services put in place for the family and the community at the time.

FINDINGS – SECTION D

272. In closing submissions, Counsel for the Commissioner of Police conceded that there were failings in the police investigation at the scene of the accident and in relation to the failure to have the vehicle secured and examined.

273. That concession was well made, given the weight of the evidence.

274. The summary of the failings detailed at [264] above, based on the evidence of DCI Quigg and Sergeant Burlin makes it clear beyond doubt, that the initial police investigation suffered from what can only be termed very serious deficiencies.

275. Moreover, those failings had a major impact on the investigation and the prospects of any future criminal prosecution. That necessarily follows because vital evidence was not collected or secured from the scene. The failure to secure the vehicle and other exhibits meant that valuable evidence as to the identity of the driver of the vehicle was lost (not least, in terms of potential evidence available on the steering wheel).

276. The reason for the multiplicity of serious failings in the initial investigation was not explained during the inquest. That matter is the subject of further consideration in Section E below, considered through the systemic lens of deep racial tensions as between the community and police at the relevant time.

Conversation between Constable McKenzie and Detective Sergeant Ehsman

277. One discrete issue of direct relevance to the initial police investigation was the conflicting evidence concerning whether DS Ehsman was made aware by then Constable McKenzie of the initial admission by Mr Grant as to driving the vehicle.

278. Senior Counsel Assisting submitted that I would accept the evidence of Mr McKenzie over Mr Ehsman on the basis that Mr McKenzie presented as a "highly credible witness"; it was put that Mr McKenzie gave clear evidence of advising Mr Ehsman of the admission made by Mr Grant at the scene. Further, that Mr McKenzie's evidence at the inquest was consistent with the evidence given during the committal proceedings in 1988.

279. Mr McKenzie also demonstrated considerable diligence and care while at the accident scene, including by making contemporaneous notes of the discussion with Mr Grant in a Spirax notebook (as he did not have his official police notebook on him), and also preparing a meticulous sketch of the scene.

280. Senior Counsel Assisting also drew my attention to concessions made by Mr Ehsman as to his failing memory about much of the investigation.

281. Counsel for Mr Ehsman disagreed with the submissions of Counsel Assisting, and pointed to the following matters as supporting his client's account:

a. Mr Ehsman's firm rejection in sworn evidence of being aware of the admission;

b. The fact that had Mr Ehsman been aware of this detail, he would have put it to Mr Grant in one of the several interviews conducted;

c. Mr Grant did not refer to this detail in the later interview with then Officer Godkin (and nor was this admission put to him by that officer);

d. The admission was not recorded in an official police notebook, but instead on what is "effectively scrap paper";

e. Mr McKenzie first made this suggestion after some 36 years, which was said to "smack of recent invention"; and

f. Mr Russell conducted his own investigations in Mr McKenzie's knighthood (being material not in evidence) in respect of which he impliedly raised doubts.

282. I have given close consideration to the vexed submissions on this issue, and note the following.

283. *First,* Mr McKenzie gave clear and credible evidence. I have no hesitation in accepting his account, which was corroborated by other witnesses (including Mr Harper, and ambulance officer Willoughby). Moreover, Mr McKenzie's use of the Spirax notepad to take contemporaneous notes (which was unremarkable in circumstances where he left the police station quickly to get to the scene), coupled with his detailed sketch of the scene, confirm his attention to detail and meticulousness.

284. *Second,* Mr McKenzie was not asked any questions concerning the details of the police investigation into Mona and Cindy's deaths that would have led him to record his recollection of advising then DS Ehsman of Mr Grant's admission at the scene. I reject the assertion of a "recent invention". Further, Mr McKenzie gave evidence of his conversation with Mr Grant in committal proceedings in 1988.

285. *Third*, Mr Russell's own investigations as to the status of Mr McKenzie's knighthood are not in evidence; nor was that material put to Mr McKenzie, as a basic matter of procedural fairness. In my view, the status of Mr McKenzie's knighthood is a distraction from the central, relevant issue on this topic – which includes the contemporaneous records from that time.

286. *Fourthly*, I do accept the submission that had DS Ehsman been aware of the admission by Mr Grant, he would certainly have put it to him during the interviews he conducted. He had no reason not do so (and in this regard, there was certainly no evidence or even suggestion of some form of cover-up).

287. On that basis, I accept both the account of Mr McKenzie and Mr Ehsman on this issue.

288. However, the important fact remains that had Mr Ehsman undertaken a thorough investigation and properly obtained and considered all relevant

evidence at the time, for example, by speaking to Constable Harper or the paramedics who attended the scene, he would surely have become apprised of this admission. Moreover, from the evidence received during the inquest, it appeared obvious to me that Mr Ehsman was not open to the clear possibility that Mr Grant could be lying – for an experienced detective, he simply accepted Mr Grant's account at face value. That was a surprising and concerning position and wrong-footed the investigation in the early stages.

289. I otherwise acknowledge however, that there were individual officers who did their very best to investigate the matter prior to the criminal trial in 1990.

