New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of Beanika Goak, Adut Mathang & Ros Alak Kuol Mawin
Hearing dates:	21 to 23 September 2020; 11 & 13 May 2026
Date of Findings:	12 June 2026
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Judge Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – New South Wales Police Force Safe Driving Policy, police pursuit, identity of driver
File numbers:	2016/0056558; 2016/00056536; 2016/00056518
Representation:	Mr T Hammond, Counsel Assisting, instructed by Ms R Campbell (Crown Solicitor's Office) Mr D Hanna for Mr J Wol, instructed by Mr N Bechara (Gerard Malouf & Partners Law) Mr R Hood for the Commissioner, New South Wales Police Force, instructed by Mr S Robinson (New South Wales Police Force Office of the General Counsel)

Findings:

In relation to the Inquest into the death of Beanika Goak:

Beanika Goak died on 20 February 2016 at Marayong NSW 2148.

The cause of Ms Goak's death was multiple blunt force injuries.

Ms Goak was a passenger in a vehicle which was travelling at high speed when it lost control, impacted with a power pole and overturned sustaining catastrophic damage. Shortly prior to the collision the driver of the vehicle had ignored a direction from New South Wales Police Force officers, in the lawful execution of their duties, to pull over and stop. The vehicle instead accelerated away at speed resulting in a brief pursuit, which complied with applicable New South Wales Police Force policies, prior to the collision.

In relation to the Inquest into the death of Adut Mathang:

Adut Mathang died on 20 February 2016 at Westmead Hospital, Westmead NSW 2716.

The cause of Ms Mathang's death was multiple blunt force injuries.

Ms Mathang was a passenger in a vehicle which was travelling at high speed when it lost control, impacted with a power pole and overturned sustaining catastrophic damage. Shortly prior to the collision the driver of the vehicle had ignored a direction from New South Wales Police Force officers, in the lawful execution of their duties, to pull over and stop. The vehicle instead accelerated away at speed resulting in a brief pursuit, which complied with applicable New South Wales Police Force policies, prior to the collision.

In relation to the Inquest into the death of Ros Alak Kuol Mawin:

Ros Alak Kuol Mawin died on 20 February 2016 at Marayong NSW 2148.

The cause of Ms Mawin's death was multiple blunt force injuries.

Ms Mawin was a passenger in a vehicle which was travelling at high speed when it lost control, impacted with a power pole and overturned sustaining catastrophic damage. Shortly prior to the

collision the driver of the vehicle had ignored a direction from New South Wales Police Force officers, in the lawful execution of their duties, to pull over and stop. The vehicle instead accelerated away at speed resulting in a brief pursuit, which complied with applicable New South Wales Police Force policies, prior to the collision.

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1. Introduction

1.1 In the early hours of the morning on 20 February 2016, four women, Ros Mawin, Beanika Goak, Adut Mathang, and Asunta Jongkir, and one man, John Wol, left a residence in Marayong in a car. The group travelled towards Marayong station. At around 1:15am, two New South Wales Police Force (**NSWPF**) officers travelling in a marked NSWPF vehicle saw the car with no headlights on driving very slowly along a street near Marayong station.

1.2 The NSWPF officers decided to perform a random breath test and activated the warning devices on the NSWPF vehicle indicating for the car to pull over and stop. The car did not do so and instead accelerated away in a northerly direction.

1.3 The NSWPF officers began pursuing the car. Within seconds the car lost control, began to fishtail and collided with a power pole. The car sustained extensive damage from the impact and Ms Mawin, Ms Goak and Ms Mathang all sustained catastrophic injuries. The other woman and man in the car also sustained injuries.

1.4 Emergency medical services were contacted but Ms Mawin, Ms Goak and Ms Mathang were all later tragically pronounced deceased.

2. Why was an inquest held?

2.1 Pursuant to the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 Certain deaths are reportable to a Coroner. Some examples of reportable deaths are where the cause of a person's death is not due to natural causes, or where the cause or manner of a person's death may not immediately be known. In these cases, concurrent inquests were held to examine the manner of the deaths or, in other words, the circumstances leading up to the deaths of Ms Goak, Ms Mathang and Ms Mawin. Relevantly, these circumstances involved the period of time between when the car they were travelling in was first seen by the NSWPF officers and the collision itself.

2.3 The inquest therefore sought to independently examine the conduct of the NSWPF officers in the discharge of their duties and exercising the lawful powers available to them. Doing so serves a number of purposes, including ensuring that such powers are exercised appropriately and responsibly, and providing reassurance to the community.

2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the coronial jurisdiction and inquest process into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will wish to attempt to cope with the consequences of such a traumatic event in private. The sense of loss experienced by family members does not diminish significantly over time. Therefore, it should be acknowledged that both the

coronial process and an inquest by their very nature unfortunately compel a family to re-live distressing memories and to do so in a public forum.

