
FINDINGS and RECOMMENDATIONS of Coroner Robert Webster following the holding of an inquest under the *Coroners Act* 1995 into the deaths of:

ROBERT BO XU and JARROD ROBERT DAVIES

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Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Robert Webster, Coroner, having investigated the deaths of Robert Bo Xu and Jarrod Robert Davies, with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

A case management conference was held on 24 April 2023 at which submissions were made as to the scope of the inquest and the inquest was then adjourned to commence on 3 July 2023.

The inquest was held on 3, 4, 5, and 6 July 2023 and on 11 October 2023. Written submissions were received from:

- Counsel Assisting, Mr Ken Read SC on 13 November 2023;
- Mr Philip Jackson SC and Ms Carly Sluiter on 20 December 2023;
- Mr Garth Stevens on 12 January 2024; and
- Mr Tom Cox on 18 January 2024.

I was advised by Counsel Assisting on 22 February 2024 Mr Hilliard had no instructions to provide any written submissions and on 23 February 2024 that no party wished to speak to the written submissions.

Counsel

Mr Ken Read SC - Counsel Assisting the Coroner.

Mr Philip Jackson SC and Ms Carly Sluiter- Counsel for Mr Ian Vaughan managing director of Pub Banc Pty Ltd and Hotel Banc Pty Ltd which operate a number of venues on the Hobart waterfront of which Mr Vaughan is the licensee.

Mr Tom Cox - Counsel for Tasmanian Ports Corporation Pty Ltd (TasPorts).

Mr Garth Stevens and Ms Ashleigh Constance for the Commissioner of Police.

Ms Gretel Chen of the Office of the Solicitor General appeared when the Commissioner for Licensing gave evidence on 5 July 2023. Mr Mark Jehne appeared from that Office for the Commissioner for Licensing when submissions were made about the scope of this inquest.

Preliminary Matters

Introduction

1. Dr Xu, a trainee surgeon, drowned in the waterfront area of Hobart in the early hours of 7 November 2019 after consuming a considerable amount of alcohol. Just over 3 months later Mr Davies, who like Dr Xu was a visitor to Tasmania and who was attending a marine and safety course, entered the water on the Hobart waterfront in the early hours of 9 February 2020 after consuming a considerable amount of alcohol. His body was recovered by police divers on 11 February 2020.
2. Both Dr Xu and Mr Davies' deaths are subject to the *Coroners Act 1995* (the "Act") because they are reportable deaths; that is a death which occurred in Tasmania being a death "*that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury*".¹ A coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be a reportable death.²
3. On 31 March 2023 the Chief Magistrate directed, pursuant to section 50 of the Act, that these two deaths were to be investigated at one inquest. "*Inquest*" is defined in section 3 of the Act as a public inquiry.

Coroner's jurisdiction and functions

4. In Tasmania, the coroner's functions are set out in s28(1) of the Act. By this section, the coroner is required to find the identity of the deceased, how death occurred, the cause of death and when and where death occurred. By s28(2), a coroner may make comment on any matter connected with the death; and by s28(3), a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
5. Coroners complete their written findings pursuant to s28(1) into a reportable death after receiving documentary evidence in the investigation. In a small proportion of reportable deaths, the coroner will hold a public inquest, which almost always involves the calling of oral testimony to further assist the coroner in his or her investigatory function and subsequently, in the making of findings. Many of the public inquests held by coroners in Tasmania are made mandatory by the Act.³ The remaining inquests are held because the coroner considers that a public inquest is desirable in the particular

¹ See s3 of the Act and the definition of *reportable death* at paragraph (a)(ii) and (iv).

² See s21(1) of the Act.

³ S24(1) of the Act.

circumstances of the investigation.⁴ I considered it desirable to hold an inquest in these matters because of the issues to be ventilated in the investigation as set out in the scope which appears below.