290. In this regard, in addition to commending the diligence of Mr McKenzie (who was not a trained detective but did his best to record relevant observations of the scene in a comprehensive manner), I particularly acknowledge the efforts of Mr Godkin. It was Mr Godkin's involvement in May 1998 that led to a reinvigoration of the initial investigation. His commitment to pursuing the investigation against resistance from senior police officers in Bourke is testimony to his dedication and strong moral code (noting also, that he was clearly supported by his senior commanding officer). His excellent memory, intellect and compassion were obvious to me when he gave evidence before this court.

291. Ultimately, however, despite the best efforts of those officers, the failures in the hours, days and weeks following the accident to investigate the matter thoroughly and to secure critical exhibits, such as Mr Grant's vehicle, had an irreparable impact on the investigation and the evidence available for use in any criminal prosecution.

E. POTENTIAL SYSTEMIC RACISM OR CULTURAL BIAS IN THE CONDUCT OF THE INITIAL POLICE INVESTIGATION (ISSUE 4)

Whether there was any evidence of systemic racism or cultural bias in the conduct of the initial police investigation? If so, how did it impact the investigation?

292. The events the subject of this inquest occurred in the remote township of Bourke in the late 1980s. The complex dynamics of that community, and the relationship between Aboriginal and non-Aboriginal people and the police, is comprehensively addressed in the Cunneen Report (see Annexure A).

293. Of note, Professor Cunneen states that by 1986, there was a "state of tension between police and Aboriginal people in Bourke" and that racial dynamics impacted on policing attitudes and communication with Aboriginal people in the 1980s (at [12.8]-[12.9]. Professor Cunneen relevantly concluded as follows:

> (i) The Racial Dynamics of Bourke
>
> "There is overwhelming evidence to show how racial dynamics structured relationships between Aboriginal and non-Aboriginal people in Bourke in the 1980s, including relationships with police.
>
> There is a long history leading up to the 1980s of racial tension, segregation and entrenched racial discrimination in Bourke (eg massacres, placement of Aboriginal people on reserves and exclusion from services).
>
> The socio-demographic details for Bourke in the 1980s in relation to health, education, housing and employment all point to the entrenched and highly marginalised position of Aboriginal people in the town. The basic structures of power, decision-making and services were overwhelmingly in non-Aboriginal hands.
>
> White stereotypes in Bourke depicted Aboriginal people in highly derogatory ways, and, in particular, as criminal. The problem of racism in Bourke during the mid 1980s was widely acknowledged in various official reports and particularly its effects on Aboriginal young people. In addition, various reports identified the high level of racial tension and anger in the town in the mid 1980s, exacerbated through a variety of incidents from the distribution of racist literature in the community to the police responses to the 1986 'riot'.
>
> During the 1980s white demands for more punitive approaches to law and order were pronounced and targeted at Aboriginal people. Extreme solutions to the 'Aboriginal problem' were publicly canvassed including vigilantism.

(ii) Policing

There were historical continuities with Aboriginal people's concerns over policing in Bourke prior to the mid 1980s, particularly in the context of policing on the reserve, and widespread use of summary offences. The mid 1980s saw serious public confrontations between Aboriginal people (particularly young people) and police. There was a view in the Aboriginal community that there was 'one law for the black and one law for the whites'. Feelings of racism and discrimination were exacerbated by the use of Tactical Response Group police in the town. Various comments from Aboriginal and non-Aboriginal leaders in the town pointed to the lack of trust, the problem of communica6on between police and Aboriginal people, and the idea that double standards applied in police responses to Aboriginal people. Certainly, from an Aboriginal perspective, and supported by various reports, racial dynamics impacted on policing practices, attitudes and communications with Aboriginal people in 1980s. The Ministry of Aboriginal Affairs Working Party (1987) noted that the lack of mutual trust between Aboriginal people and the police was 'a significant contributing factor' to the 1986 disturbances and that more generally there was a state of tension between police and Aboriginal people in Bourke.

The Ministry of Aboriginal Affairs Working Party also noted the mistrust between Aboriginal people and police was exacerbated by the fact that very few Aboriginal people were police officers and that those in positons of authority, such as police, teachers and politicians, did not understand Aboriginal people nor make an effort to understand them. The Working Party also noted the resentment by some police officers in Bourke to how they were treated by some Aboriginal people. From the evidence presented by the Working Group, racial dynamics impacted on policing attitudes and communication with Aboriginal people in 1980s.

The BOCSAR (Cunneen & Robb 1987) analysis of police charge books and court records for Bourke showed a criminal justice system overwhelmingly focused on Aboriginal people as offenders, and was particularly dominated by public order offences. Aboriginal people were by far the majority of people charged (particularly for police offences and public order offences), convicted and sentenced to imprisonment.

Contemporaneous reports like the ADB (1982), Cunneen & Robb (1987), ICJ (1990) and Royal Commission into Aboriginal Deaths in Custody (WooPen 1991a) showed that 'over-policing' of Aboriginal communities in Bourke and northwest NSW was occurring through arrests for trivial offences; and that more punitive police decision-making occurred in relation to Aboriginal people (use of arrest instead of summons, over-charging). The ICJ concluded that there was 'little legal or practical justification for "over-charging" and "over prosecuting" in this way'. These Reports pointed to the impact of 'race' on police discretionary practices.