2.5 In the case of Ms Goak, Ms Mathang and Ms Mawin the time taken for the coronial process to unfold and be finalised has been unusually lengthy. It is acknowledged that this period of time has compounded the grief and loss that the families of Ms Goak, Ms Mathang and Ms Mawin have already experienced.

3. The lives of Ms Goak, Ms Mathang and Ms Mawin

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. It is hoped that what is set out briefly below acknowledges the lives of Ms Mawin, Ms Goak and Ms Mathang in a meaningful way.

3.2 Ms Mawin previously lived in Sudan before fleeing due to conflict in that country. She later moved to Egypt. In 2006, Ms Mawin moved to Australia with her family. She had five children and one grandchild at the time of her death. Those closest to Ms Mawin describe her as a loving and caring person who put the needs of others above her own, and who helped others when she could.

3.3 Ms Goak was also originally from Sudan. She later moved to Australia and lived in Victoria. She was the mother of eight children. Those closest to Ms Goak describe her as a loving and kind person.

3.4 Ms Mathang also previously lived in Sudan and Egypt before moving to Australia. She was the eldest of three siblings and had family members throughout Australia.

3.5 There is no doubt that Ms Mawin, Ms Goak and Ms Mathang are all greatly missed by their families, loved ones and friends.

4. The events of 19 and 20 February 2016

4.1 On 19 February 2016, Ms Goak and Ms Mathang travelled from Victoria to Sydney to visit family and friends. During the afternoon and evening, Ms Goak and Ms Mathang gathered at Ms Mawin's house with other members of the local South Sudanese community. Ms Jongkor had been staying at Ms Mawin's house and was also present at the gathering.

4.2 There were about nine adults in total present at Ms Mawin's house. One of them was Mr Wol who was a friend of Ms Mawin's and also knew Ms Goak, Ms Mathang and Ms Jongkor. Mr Wol had driven his Holden Commodore (**Commodore**) to the gathering.

4.3 A substantial amount of alcohol was consumed by most of the adults present. At some stage, Ms Jongkor and another woman left to buy more alcohol.

4.4 Shortly after midnight, Mr Wol complained of an injury to his shoulder. It was decided that Mr Wol would attend hospital. Ms Goak, Ms Mathang, Ms Mawin and Ms Jongkor all got into the Commodore with Mr Wol. The seating positions of each of the occupants is discussed in more detail later.

4.5 After leaving Ms Mawin's house, the Commodore travelled to the vicinity of Marayong station where it was seen by Constable[1] Kaan Sengoz and Senior Constable Bradley Davis at the corner of Cobham Street and Vardys Road. The Commodore was driving very slowly with no headlights on. The two NSWPF officers were in a fully marked NSWPF vehicle, callsign QH36, with Constable Sengoz driving.

4.6 Whilst on Vardys Road, Constable Sengoz activated the warning lights on QH36 to indicate for the Commodore to stop so that a random breath test could be performed. The location was near the Brewhouse, a licensed premises which closed at around 1:00am, and Constable Sengoz suspected that the occupants of the Commodore had attended the Brewhouse.

4.7 The Commodore kept travelling at a speed of around 40 kilometres per hour. Constable Sengoz activated the horn on QH36, and later the siren, to signal to the Commodore to stop but it did not do so. Instead, the Commodore travelled on to Quakers Road and then Railway Road where it accelerated away in a northerly direction along Railway Road.

4.8 Constable Sengoz followed after the Commodore and told Senior Constable Davis to call a pursuit. QH36 was travelling at around 80 kilometres per hour but the Commodore was increasing the distance between the two vehicles.

4.9 Almost immediately after the pursuit was called, the Commodore lost control, began to fishtail and impacted with a power pole at the intersection of Shedworth Street and Railway Parade. The force of the impact caused the rear section of the Commodore to almost entirely separate from the front section before it came to rest in the yard of a residential property.

4.10 The Commodore was heavily damaged with the front section twisting and coming to rest on its roof. Ms Mawin, Ms Goak and Ms Mathang all sustained catastrophic injuries. Ms Jongkor and Mr Wol both suffered less serious injuries.

4.11 Emergency medical services were contacted and New South Wales Ambulance (**NSWA**) paramedics attended promptly. Ms Mawin and Ms Goak could not be revived and were later pronounced life extinct at the scene. Ms Mathang was taken by ambulance to Westmead Hospital where she also could not be revived and was later pronounced life extinct.

4.12 A NSWPF Assistant Commissioner and Region Commander subsequently declared the matter to be a Critical Incident. Detective Superintendent Grant Healey was appointed as the Senior Critical Incident Investigator.

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[1] For clarity and convenience, the ranks of the New South Wales Police Force officers as at February 2016 have been used in these findings. No disrespect is of course intended to any officer who now holds a different rank.

5. The post-mortem examinations

5.1 On 23 February 2016, Dr Rebecca Irvine, forensic pathologist, performed post-mortem examinations of Ms Mawin, Ms Goak and Ms Mathang at Forensic Medicine Sydney.