6. When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial; whereas in criminal or civil proceedings the proceedings are adversarial; that is one party against another.⁵ In these proceedings I am required to thoroughly investigate the death and answer the questions (if possible) that s28 of the Act asks. Those questions in s28(1) include who the deceased was, how they died (that is the circumstances surrounding their deaths), what was the cause of the deaths and where and when they occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death.⁶ A coroner is required to make findings of fact from which others may draw conclusions.
7. A coroner does not have the power to charge anyone with a crime or an offence nor does she or he have the power to award compensation. A coroner also does not have power to determine issues associated with an inheritance or other matters arising from the administration of deceased estates.
8. As noted, one matter that the Act requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by s28(1)(b) upon the coroner.⁷
9. A coroner may comment on any matter connected with the death into which she or he is enquiring. The power to make comment "*arises as a consequence of the [coroner's] obligation to make findings ... It is not free ranging. It must be comment 'on any matter connected with the death' ... It arises as a consequence of the exercise of the coroner's prime function, that is, to make 'findings'.*"⁸
10. The standard of proof applicable to a coronial investigation is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings may reflect adversely upon an individual, the law is that

⁴ S24(2).

⁵ *Attorney-General v Copper Mines of Tasmania Pty Ltd* [2019] TASFC 4 at [21].

⁶ *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at [7].

⁷ See *Atkinson v Morrow & Anor* [2005] QCA 353.

⁸ See *Harmsworth v The State Coroner* [1989] VR 989 at 996.

the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.⁹

Issues at the inquest

11. I ruled on the scope of the inquest on 3 May 2023 after hearing submissions from the parties on 24 April 2023. The scope of this inquest is as follows:

1. The service of alcohol to Dr Xu and Mr Davies on the evening before each died and the extent to which that service might be characterised as causing or as a cause of the death of either Dr Xu or Mr Davies.
2. In respect of Mr Davies did the assault and/or the care afforded to him thereafter cause or contribute to his death.
3. What conditions were specified in the licences issued to each of the premises – s 7, 8, 9, *Liquor Licensing Act 1990*.
4. Whether the service of alcohol to Dr Xu and Mr Davies was in accord with the *Liquor Licensing Act 1990* and any conditions specified in the licence of the premises concerned.
5. Whether (and if so what) recommendations should be made, with a view to preventing further deaths in like circumstances, as to conditions that ought to be generically specified in out-of-hours permits issued pursuant to s12 of the *Liquor Licensing Act 1990*.
6. (a) Whether procedures in place at the Observatory Bar on 9 February 2020 to ensure compliance with conditions specified in its out-of-hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies' death.
- (b) Whether procedures in place at the Observatory Bar on 9 February 2020 to ensure compliance with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act 1990* were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies' death.
- (c) Whether any failure on the part of any police officer or of any authorised officer under s209 of the *Liquor Licensing Act 1990* to take steps to enforce

⁹ (1938) 60 CLR 336 per Latham CJ at 347 and Dixon J at 362 and 368-9.

compliance by the licensee of the Observatory Bar on 9 February 2020 with conditions specified in its out-of-hours permit, or with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act 1990*, resulted in non-compliance that caused or contributed to Mr Davies' death.

(d) Whether procedures in place at the Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 to ensure compliance with conditions specified in its out-of-hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(e) Whether procedures in place at the Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 to ensure compliance with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act 1990* were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(f) Whether any failure on the part of any police officer or any authorised officer under s209 of the *Liquor Licensing Act 1990* to take steps to enforce compliance by the licensee of the Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 with conditions specified in its out-of-hours permit, or with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act 1990*, resulted in non-compliance that caused or contributed to Dr Xu's death.

(g) Whether procedures in place at Mobius Lounge Bar on 7 November 2019 to ensure compliance with conditions specified in its out-of-hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(h) Whether procedures in place at Mobius Lounge Bar on 7 November 2019 to ensure compliance with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act 1990* were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

(i) Whether any failure on the part of any police officer or any authorised officer under s209 of the *Liquor Licensing Act 1990* to take steps to enforce compliance by the licensee of Mobius Lounge Bar with conditions specified in its out-of-hours permit, or with relevant provisions in Division 5 of Part 2 of the *Liquor Licensing Act 1990*, resulted in non-compliance that caused or contributed to Dr Xu's death.