Reports also showed that over-policing occurred through significantly

> disproportionate police numbers in Bourke for the size of the population (ADB, 1982; Cunneen & Robb, 1987). The Royal Commission into Aboriginal Deaths in Custody referred to the 'massive police presence' in Bourke (WooPen 1991a), and the International Commission of Jurists (1990) similarly commented adversely on the heavy police presence in Bourke. In summary, there was no shortage of police in Bourke.
>
> In relation to Aboriginal women and girls, the Royal Commission into Aboriginal Deaths in Custody noted that there was a 'very widespread perception by Aboriginal women' that police were indifferent to acts of violence against them. The ICJ Report offered some insights into how the law and order problem was defined in Bourke: a white person allegedly forcing Aboriginal children to perform sexual acts was seen as 'not relevant' to the law and order concerns of the white citizens. There is evidence that Aboriginal views of social and potentially criminal problems in the town were not taken seriously."

294. The observations of Professor Cunneen squarely accord with the experiences outlined by Mona and Cindy's family. For example, in a statement dated 9 November 2023, June Smith recalled:

> *Back then you wouldn't walk on the street from the reserve to town. I stuck to the reserve and would only go into town when I needed the shops, and even then it would be straight in and straight out. Town didn't feel safe at that time, I always felt like I was being watched and I was worried about the kids. We couldn't go to town, because we'd have to walk to town and we'd get harassed, so we stuck to ourselves.*

295. Similarly, Dawn Smith's statement of 9 November 2023 was as follows:

> There were a lot of racist white people in town in the 80s, so we would keep to ourselves. The Aboriginal people all lived on one end of town, near The Reserve and Adelaide St, and the white people all lived up the other end. I never had many non- Aboriginal friends back in those days. The white people would look down at us at the pub and in the shops. The store keepers would follow us around as if we were going to steal off them.

296. Kerrie Smith, Cindy's sister, stated the following (in her statement of 6 November 2023):

> I remember there were a lot of police in Bourke in the 80s. They used to come down and drive around the reserve and when we saw them we would run and hide. It was like everyone was frightened of them. If we were in trouble, we wouldn't call the police. We would just try to sort it out ourselves.

297. On 1 December 2023, Carl Smith, cousin of Mona and Cindy, gave evidence about an incident in which he went to Bourke Police Station to seek police assistance in relation to a male holding a gun. He explained:

> *I was drunk and I went to the police station and I told them that there was a man up the road with a gun, was supposed to be at their party and then, because I was drunk, they just – they just laughed at me.*

298. At the hearing, evidence was also received from the officers working at Bourke Police Station in the 1980s.

299. On 30 November 2023, Mr Vaughan Reid told the Court that he worked as a Detective Sergeant of Police in the Bourke region from about June 1983 until the end of 1990. While in Bourke, Mr Reid was aware of tensions between parts of the Aboriginal community and some police. There was this exchange with Senior Counsel Assisting:

> *Q. Did you hear at those meetings anybody talk about not feeling protected by police, so a perception that they weren't treated as fairly or the same as white people were?*
>
> *A. Yes, that was the general - yeah, yep, I got that impression. There was one instance I forgot about until you say now, rather than sort of let things get out of hand, if I could say that, late at night at the hotels, we would go to the hotels early in the day, early in the evening and talk to people and get to know them before the trouble started so that when the cops turned up later on - if they had to - a lot of the people already knew those cops and had some level of trust. A few police began to take people home in the trucks and there was one though, one occasion where an older Aboriginal man - other Aboriginal people were trying to encourage him into the back of the truck to take him home and the story came out from him, he didn't trust the cops. As far as he was concerned, every time he got put in the back of the truck, he was taken somewhere and bashed and that's why he was reluctant to - anyway, eventually he did get in the truck and he was taken home, but yeah, that was there, of course it was.*

300. Mr Reid was also questioned about an incident involving the actions of police at an event in 1989 where two officers mocked the tragic deaths of Lloyd Boney and David Gundy by attending a function with their faces painted black and wearing a noose. Of this incident, Mr Reid stated (emphasis added):

> I knew the two young fellows who were involved in that. I spoke to them about it after it all came out. I mean, it was just an act of stupidity and I took the view - from what they said at the time - it was just - **it was certainly absolutely stupid but it wasn't necessarily a racist thing**

to do. They were just at a function, it was a spur of the moment thing, maybe a bit too much alcohol involved, but I don't believe either of those two boys were actually racist, just stupid.

301. On 28 November 2023, Mr Christopher Clarke gave evidence of his time as a Constable of Police in Bourke from 1985-1988 which included the following:

> *Q. It would have been the case that within the Bourke Police Station there were some police officers with a negative attitude towards Aboriginal people?*
>
> *A. I would agree with that, yes. I would agree that across the board there was dislike among the non-Aboriginal and Aboriginal communities towards both parties. You know, it's - it's - it's - I would be a fool to sit here and say that, "No, that didn't - that didn't happen."*

302. Other witnesses gave evidence about their experience in the NSW Police Force in Bourke in the 1980s, including as to the use of racist language by some police during that period.