5.2 The significant findings from the examination of Ms Mawin can be summarised as follows:

(a) subarachnoid haemorrhage;

(b) fractures of the upper and lower jaw, maxilla, ribs, left femur and distal lower leg;

(c) traumatic amputation of the left mid forearm;

(d) degloving and crush injury and multiple pulped lacerations of the left knee, left lower leg and medial right lower leg;

(e) laceration of the left lower lobe of lung and moderate left pneumothorax;

(f) toxicological analysis of post-mortem blood detected the presence of cannabinoids with no alcohol detected.

5.3 In the post-mortem examination report dated 31 October 2016, Dr Irvine opined that the cause of Ms Mawin's death was multiple blunt force injuries.

5.4 The significant findings from the examination of Ms Goak can be summarised as follows:

(a) subarachnoid haemorrhage;

(b) possible undisplaced fracture of the left temporal bone of the skull, fracture of the 2nd cervical vertebra and possible end plate fractures of the thoracic vertebra;

(c) large laceration on the left side of the neck with multiple abrasions; and

(d) toxicological analysis of post-mortem blood detected a blood alcohol level of 0.246 g/100mL.

5.5 In the post-mortem examination report dated 31 October 2016, Dr Irvine opined that the cause of Ms Goak's death was multiple blunt force injuries.

5.6 The significant findings from the examination of Ms Mathang can be summarised as follows:

(a) bleeding within and around the lungs, blood within the peritoneal cavity, lacerations of the spleen and liver;

(b) multiple pelvic fractures, multiple left-sided rib fractures, and fractures of the extremities;

(c) toxicological analysis of post-mortem blood detected a blood alcohol level of 0.319 g/100mL.

5.7 In the post-mortem examination report dated 31 October 2016, Dr Irvine opined that the cause of Ms Mathang's death was multiple blunt force injuries.

6. Outcome of the NSWPF investigation

6.1 The NSWPF investigation identified the following matters:

(a) Constable Sengoz and Senior Constable Davis were required to undertake mandatory breath and urine testing. All of these tests returned negative results.

(b) The Commodore was subjected to a forensic mechanical examination. This did not identify any mechanical defect or fault which contributed to the collision.

(c) The road surface was examined by the NSWPF Crash Investigation Unit and found to be in good condition and free of surface contaminants or obstacles.

(d) The Commodore was estimated to be travelling at about 98.4 kilometres per hour at the time it began to rotate and lose control.

(e) The designated speed limit along Railway Road was 50 kilometres per hour.

7. What issues did the inquest consider?

7.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

(1) What were the circumstances leading up to the motor vehicle accident on 20 February 2016 including:

(a) the timeline and travel of the 1999 Holden Commodore sedan registered CF 47 EZ;

(b) the police attempt to stop the vehicle;

(c) the police pursuit of the vehicle;

(d) who was driving the vehicle at the time; and

(e) whether there is sufficient evidence requiring the referral of a known person to the Director of Public Prosecutions pursuant to section 78 of the *Coroners Act 2009*.

(2) Was the police pursuit of the vehicle conducted in compliance with the NSWPF Safe Driving Policy.

7.2 Two independent experts provided opinions relevant to consideration of some of the above issues:

(a) Michael Griffiths, biomedical and mechanical engineer;

(b) Dr Andrew McIntosh, biomechanical engineer and expert in ergonomics/human factors.

7.3 Both experts provided reports and also gave evidence at the inquest.

7.4 In the course of the inquest, the above issues were narrowed so that only issues 1(d) and 2 required consideration.

8. Procedural history

8.1 The inquest initially commenced on 21 September 2020. Oral evidence was adduced on that day and the next two days.

8.2 On 23 September 2020, the evidence adduced to date raised issue 1(e) for consideration, namely whether section 78 of the Act was enlivened. After receiving submissions, the inquest was suspended pursuant to section 78(3)(b) of the Act and steps were taken in accordance with section 78(4).

8.3 Following advice from the Director of Public Prosecutions (NSW) that criminal proceedings would not be commenced, the inquest resumed on 11 May 2026 in accordance with section 79(1)(a) of the Act.

9. Was the pursuit conducted in accordance with the NSWPF Safe Driving Policy?

9.1 Consideration of this issue requires examination of discrete periods of time after Constable Sengoz and Senior Constable Davis first saw the Commodore in the early hours of the morning on 20 February 2016.

Direction to stop

9.2 Constable Sengoz gave evidence that when he first saw the Commodore he noticed that its headlights were off and it was driving very slowly, which he considered to be suspicious, and that there were "*multiple people on board*".

9.3 Senior Constable Davis gave evidence that the Commodore did not have its headlights on and that "*they were giving way to nobody*" which he considered to be suspicious.

9.4 Senior Constable Davis gave evidence that he mentioned to Constable Sengoz to pull over the Commodore so that a random breath test could be performed. Senior Constable Davis gave evidence that he had regard to the fact that there had been an increase in property-related offences in the area and there was a possibility that the driver was "drink-driving" given the manner in which the Commodore was travelling and that there was a licensed premises nearby.