7. Whether recommendations should be made as to procedures to ensure compliance with the *Liquor Licensing Act 1990* and conditions specified in the licences.

8. The safety features of the Hobart waterfront and the extent to which the layout of the Hobart waterfront ought be characterised as causing or as a cause of the death of either Dr Xu or Mr Davies.

9. Whether recommendations should be made for improvement of safety features of the Hobart waterfront.

Evidence in the Investigation

12. The evidence of all witnesses was received in affidavit or report form with a number of those witnesses not called to give evidence at the inquest. Documentary and other evidence was also tendered. The affidavits, reports, documentary and other evidence at the inquest comprised of exhibits X1 to X33 which were relevant to the investigation of the death of Dr Xu and exhibits D1 to D62B which were relevant to the investigation of the death of Mr Davies. Exhibits C1 to C5 contained evidence relevant to the investigation of both deaths. The exhibit lists are annexed to this finding.

13. In addition to the affidavits, reports, documentary and other evidence the following witnesses gave oral testimony during the course of the inquest:

- a. Detective Senior Constable Martin White;
- b. Mr Ian Vaughan;
- c. Mr Alexander Hodge;
- d. Mr Robert Davies;
- e. Dr Sameer Thakur;
- f. Mr Benjamin Granger;
- g. Mr Hayden Clark;
- h. Mr Umer Khan;
- i. Mr Eric Elford;
- j. Ms Jesse Crossin;
- k. Mr Mubin Ahmed;
- l. Mr Andrew Goss;
- m. Mr Tuesa Vailepa;
- n. Dr Donald Ritchey;
- o. Assistant Police Commissioner Adrian Bodnar;
- p. Sergeant Peter Andricopoulos;

- q. Mr Jonathon Root;
- r. Mr David Dunn;
- s. Ms Prudence Cunningham;
- t. Ms Amy Fogarty;
- u. Mr Matthew Casey;
- v. Mr Benjamin Hickey;
- w. Ms Brianna Fenton;
- x. Mr Vickas Kumar;
- y. Ms Anna Packer;
- z. Mr James Barr;
- aa. Mr Broden Barlow; and
- bb. Dr Anthony Bell.

The Evidence

Background- Dr Xu

14. Dr Xu was 32 years of age (date of birth 13 February 1987), single and employed as a trainee medical surgeon at the date of his death. His parents are Ruojun Xu and Shu Zang and he has a brother Louis.
15. Dr Xu was born in Melbourne in Victoria and he was a healthy and happy child. He went to Kennedy Primary School in Hong Kong between 1992 and 1998 and Westminster School in Adelaide where he graduated as Dux in 2003. He then attended the school of medicine at the University of Adelaide where he graduated after which he worked and trained at the Royal Adelaide Hospital until 2018. Dr Xu then moved to Epworth Hospital in Melbourne where he was training as a surgeon. He was dedicated and hard-working. To the best of his father's knowledge, Dr Xu as an adult was happy and healthy. He had no issues with his mental health. In 2019 Dr Xu separated from his fiancée of a number of years. Mr Xu senior says his son was able to swim but he was not good at it. Dr Xu's parents seldom saw him consuming alcohol and they did not believe he had a problem with alcohol abuse. To their knowledge he was not prescribed any prescription medication and he did not take illicit drugs.¹⁰
16. Dr Xu was in Hobart to attend the Australia New Zealand Society of Cardiothoracic Surgeons Annual Scientific Meeting ("the conference") which was held at the Hotel Grand Chancellor. The conference was held between 7 and 10 November 2019.¹¹ Dr

¹⁰ Exhibit XI-Police Report of Death for the Coroner and exhibit X7-affidavit of Ruojun Xu.

¹¹ Exhibit XI I-affidavit of Dr Sameer Thakur.

Xu had intended to move to Hobart in February 2020,¹² presumably to work at the Royal Hobart Hospital.