303. For example, Mr Clarke gave evidence that he had heard some police officers use racist language when he was working in Bourke. Mr Ehsman also told the Court that: "I probably have heard racist language used by police and members of the community, at different times." This is despite his earlier evidence on 29 November 2023 when Mr Ehsman denied ever hearing police officers use racist language in the Bourke region. Mr McKenzie provided a statement which noted that "It was common terminology to refer to Aboriginal persons as Abos, Boongs, Black Fellas and Darkies. I can't escape being guilty of talking in this manner when in their company."

304. As to the aftermath of the girls' death, Constable Harper's evidence was that he attended the accident scene with Constable McKenzie because:

> ... we must have been told that there was two Aboriginal girls that had been killed, because that was part of the reason I went, because I didn't want to get down there, and then I've had the scenario before where this sort of thing, where Aboriginal people have been injured, and then everybody finds out about it, and everybody swarms it, or swarms the scene, and I just didn't want 20 or 30 Aboriginal people there, upset, and Ken have to deal with it by himself.

305. As set out at [88] above, Mr Ehsman's evidence was that he accepted Mr Grant's account that Mona was driving a manual utility at speed, at face value

without any doubt on the basis that "it wouldn't be unusual for young kids, unlicensed drivers to be driving cars. There's nothing unusual about that." On that basis, Mr Ehsman did not consider it relevant to obtain any evidence from Mona's family as to her driving experience.

306. As to the manner in which Mr Ehsman liaised with the families of Mona and Cindy, he gave evidence that one or two days after their passing:

> We arranged a meeting at the Bourke Police Station in the Court yard and all the families, about 20 people came up and we discussed it or we told them what stage the investigation was going. We told them what was going on, what happened.

307. Mr Ehsman later gave further evidence about the meeting on 19 December 2023 in these terms:

> Q So, the mothers, June and Dawn, said no Aboriginal liaison officer. So, whether it was Trevor Demery or one of the other ones, no Aboriginal liaison officer came to see them about this supposed meeting that happened in the courtyard. Let me ask you the next question just to follow up what you were saying. Did you see June and Dawn, the mothers of Mona and Cindy, at the meeting you say occurred in the courtyard?
>
> A. First of all, it's not a supposed meeting; it was a meeting. But I don't recall seeing the two mothers there. I have no memory of specific people there, but there was 20 people there.
>
> Q. Did you see any of the other immediate family of Mona and Cindy at the community meeting that you say you explained--
>
> A. Well, you've got to appreciate I'd only been to Bourke a short time and I didn't know the family, the family members. So, I don't recall seeing who was there but there was a lot of people there. [6]
>
> ...
>
> Q. So, what makes you think that an Aboriginal liaison officer went to speak to June and Dawn and the family of Mona and Cindy? What gives you that idea that that happened, if you don't remember whether you requested that to happen?
>
> A. Well, that was the standard procedure to get Ted or the other liaison officer to go and talk to the community, and tell them what was going on.
>
> Q. You don't have a memory of that happening? You just assumed that would've happened, is that right?
>
> A. Yes, someone rounded them up and brought them all up.

[6] T 19 December 23 at p43

Q. Someone rounded them up?

A. (No verbal reply).

Q. Yet, if you're talking about Auntie June and Auntie Dawn, the mothers of Mona and Cindy, did someone actually inform them that you were hosting a community meeting to explain the status of the investigation in relation to their daughters' deaths?

A. Somebody did.

Q. You don't know who that somebody was?

A. I don't know.

Q. You don't know if they delivered the message?

A. Well, they must've cause 20 people turned up.

Q. June and Dawn weren't there, so--

A. I don't know.

Q. Wouldn't you have ascertained if this was an important meeting and two children have just died, wouldn't you ascertain whether the mothers and parents were there at this community meeting where you explained everything?

A. I thought they were there. But if they say they weren't, they weren't.

308. Statements from Dawn Smith and June Smith were received into evidence clearly stating that they were unaware that such a meeting had occurred, and that they certainly did not attend any such meeting.

Submissions

309. In relation to this issue, Senior Counsel Assisting submitted as follows:

a. There was racism in the police force at the time. This was clear from the evidence of Mr McKenzie concerning the use of racist language by some police officers. Similarly, Mr Ehsman accepted that he was aware of police using racist language when he gave evidence on 19 December 2023. The incident following the deaths of Lloyd Boney and David Gundy also attested to the attitudes within the police force at the time;

b. As to examples of bias (subconscious or otherwise) in relation to the treatment of the family, the best example was the failure to meet with Mona and Cindy's family after the vehicle crash to obtain statements as to whether or not the girls were capable of driving. An assumption was made that they were teenage girls capable of driving a vehicle. That was completely inappropriate. A further example was the "completely lacklustre investigation of the charge of interfering with a corpse". Although the evidenced established that both Detectives Ehsman and Reid believed Mr Grant to have done something untoward in relation to Cindy's body, there was very limited investigation of that charge.