9.5 Part 7 of Version 7.2 of the NSWPF Safe Driving Policy (**SDP**), which was in force at the time, provides that when attempting to perform a traffic stop, if "*the driver of the other vehicle attempt[s] to avoid apprehension or appears to be ignoring requests to stop and a decision has been made to pursue the vehicle, then a pursuit has commenced and the [SDP] must be adhered to*".

9.6 Although "traffic stop" is not defined in the SDP, Part 6 provides:

> When engaging in a pursuit, you should ensure that there is reasonable cause to believe that the person being pursued has committed, or has attempted to commit, an offence; and the offender is attempting to abate apprehension.

9.7 **Conclusions:** When Constable Sengoz and Senior Constable Davis first saw the Commodore turning from Cobham Street onto Vardys Road, there were several features regarding its appearance and manner of driving that legitimately gave rise to a suspicion in the minds of the NSWPF officers. The Commodore was travelling very slowly without its headlights in a location where there was a licensed premises nearby. In these circumstances, it was reasonable to consider that the driver of the Commodore may have been driving under the influence of alcohol and that performing a random breath test was warranted.

9.8 In addition, both Constable Sengoz and Senior Constable Davis gave evidence that from their experience there had been a recent increase in property related offences in the area which the Commodore was in. Having again regard to the manner in which the Commodore was travelling, it was also reasonable to consider that the Commodore and its occupants may have been associated with some type of offending and that a traffic stop was also warranted.

Commencement of pursuit

9.9 Constable Sengoz gave the following evidence in deciding to commence a pursuit:

> I considered the dangers to the public and because of the time of night, no vehicles apart from this one other vehicle, I decided it was safe at that time to pursue after it, or I assessed the risk. I wouldn't say, "safe" is the correct word, but I assessed the risk.

9.10 Constable Sengoz also gave evidence that in commencing the pursuit he considered that there had been property offences in the local area, he was unsure why the Commodore had ignored directions to stop and instead accelerated away, and that he did not have the registration details of the Commodore.

9.11 Senior Constable Davis gave evidence that he considered it was important to stop the Commodore "*for the safety of the community*" because it had ignored a direction to stop and was driving in a manner which was considered to be suspicious.

9.12 Senior Constable Davis gave evidence that "*what alarmed [him]*" was the fact that the Commodore was travelling at a "*very slow pace*" along Railway Road, with no traffic or pedestrians around, and had ignored several spots where it could have pulled over.

9.13 Part 6 of the SDP relevantly provides the following:

> You must consider a pursuit as a last resort. It will only be engaged with the gravity and seriousness of the circumstances require such action and there are no other immediate means of responding.
> […]
> The decision to initiate and/or continue a pursuit requires weighing the need to immediately apprehend the offender, against the degree of risk to the community and police as a result of the pursuit.

9.14 **Conclusions:** The evidence establishes that, without any legitimate reason, the driver of the Commodore ignored three clear directions to stop after the warning lights, horn and siren of QH36 were all activated. Instead, the Commodore increased speed and accelerated away quickly. At the time that this occurred, Constable Sengoz and Senior Constable Davis had not had an opportunity to obtain the registration details of the Commodore and were still legitimately concerned that the Commodore or its occupants may have been associated with the commission of an offence.

9.15 Constable Sengoz correctly applied the SDP in considering the need to investigate the possible commission of an offence against the degree of risk involved. At the time that the pursuit was commenced, there were no other vehicles or pedestrians in the area. The road and weather conditions also did not preclude a pursuit being commenced. In all circumstances, the decision made by Constable Sengoz and Senior Constable Davis to commence a pursuit was appropriate.

Termination of the pursuit

9.16 Both Constable Sengoz and Senior Constable Davis gave evidence that after the Commodore accelerated away, QH36 reached a speed of about 80 kilometres per hour but was not closing the distance between it and the Commodore.

9.17 Constable Sengoz gave evidence that "*possibly*" five seconds passed between the Commodore accelerating away and then swerving three or four times before impacting with the gutter.

9.18 Senior Constable Davis gave evidence that "*five/ten seconds*" passed between when the Commodore accelerated away and when it lost control.

9.19 Part 6 of the SDP provides:

> You are under no legal obligation to initiate a pursuit and in many circumstances the safety of the community are police will dictate that no pursuit be initiated. Similarly when a pursuit is considered to be too dangerous it must be terminated.
>
> No criticism will be levelled at any officer who decides to terminate a pursuit.

9.20 **Conclusions:** It is evident that the pursuit only lasted a very short time, likely between five and 10 seconds. During that period, QH36 did not travel at an excessively high speed. In addition, there is no evidence to suggest that the speed of QH36 or the manner in which it was being driven had any bearing upon the speed of the Commodore or the manner in which it was being driven. Indeed, the evidence indicates that the Commodore was increasing the distance between it and QH36.