310. Ms Buxton of Counsel, on behalf of the Smith families, also submitted that there was evidence of systemic racism or cultural bias playing a role in at least some aspects of the police investigation having regard to the following:

a. Mona and Cindy's families have consistently maintained that they felt "incredibly discriminated against. They continue to feel that the investigation, the original investigation and the way they were treated by the police was different because they were Aboriginal. They felt less important. They felt that Mona and Cindy's lives were treated by the police as less important than the lives of white children."

b. There were important failings in the investigation, including in relation to the fact that police did not inform the families of Mona's and Cindy's deaths and that they did not speak to them about Mona's lack of driving experience.

c. The evidence of Mr Ehsman in relation to the community meeting to update the families about the status of the investigation was disturbing. Mr Ehsman could not say with certainty whether June and Dawn were personally invited to the meeting. Further, the manner in which he described the family's invitation was hurtful, stating that "he asked the Aboriginal liaison officer to go and *round them up*."

d. Similarly, Constable Harper's evidence was that the primary reason that he attended the accident scene was to keep the peace. Constable Harper said:

> the main aim was to go down there, and assist Constable McKenzie, being the fact that it must have, we must have been told that there was two Aboriginal girls that had been killed, because that was part of the reason I went, because I didn't want to get down there, and then I've had the scenario before where this sort of thing, where Aboriginal people have been injured, and then everybody finds out about it, and everybody swarms it, or swarms the scene, and I just didn't want 20 or 30 Aboriginal people there, upset, and Ken have to deal with it by himself.

e. Further, Mr Reid's response that the officers involved in the incident following the deaths of Mr Gundy and Mr Boney had committed "an act of stupidity .. it was certainly absolutely stupid but it wasn't necessarily a racist thing to do." is important contextual evidence about the prevailing attitudes at the time.

311. Ms Melis of Counsel, on behalf of the Commissioner of Police, submitted that there was no evidence of systemic racism or cultural bias in the original investigation. She noted the following matters:

a. The derogatory words in the brief of evidence emanated only from a civilian witness and Mr Grant himself.

b. The failure of investigators to meet with the family was just that, a failure only. While there should have been a meeting, there is no evidence demonstrating bias, unconscious or otherwise, in the conduct of the investigation.

c. Bias cannot be established on the basis that Mr Grant was not originally charged with interfering with Cindy. The evidence on why that charge was not originally pursued is far from clear, especially in circumstances when police requested swabs be taken and analysed during the post-mortem.

d. It was conceded that the original investigation was deficient but there was a lack of exact and cogent evidence to base any finding of systemic racism or cultural bias on the *Briginshaw* standard.

e. There was persuasive evidence from a number of officers who worked in Bourke about their positive interactions with the Aboriginal community.

This included the evidence of Mr Harper that he worked with Aboriginal Community Liaison Officers (**ACLOs**) in Dubbo and Bourke. Mr Clarke also gave positive evidence about working with the ACLOs.

f. Mr Clarke was very passionate about his views that he did not and does not care what colour a person is – rather, he investigated crime regardless of race.

g. Ms Linda Edwards was an ACLO at the time. She recalls that the other ACLOs (Mr Demery and Mr Sullivan) went to the hospital to assist with the identification process. She was not involved in the delivery of the death message but believes Mr Demery and Mr Sullivan were. Ms Edwards was heavily involved in supporting the family and ensuring they had counselling. She says she liaised with local inter-agencies who offered support services. She says that she did attend the family homes regularly to support and was also regularly contacted through the phone.

h. Mr Kelvin Brennan, the ambulance officer gave evidence that he never witnessed police acting racist or being derogatory with anyone.

i. Mr Vaughn Reid told the Court that it was his first time working with Aboriginal people when he came to Bourke. He described proactive policing, with police going to the pubs early in the day to build trust and taking people home.

FINDINGS – SECTION E

312. I accept entirely, the evidence of Professor Cunneen as to the significant tensions between the Aboriginal community and law enforcement in the 1980s, and which had become acute by 1987, given the events in 1986 in the Bourke and Brewarrina region, as outlined in the Cunneen Report.

313. I accept the submissions of both Senior Counsel Assisting and also Ms Buxton on behalf of the Smith families as to the existence of racial bias within the NSW Police Force at the relevant time, and that it did in fact impact upon the investigation into the deaths of Mona and Cindy.

314. In fact, I have little hesitation in doing so, having regard to the following matters which I place within the context outlined in the Cunneen Report :

a. *First,* the sheer *extent* of the failings in the police investigation, being the worst investigation that Mr Godkin had ever seen (of over 500);

b. *Secondly,* I place great weight on the evidence of June and Dawn as to their lived experience of their treatment in the aftermath of the girls' deaths, and the numerous distressing failings they endured, which started with the manner in which they became aware of the girls' deaths from other family members, rather than being formally advised by police;

c. *Thirdly,* even in giving evidence before the inquest in 2023, there was some unfortunate phraseology used by certain witnesses (as adverted to by Ms Buxton), such as the suggestion of "rounding up" the family, which was revelatory of at least sub-conscious bias;

d. *Fourthly,* and similarly, the lack of appreciation by former police as to the nature of the deeply offensive mocking of the deaths of Lloyd Boney and David Gundy by police, downplaying such conduct as an "act of stupidity" rather than racism speaks to the existence of casual racism within the police force at the relevant time;

e. *Finally*, Mr Ehsman's evidence simply cannot be understood without imputing a level of unconscious bias on his part. I have outlined Mr Ehsman's concession that he accepted without question Mr Grant's account that Mona was the driver, an *assumption* made based on his apparent views about teenage Aboriginal girls being able to drive a manual vehicle. This was most troubling, given his appreciation that Mr Grant was being untruthful in relation to other matters (such as the issue of sexual interference with Cindy).