9.21 Given this increase in distance and the very short period of the pursuit, there was no opportunity for either Constable Sengoz or Senior Constable Davis to consider whether the pursuit should have been appropriately terminated prior to the collision. At the time that both NSWPF officers observed the Commodore to be swerving and losing control, the collision occurred almost immediately afterwards.

10. Who was driving the Commodore on 20 February 2016?

10.1 The inquest received evidence that it could only have been either Mr Wol or Ms Jongkor who was driving the Commodore on 20 February 2016. In order to preserve the integrity of any potential future criminal proceedings, neither Mr Wol nor Ms Jongkor were called to give evidence.

10.2 In addition, Ms Jongkor was not legally represented at the inquest and English is not her first language. In these circumstances it was considered that it would be procedurally unfair for Ms Jongkor to consider the implications of section 61 of the Act and possibly be asked questions that may enliven section 78 of the Act without being legally represented.

10.3 The evidence relating to either Mr Wol or Ms Jongkor being the driver of the Commodore on 20 February 2016 is summarised below.

Evidence relating to Mr Wol as the driver of the Commodore

10.4 *First*, Mr Wol was the registered owner of the Commodore.

10.5 *Second*, at 1:20pm on 23 February 2016, Mr Wol took part in an electronically recorded interview with NSWPF officers whilst he was still an inpatient in the intensive care unit at Westmead Hospital. Whilst a social worker was present during the interview, it was conducted without the assistance of an interpreter although Mr Wol indicated that he had an understanding of English. When asked directly who was driving the Commodore on 20 February 2016, Mr Wol gave this answer:

> […] before I told you that my English […] (INDISTINCT) on that time exactly I don’t know, I don't know maybe I'm driving on that time I am drunk, I’m drunk on that time I don’t know yeah I’m driving, driving or another one is driving. That one I cannot say yes I cannot say no but that’s why because on that time I’m, I'm drunk […]

10.6 The interview was subsequently terminated after Mr Wol requested the assistance of a Dinka interpreter.

10.7 *Third*, later at 3:11pm on 23 February 2016, Mr Wol participated in second electronically recorded interview with NSWPF officers, this time with the assistance of a Dinka interpreter. When asked who the driver of the Commodore was on 20 February 2016, Mr Wol, through the interpreter, answered:

> I was driving.

10.8 However, later in the interview, Mr Wol, again through the interpreter, said that he "*was not the driver*". When asked to explain this apparent contributory answer, Mr Wol said himself (not through the interpreter):

> I told you on that time I don't […] you know, I'm drunk, I'm drunk. Maybe, I'm because I'm driving that I told you, I told you that I'm driving for me there's someone else, no, there's someone else driving. After that, you know, you don't know what I'm saying for you, I told it that's one, I told […]

10.9 Later, when asked to clarify, Mr Wol, through the interpreter, gave this answer:

> I say at that time we were drunk and I'm not sure whether I was driving or somebody else was driving.

10.10 *Fourth*, on 25 April 2016, Mr Wol participated in a further electronically recorded interview at Mount Druitt police station with the assistance of a Dinka interpreter. Mr Wol where he was sitting in the Commodore at the time of the collision and gave this answer:

> Yeah, that during the collision period that I wasn't aware where did I sit in the, in the car.

10.11 However, when later asked about the positions of the occupants of the Commodore, Mr Wol, through the interpreter, said that Ms Jongkor was in the driver's seat and that he was in the front passenger seat.

10.12 *Fifth*, Ms Jongkor made a statement dated 22 February 2016 in which she said that when the Commodore departed, Mr Wol got into the driver's seat whilst she sat in the front passenger seat. Ms Jongkor went on to state that after the warning devices on QH36 were activated she asked Mr Wol to stop the Commodore but that he instead "*accelerated very hard and drove off*". Ms Jongkor also stated that Ms Goak instructed Mr Wol to stop the Commodore because he was endangering the occupants and that she pulled on the steering wheel shortly before the Commodore lost control.

10.13 *Sixth*, as at 20 February 2016, Ms Jongkor did not hold a driver's licence. During his 25 April 2016 interview, Mr Wol was asked why he would let Ms Jongkor drive his car (according to his version) in these circumstances. Mr Wol said that the other occupants refused to drive and Ms Jongkor "*just jump[ed] in*". Mr Wol also indicated that he was "*happy*" for Ms Jongkor to drive despite being unlicenced.

10.14 *Seventh*, Crezina Khan, Ms Mawin's daughter, gave evidence that after finishing work at Blacktown she arrived home at around 7:00pm or 7:30pm on 20 February 2016. She also gave evidence that she had first met Mr Wol in 2008 and that she had seen him "*several times a year*" since that time. Ms Kahn gave evidence that she did not consume any alcohol that night and that at some stage, she

saw Mr Wol get into the driver seat of the Commodore before it departed. Ms Khan gave evidence that she "*clearly saw John Wol drive off at night*" and that she was standing about three metres away at the time.