315. The uncomfortable truth, to my mind, is that had two white teenage girls died in the same circumstances, I cannot conceive of there being such a manifestly deficient police investigation into the circumstances of their deaths.

316. It is very plain, however, that there was a paucity of indigenous cultural training available to officers within the NSW Police Force at the relevant time; moreover,

the unconscious racial bias outlined above was simply representative of the ill-informed, and frankly racist social views of many within the Australian community at the relevant time.

317. I certainly accept that there has been significant improvement in the relationship as between police and the Aboriginal community in the Bourke township since this period. Ultimately, however, and notwithstanding the commendable progress and reform since the time of Mona and Cindy's deaths, the centrality of this issue informs Recommendation 2, as set out at [340] below.

F. RECOMMENDATIONS (ISSUE 5)

318. The power to make recommendations connected with a death under s 82 of the Act derives from the Coroner's death prevention role and function in identifying systemic deficiencies or failings within organisations or agencies, and relatedly, proposing reform measures for the broader public benefit.

319. In this section, I note two proposed recommendations to the Commissioner of the New South Wales Police, which arise from the evidence received during this inquest.

320. I otherwise deal with the helpful submissions of the parties (in particular, those received from NJP on behalf of the families of Mona and Cindy) as to proposed recommendations.

Recommendation 1 – development of guidelines for a review of investigations by the NSW Police Force where there is an application for a fresh or further inquest

321. As noted at [18], on 14 July 2022, I directed that the inquest into the deaths of Mona and Cindy resume following an application on behalf of Mona and Cindy's families requesting this course.

322. Importantly, this was not the first request by the families for a re-investigation of the deaths.

323. Given the deficiencies in the initial police investigation which have not been catalogued or acknowledged until this inquest, the perseverance and strength of the Smith families in pursuing justice in the form of answers and a thorough investigation (albeit many years too late) cannot be overstated.

324. The failings identified regarding the police investigation in the correspondence from February 1990 after the acquittal of Mr Grant were absolutely accurate. The families' concerns have been squarely vindicated by the evidence received during this inquest.

325. I find it somewhat troubling that these issues were not formally acknowledged by the Commissioner until certain concessions were made in closing submissions on 20 December 2023.

326. The chronology of concerns raised by Mona and Cindy's families warrants detailing.

327. *First,* in response to the issued raised in the aftermath of the acquittal, in March 1990, "preliminary enquiries" were undertaken by Detective Sergeant Hapgood, and recorded in a brief (four-page) note. That note touched on some issues concerning the investigation but referred to a misunderstanding "caused by an apparent lack of communication between some police and the aggrieved parties" and ultimately referred to a "satisfactory conciliation" of the issues raised in the complaint. It seems plain that the "preliminary enquiries" conducted by Detective Habgood did not substantively investigate the concerns raised about the police investigation, and these concerns were effectively summarily dismissed.

328. *Secondly,* I have outlined at [200] above, the actions taken by DSC Butcher in 2004 concerning information provided by the Smith families to the NSW Police Force and the limited investigations that followed. By statement dated 26 April 2023, DSC Butcher was very clear that the steps taken by him in 2004 were not a "reopening" nor "review" of the 1987 brief of evidence or investigation; instead, he was tasked to investigate the new information. If necessary, he would have undertaken a "full review" of the brief and investigation from 1987.

329. *Thirdly,* on 18 December 2018, the NJP, on behalf of the families requested that the Attorney General direct an inquest into Mona and Cindy's deaths. That request was based on the limited information then available to the families regarding the girls' deaths.

330. On 29 May 2019, Detective Sergeant Magnus and Detective Sergeant Quilter met with the family, together with NJP. The police report relating to this meeting stated that: "The family asked a number of questions which were answered taking into account all known facts. The family appeared happy with the meeting …". The report concluded that "No further investigation is contemplated. It is to be noted that GRANT has since died (of natural causes - in 2017)."

331. On 2 March 2020, then Commissioner Fuller sent a letter responding to correspondence from the then AG (Mr Speakman SC). Commissioner Fuller stated:

> The brief of evidence has been subject to thorough independent reviews in 2004 and in 2018. Both reviews found that an adequate investigation was conducted with the available evidence and technology at the time. This was supported by findings from the Department of Forensic Medicine in relation to the cause of death of both girls.
>
> I note that the accused Alexander Ian Grant (born 22 September 1947) was discharged by a jury and is now deceased. All police involved in the original investigation are now discharged and further investigation is not planned by police.
>
> It is for these reasons that I do not believe an inquest into the deaths of Jacinta and Mona Lisa Smith will adduce new or additional information,

332. On 2 September 2021, a further letter was sent from George Newhouse, NJP to the Attorney General requesting that an inquest be directed.

333. By letter dated 7 March 2022, the Attorney General advised that he had decided not to direct a coronial inquest as "a further coronial inquest would not be capable of finding any new information not already known, or of providing any meaningful information or closure for Mona or Cindy's families."

334. This conclusion is seemingly based on the perfunctory and piecemeal reviews conducted by police over the years, apparently based on limited information considered at the relevant times.

335. The submissions on behalf of Counsel Assisting and the Smith families sought a recommendation to the NSW Police Force directed towards ensuring that future reviews are conducted in an appropriately thorough and uniform manner.

336. The following recommendation was proposed by Counsel Assisting:

> *That the Commissioner of the NSW Police Force develop guidelines for the review of investigations relating to deaths that are the subject of a request for advice from the NSW Attorney General to the Commissioner of the NSW Police Force, where the Attorney General is considering an application for the holding of a fresh or further inquest into the death/s. Such guidelines should include:*
>
> *a) the methodology of the review;*
>
> *b) transparency of the review process;*
>
> *c) the involvement of any experts (including independent experts as required); and*
>
> *d) consultation with the family of the deceased.*
>
> *In formulating the guidelines, the standard operating procedures applicable to the review of homicide investigations should be considered and applied as appropriate.*

337. Following very constructive engagement with the legal representatives acting for the Commissioner, it is understood that the Commissioner does not oppose a recommendation in these terms.

338. Having regard to the evidence and given my concern regarding the then Commissioner's reference to "thorough and independent reviews" (in a letter to the then Attorney General in 2020), I consider the proposed recommendation both necessary and desirable.

Recommendation 2 – Training in cultural competence

339. The evidence in the inquest touched upon the nature of cultural competency training extant in the New South Wales Police Force in the late 1980s.

340. Mr Ehsman told the Court that he did not receive any training or teaching in relation to the history of Aboriginal people in Bourke in the 1980s.

341. Similarly, Mr Clarke gave the following evidence:

> Q. During any of the period of time when you were in Bourke in the 1980s, was there anything like cultural training?
>
> A. No. At the time of each officer coming into the command, there was - there was a - advice and guidance given in relation to the fact that Bourke was an unusual location in relation to the split between indigenous and non-indigenous. I believe the community was approximately 50/50, at

that 20 stage, and that was something that was - that was instilled in - in us, as we accepted our transfers there.

342. Submissions were made by NJP on behalf of the Smith families as to a recommendation directed towards the introduction of mandatory cultural competency training. The formulation of the proposed recommendation was very broad, and in its terms, extended beyond the evidence received in this inquest.[7]

343. The underlying concern informing the submissions on behalf of the Smith families are well justified given their experience of policing in relation to the death of their loved ones. It is absolutely plain that during the initial police investigation, Mona and Cindy's families were not dealt with in a respectful or appropriate manner; nor was there any apparent appreciation of the attendant cultural sensitivities.

344. In response to the proposed recommendation, on 4 April 2024, those assisting me sent correspondence to the legal representatives for the Commissioner seeking a response to a more targeted recommendation directed to the Commissioner relating to cultural training. The recommendation proposed was in these terms:

> *That the NSW Police Force review their training in relation to the history of First Nations Peoples to ensure that it is as comprehensive as possible in relation to the history of colonisation and the ongoing impact of colonisation on First Nations peoples today. Where possible, Aboriginal Liaison officers should be engaged in delivering ongoing training for Police.*

345. The Commissioner provided a comprehensive statement dated 21 April 2024 from Inspector Jade Symons, Aboriginal Strategy & Coordination Team, Crime

---

[7] The proposed formulation was in these terms:

> *Mandatory, First Nations-led, anti-racism and cultural competency education and training should be developed and implemented for police, oversight bodies and government agencies within the justice system and the professional conduct and accountability system.*
>
> *This includes all Integrity Agencies ('IA'), State/Territory corruption and complaints bodies, professional complaints bodies and Coroner's courts that engage with First Nations people.*
>
> *Education and training must be provided on an ongoing basis.*

Prevention Command. That statement provided a helpful outline of the current initiatives undertaken by the New South Wales Police Force to strengthen the communication links between First Nations people and local police, and to seek to provide officers in various regions, with training and awareness of Aboriginal cultural perspective.

346. Amongst other matters, the statement emphasized the Aboriginal Community Liaison Officer (ACLO) Program; detailed the Aboriginal Strategic Direction (ASD), a working document which outlines NSWPF's plan to strengthen relationships with and support the Aboriginal and Torres Islander communities within NSW. It also detailed programs and positions administered under the ADS (2024), which includes in the Western Region, 26 ACLOs and six Aboriginal Engagement Officers (being Inspectors with local responsibility for engagement with Aboriginal Communities).

347. The statement of Inspector Symonds also set out the cultural awareness packages operative within the NSWPF, including the Central North Police District (which includes the Bourke and Brewarrina regions).

348. Ultimately, having regard to this evidence, I have formed the view (including because the matter was not further explored during the inquest), that the recommendation that I had contemplated is not necessary or desirable.

349. However, I underscore the importance of the Cunneen Report for the purposes of officers "on the ground" in the Bourke and Brewarrina region, given the critical historical and cultural background that report sets out.

350. I would hope that those representing the Commissioner, and indeed, Inspector Symonds, would review that report for the purposes of incorporating its key content into local training material.

Suggested recommendation as to mechanism for the resumption of inquests

351. A number of parties lamented the delay in the resumption of the inquest proceedings (noting that it would have been highly desirable for the proceedings to have resumed immediately after the criminal proceedings had finalised).