10.15 *Eighth*, Constable Sengoz gave evidence that when the Commodore turned in front of QH36 the headlights of the NSWPF vehicle shone "*straight on the driver*". Constable Sengoz described seeing a Sudanese male with short black hair and wearing a yellow mustard coloured shirt with red triangles. Constable Sengoz gave evidence that he was able to recall the clothing worn by the male because it "*just stuck with [him]*". Constable Sengoz acknowledged that he did not subsequently make any notebook entry regarding the description of the driver and explained that he was not considering the possibility of criminal proceedings at the time.

10.16 Constable Sengoz also gave evidence that when arrived at the collision scene he saw Mr Wol "*within the cabin on his back sort of propped, sitting up, splayed out with both arms to his sides*" who he immediately recognised as the driver of the Commodore he had seen a short time earlier.

10.17 *Ninth*, Acting Sergeant Tyler Ryan gave evidence that when he attended the collision scene he saw that Mr Wol was propped up on the roof section of the Commodore wearing "*like a yellowy brownie, coffee shirt*" which was "*quite distinctive*" and that "*nobody else at the scene was wearing that colour shirt*".

10.18 In his electronically recorded interview of 25 April 2016, Mr Wol asserted that he was wearing a black long sleeved shirt over a white singlet at the time of the collision. CCTV footage obtained from a liquor store in Marayong shows Mr Wol attending the store at around 1:42pm on 19 February 2016 wearing a dark-coloured shirt, almost 12 hours prior to the collision. Whilst a black long sleeved shirt with a blue/white pattern was located in a pool of blood on the roof liner on the driver's side of the Commodore, no witness described Mr Wol as wearing a shirt of this description.

10.19 *Tenth*, in his first report dated 20 September 2024, Dr McIntosh expressed the opinion that there is "*strong evidence*" that Mr Wol was the driver of the Commodore on 20 February 2016 when his injuries are considered in isolation from the evidence regarding Ms Jongkor. Dr McIntosh explained that the driver's seat area "*was the safest occupant position because the occupants cell remains largely intact and there was limited intrusion*".

10.20 Dr McIntosh also explained that Mr Wol's injuries were largely right-sided and that if he had been a front seat passenger it would be "*very challenging to explain*" why he did not suffer critical left-sided injuries, such as those suffered by Ms Mawin and Ms Mathang. Finally, Dr McIntosh considered that Mr Wol's right arm injury was most likely caused by "*partial ejection and/or via a tourniquet loading on the arm by the seatbelt as the Commodore rolled with the driver's side leading*".

Evidence relating to Ms Jongkor as the driver of the Commodore

10.21 *First*, Martin Mawien, Ms Mawin's partner, gave evidence that when the Commodore departed Mr Wol was sitting in the front passenger seat and Ms Jongkor was sitting in the driver's seat. This was consistent with a statement given by Mr Mawin on 20 February 2016 and with answers he gave in an electronically recorded interview on 22 February 2016.

10.22 *Second*, Paramedic Wayne Blackburn gave evidence that when he attended the scene he saw that Mr Wol was lying in the roof area of the Commodore and that "*there was a seatbelt that was connected to him which had […] stripped his arm down*". Paramedic Blackburn gave evidence that he "*didn't end up doing anything with that seatbelt*", he did not remove it, and that he was unsure who did remove it. Paramedic Blackburn went on to give this evidence:

> Well, it appears, like, on first view of this patient that the seatbelt had done numerous amounts of loops around the arm, whether that was from being thrown around in the vehicle, whether it was secured at the time or whether it was just draped over a shoulder, which to me was more probably what it was, and then as it's gone around, it's skinned, I think, like, his arm down.

10.23 *Third*, Intensive Care Paramedic Daniel Duncan gave evidence that he saw that Mr Wol's right arm "*was tangled up in a seatbelt of some nature*" and that because of the entanglements "*we just needed to cut whatever we could to free that up"*.

10.24 *Fourth,* in his first report dated 30 August 2023, Mr Griffiths explained that "*[t]here were two right side outboard seating positions which were well outside the path of intrusion and were potentially survivable with minor injury*". From this, Mr Griffiths expressed the view that Ms Jongkor was the driver because "*her near complete lack of injury matches being the occupant of the safest sitting position in the car*".

10.25 Mr Griffiths noted that attending paramedics described a degloving injury to Mr Wol's right arm with the injury mechanism described as being seatbelt entanglement. Mr Griffiths explained that he had previous experience of three incidents where vehicle occupants had suffered complete arm amputations after placing their arm under the sash webbing of the seatbelt (to give the appearance of wearing the seatbelt) without actually engaging the seatbelt tongue in the buckle. Mr Griffiths therefore considered that Mr Wol had suffered his injury in the same manner and because he was not wearing a seatbelt at the time of the collision. Mr Griffiths ultimately concluded that as attending paramedics had reported cutting the seatbelt from Mr Wol's arm in order to free the entanglement and that the scene photos showed the driver's seatbelt intact and the rear offside passenger seatbelt cut, this meant that Mr Wol was seated in the rear passenger seat with Ms Jongkor being the driver.

10.26 *Fifth*, Mr Griffiths gave evidence that Mr Wol's injury was "*a keystone of the analysis*" and that he had "*a unique injury that could only have been received in that [driver's] seating position*". Mr Griffiths ultimately gave this evidence:

> [T]he most influencing factor in terms of identifying Mr Wol's position was the specific nature of his injury to his arm, put together with the commentary from the paramedics and the fact that, both by what they said and just the vehicle assessment, it was the right rear seatbelt that was cut and the driver's seatbelt was intact.

10.27 However, in assessing whether the rear offside passenger seatbelt had actually been cut, Mr Griffiths gave evidence that the "*weight of [his] report*" was based on the statements and evidence given by the attending paramedics and that it would be "*wishful thinking*" on his part to interpret the scene photos.

10.28 *Sixth*, in a supplementary report dated 5 March 2026, Dr McIntosh expressed the view that if the offside rear seatbelt was cut and a cut seatbelt was wrapped around Mr Wol's arm "*this most likely places him the offside rear position at the time of the crash*". Dr McIntosh also expressed the view that on the basis that the offside front seatbelt was intact and retracted, this meant that Ms Jongkor was the driver. However, Dr McIntosh noted that there are "*still confounding factors*" namely the relatively low severity injuries to Ms Jongkor if it is assumed that she was the unrestrained driver.

10.29 *Seventh*, Dr McIntosh gave evidence that when he expressed his opinions in his first report he did not have the benefit of closely examining all of the scene photos. Dr McIntosh explained that this closer examination altered his original opinion and confirmed in his mind that the rear offside passenger seat belt had in fact been cut and given what was described by the paramedics, he felt comfortable with expressing the opinion that Mr Wol was seated in the driver seat.

Analysis

10.30 It is evident from the above that whilst the lay evidence suggests that Mr Wol was driving the Commodore on 20 February 2016 at the time of the collision, the expert evidence instead suggests that Ms Jongkor was the driver. It is also evident that particular consideration needs to be given to some aspects of each category of evidence.

10.31 *First*, the apparent admission made by Mr Wol on 23 February 2016 occurred three days after the collision when Mr Wol was still in hospital and not assisted by an interpreter.

10.32 *Second*, even when assisted by an interpreter, Mr Wol gave contradictory answers regarding the question of driver identity during his second interview on 23 February 2016. The explanation advanced by Mr Wol regarding why he gave two completely different answers to the same question was unconvincing.

10.33 *Third*, during his interview on 25 April 2016, Mr Wol initially said that he could not recall where he was seated in the Commodore. However, later in the interview, Mr Wol asserted that he was in the front passenger seat. It should be noted that this assertion is entirely inconsistent with the expert evidence that this seating position would have suffered significant collision intrusion and that Mr Wol's relative lack of injuries can only be explained by him being located in one of the offside seating positions. Equally, the version provided by Ms Jongkor in her statement that she was seated in the front passenger seat is also inconsistent with the expert evidence in this regard.

10.34 *Fourth*, despite being examined by counsel for Mr Wol, Ms Khan and Constable Sengoz remained steadfast in their evidence that they had observed Mr Wol in the driver's seat. In particular, Constable Sengoz rejected any assertion that his view had been affected by the reflection of the headlights of the NSWPF vehicle or that he had reconstructed his memory after the event. Overall, the questions posed to Ms Khan and Constable Sengoz did not reveal any reasonable basis upon which their accounts could be doubted. It should also be noted that the evidence given by Acting Sergeant Ryan regarding his observations at the collision scene of Mr Wol's clothing was similarly reliable and corroborated the account given by Constable Sengoz.

10.35 *Fifth*, whilst Mr Mawien gave evidence consistent with his statement and electronically recorded interview that he saw Ms Jongkor get into the driver's seat of the Commodore and Mr Wol get into the front passenger seat, Mr Mawien's evidence is unreliable. Mr Mawien was argumentative and combative in his oral evidence, refusing to answer questions at times, and giving tangential answers at other times. He frequently spoke over the top of the interpreter and on other occasions refused the assistance of the interpreter entirely.

10.36 *Sixth*, whilst Dr McIntosh agreed with Mr Griffiths' opinion about how Mr Wol might have potentially sustained his right arm injury, Dr McIntosh also considered that the injury could be explained by another mechanism namely partial ejection during a vehicle rollover where "*part of the skin gets caught and torn off*".

10.37 *Seventh*, Mr Griffiths referred to witness accounts being "*potentially frail*" and subject to "*rationalisation*" whereas physical evidence is "*of an objective nature and it's confirmable and unchanging".* However, both he and Dr McIntosh acknowledged that it was not within the scope of their instructions or expertise to assess the veracity of the witness accounts. On this issue, Mr Griffiths gave this evidence:

> I'm not needed to, to verify whether a police officer has made an accurate observation in that regard. So, so I, I put - I - if a police officer, as you said, has shone a light on a vehicle and said that there's a male driving and then they say there's a male in the front seat, then I certainly take that seriously.