352. In this respect, counsel for the Smith families submitted:

> It should not be incumbent on the family of a deceased person/s to agitate for the resumption of an inquest where it is required to occur.
>
> We hope to see the establishment of a clear mechanism at the Coroner's Court to trigger the timely review and resumption of inquests that are paused due to the criminal prosecution of an alleged perpetrator, as occurred in the case of Mona and Cindy.

353. I can well appreciate the sentiment underlying this submission.

354. However, as State Coroner with clear visibility as to the processes and procedures of the Coroner's Court, I am well satisfied that there now exist clear and efficient mechanisms in place to ensure the timely review and resumption of inquests after the finalisation of criminal proceedings, where appropriate.

355. Accordingly, I do not consider that a recommendation as proposed is necessary.

Suggested recommendation as to proposed legislative reform of s 81, Crimes Act 1900

356. Ms Buxton and NJP on behalf of Cindy's family proposed legislative reform and review of s 81 of the *Crimes Act 1900* (NSW), noting the evidence that indicated Cindy was sexually interfered with, but that the perpetrator escaped justice "due to a loophole such as time of death".

357. The powerful submission was in these terms:

> We recommend legislative reform to the Crimes Act to ensure that alleged perpetrators of s 81C of the Crimes Act 1900 (NSW) 'Misconduct with regard to corpses' and of s 61I of the Crimes Act 1900 (NSW) 'Sexual assault' cannot escape prosecution because the precise time of a victim's death cannot be ascertained with sufficient precision to determine whether they were alive or dead at the time that sexual interference occurred.
>
> We understand that this may be outside of her Honour's domain but we raise it for the record as this is an important and devastating aspect of Cindy's tragic passing and the subsequent no-billing of the interference charge by the DPP. This issue is directly linked to the issues at hand, given the evidence demonstrates that if timely evidence was gathered from first responders and witnesses, time of death would have likely been ascertained and, if so, the DPP would likely not have 'no-billed' the charge.

358. As was appropriately acknowledged, a recommendation of this nature is outside the scope of this inquest, and indeed, beyond the power conferred by s 82 of the Act.

359. However, I propose to send correspondence to the Attorney General to draw this issue to his attention for the purposes of consideration as to whether legislative reform may be warranted, noting the very distressing circumstances concerning Cindy's death.

G. FINDINGS REQUIRED BY SECTION 81(1) OF THE ACT

360. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the deaths occurred and make the following findings in relation to them.

361. In relation to Mona Lisa Smith, I find the following:

a. *Identity of the deceased:* the person who died was Mona Lisa Smith.

b. *Date of death:* Mona died on or around the early hours of Sunday, 6 December 1987.

c. *Place of death:* Mona died on the Mitchell Highway, 34 kilometres south of Enngonia.

d. *Manner of death:* Mona died in a single-vehicle collision when a Toyota utility 4WD vehicle driven by Mr Alexander Grant was involved in a roll-over accident, in which contributing factors were intoxication, fatigue, road speed and the lack of lighting.

e. *Cause of death:* Mona died from multiple internal injuries (including head and lung injuries) sustained in the accident, leading to extensive blood loss

362. In relation to Jacinta Rose Smith, I find the following:

a. *Identity of the deceased:* the person who died was Jacinta Rose Smith (**Cindy**).

b. *Date of death:* Cindy died on or around the early hours of Sunday, 6 December 1987.

c. *Place of death:* Cindy died on the Mitchell Highway, 34 kilometres south of Enngonia.

d. *Manner of death:* Cindy died in a single-vehicle collision when a Toyota utility 4WD vehicle driven by Mr Alexander Grant was involved in a roll-over accident, in which contributing factors were intoxication, fatigue, road speed and the lack of lighting.

e. *Cause of death:* Cindy died from multiple internal injuries (including pelvic and lung injuries) sustained in the accident, leading to extensive blood loss.

H. CONCLUSION

363. I wish to thank all of the legal representatives for the sufficient interest parties. The constructive approach to the inquest was very much appreciated.

364. I have also observed the impact of these proceedings on all those who were at the Bar Table, as well as the lawyers and support persons in the body of the Court. It is clear to me that everyone has been affected by the circumstances of this inquest.

365. I would like to thank my counsel assisting team, including in particular, Elizabeth Trovato, Principal Solicitor, Jessica Best, Senior Solicitor, Laura Carter, Graduate Solicitor whose exceptional work warrants acknowledgment, together with the excellent assistance provided by my counsel Dr Peggy Dwyer SC and Emma Sullivan.

366. I would also like to thank and commend Detective Inspector Paul Quigg for his extremely diligent and thorough coronial investigation.

367. I also note my appreciation for Ms Nicolle Lowe in providing her superb assistance, and cultural expertise both throughout the coronial investigation, and during the inquest hearing in Bourke.

368. My final words of thanks and praise go to Mona and Cindy's family. Without their tireless advocacy, it is doubtful that this inquest would have been re-opened.

369. I will conclude by again expressing my sincere condolences to those who knew and loved Mona and Cindy and I also express my thanks to them for participating in this process and for sharing their memories of their loved ones.

370. I close this inquest.

Magistrate Teresa O'Sullivan

NSW State Coroner

23 April 2024