10.38 **Conclusions:** When considered in totality, the available evidence does not allow for a conclusion to be reached as to who was driving the Commodore at the time of the collision on 20 February 2016. On the one hand, when asked the question for the very first time, Mr Wol identified himself as the driver and the accounts of Ms Khan and Constable Sengoz, which are considered to be reliable, support this position. On the other hand, the expert evidence indicates that Mr Wol's right arm injury could likely only be explained by him being seated in the rear offside passenger seat but Dr McIntosh's evidence leaves open the possibility of another injury mechanism. Further, as summarised above, there are particular limitations with each category of evidence that points to either Mr Wol or Ms Jongkor being the driver of the Commodore on 20 February 2016.

10.39 A further significant issue is that neither Mr Wol nor Ms Jongkor gave evidence at the inquest for reasons which have already been explained. Accordingly, it has not been possible to test in oral evidence the accounts which they have provided which in turn has precluded synthesising the entirety of the evidence. This is particularly critical in circumstances where a finding as to the identity of the driver would likely enliven section 78 of the Act and have potential consequences within the criminal jurisdiction. Given the gravity of such consequences, the evidence that is available is not sufficiently clear and cogent[2] to allow for a conclusion to be reached with reasonable satisfaction as to the identity of the driver of the Commodore on 20 February 2016.

[2] **Briginshaw v Briginshaw** (1938) 60 CLR 336.

11. Findings pursuant to section 81(1) of the Act

11.1 I acknowledge and express my gratitude to Mr Timothy Hammond, Counsel Assisting, and his instructing solicitor, Rebecca Campbell. I am also grateful to the assistance provided by the previous solicitors with carriage of the matters, Mr Paul Armstrong and Ms Alexis McShane. The entire Assisting Team has provided exceptional assistance during the conduct of the coronial investigation and the inquest. I am extremely grateful for their commitment and efforts, and for the sensitivity that they have shown to the families of Ms Goak, Ms Mathang and Ms Mawin throughout the coronial process.

11.2 I also thank Detective Chief Inspector Grant Healey, and his Critical Incident Investigation Team, for their thoroughness in conducting a critical incident investigation in a professional and independent manner, and for compiling the initial comprehensive brief of evidence.

11.3 The findings that I make under section 81(1) of the Act in relation to Beanika Goak are:

Identity
The person who died was Beanika Goak.

Date of death
Ms Goak died on 20 February 2016.

Place of death
Ms Goak died at Marayong NSW 2148.

Cause of death
The cause of Ms Goak's death was multiple blunt force injuries.

Manner of death
Ms Goak was a passenger in a vehicle which was travelling at high speed when it lost control, impacted with a power pole and overturned sustaining catastrophic damage. Shortly prior to the collision the driver of the vehicle had ignored a direction from New South Wales Police Force officers, in the lawful execution of their duties, to pull over and stop. The vehicle instead accelerated away at speed resulting in a brief pursuit, which complied with applicable New South Wales Police Force policies, prior to the collision.

11.4 The findings that I make under section 81(1) of the Act in relation to Adut Mathang are:

Identity
The person who died was Adut Mathang.

Date of death
Ms Mathang died on 20 February 2016.

Place of death
Ms Mathang died at Westmead Hospital, Westmead NSW 2716.

Cause of death
The cause of Ms Mathang's death was multiple blunt force injuries.

Manner of death
Ms Mathang was a passenger in a vehicle which was travelling at high speed when it lost control, impacted with a power pole and overturned sustaining catastrophic damage. Shortly prior to the collision the driver of the vehicle had ignored a direction from New South Wales Police Force officers, in the lawful execution of their duties, to pull over and stop. The vehicle instead accelerated away at speed resulting in a brief pursuit, which complied with applicable New South Wales Police Force policies, prior to the collision.

11.5 The findings that I make under section 81(1) of the Act in relation to Ros Alak Kuol Mawin are:

Identity
The person who died was Ros Alak Kuol Mawin.

Date of death
Ms Mawin died on 20 February 2016.

Place of death
Ms Mawin died at Marayong NSW 2148.

Cause of death
The cause of Ms Mawin's death was multiple blunt force injuries.

Manner of death
Ms Mawin was a passenger in a vehicle which was travelling at high speed when it lost control, impacted with a power pole and overturned sustaining catastrophic damage. Shortly prior to the collision the driver of the vehicle had ignored a direction from New South Wales Police Force officers, in the lawful execution of their duties, to pull over and stop. The vehicle instead accelerated away at speed resulting in a brief pursuit, which complied with applicable New South Wales Police Force policies, prior to the collision.

12. Epilogue

12.1 On behalf of the Coroner's Court of New South Wales and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences, to the families, loved ones and many friends of Ms Goak, Ms Mathang and Ms Mawin for their most painful and tragic loss.

12.2 I close this inquest.

Judge Derek Lee
Deputy State Coroner
12 June 2026
Coroner's Court of New South Wales