Circumstances Leading to Death-Dr Xu

17. Dr Thakur says 2019 at the Epworth Hospital was Dr Xu's first year of formal training as a surgeon. On Tuesday 5 November 2019, Dr Thakur telephoned Dr Xu to see how he was going and whether he was attending the conference. They had known each other for about six years and first met when they were both working at the Royal Adelaide Hospital. They spoke about Dr Xu's work experiences in Melbourne and Dr Thakur learnt Dr Xu's relationship with his fiancée was at an end. Dr Xu's former fiancée was a junior doctor in Adelaide and they had attempted to continue their relationship on a long-distance basis but it did not work out. Dr Thakur says Dr Xu sounded okay when he was discussing this. Dr Xu confirmed he was attending the conference and he was staying at the Hotel Grand Chancellor.¹³
18. Dr Thakur arrived in Hobart on the evening of 6 November 2019 and travelled to his accommodation on the Hobart waterfront. After checking in he met others from the conference and attended a trainees' dinner, organised by the medical indemnity insurer Avant. The dinner was part of the conference program and was held at The Glass House between approximately 6:30pm and 10:30pm. There were 3 to 4 long tables with 10 persons per table at the dinner. There was no seating allocation and Dr Thakur ended up sitting next to Dr Xu. Towards the end of the dinner there was a discussion about moving on to a nearby bar.¹⁴
19. After dinner a number of the attendees at the dinner, including Dr Thakur and Dr Xu, walked to the Evolve Spirits Bar at MACq 01 Hotel. They left those premises at approximately 12:30am.¹⁵ Most of the attendees who were at the Evolve Spirits Bar left to return to their accommodation while Dr Xu and Dr Thakur attended a bar known as Mobius before Dr Thakur left to visit a friend who resided in Lenah Valley. Dr Thakur remained at his friend's residence for one to two hours before he returned to his accommodation at MACq 01 Hotel.¹⁶
20. Dr Thakur's evidence was verified by his Google location data on his mobile phone which confirmed he reached MACq01 Hotel from the Hobart airport at approximately 6:41pm. He was at The Glass House restaurant between 6:49pm and

¹² Exhibit X7-affidavit of Ruojun Xu.

¹³ Exhibit X11-affidavit of Dr Sameer Thakur.

¹⁴Exhibit X11-affidavit of Dr Sameer Thakur.

¹⁵Exhibit X 13-affidavit of Dr Jordan Ross.

¹⁶ Exhibit X11-affidavit of Dr Sameer Thakur.

11:13pm, he was at the Evolve Spirits Bar between 11:20pm and 12:32am and he was at Mobius between 12:45am and 1:24am before departing for the address in Lenah Valley.¹⁷

21. CCTV obtained by police from a number of Hobart waterfront businesses show the dinner attendees leaving MACq 01 Hotel at 12:34 am and at 12:37am Dr Thakur and Dr Xu are seen together walking past the Drunken Admiral restaurant in Hunter Street. Next they are observed entering Mobius. Dr Xu is observed inside Mobius before he is next observed walking past the Black Footed Pig restaurant at 1:23am. Next he is seen walking past the Telegraph Hotel towards Morrison Street. At 1:32am Dr Xu is captured on CCTV walking into the carpark at Mures where he proceeds through the carpark. At the north-western corner of Victoria Dock there is a foot path and a ledge between the carpark and the dock. At approximately 1:35am Dr Xu walks from the carpark onto the foot path and he falls into the water. It appears from the footage Dr Xu does not see the ledge which he hits and he falls directly into the water. It also appears Dr Xu has walked off the footpath and into the water between two fishing vessels namely “Sagitta” and “Brid Venture” which were moored in Victoria Dock and photographed by police in situ.¹⁸
22. Mr John Birmingham was staying at the Hotel Grand Chancellor with his partner when at 4:15am on 7 November 2019 he was woken by a wailing sound coming from the direction of the docks and waterfront. His room faced that direction. He verified the time by looking at a clock. He says the wailing sound was from a man. He got up and looked out the window but could see no activity and he could not see anyone on foot or any vehicles on Davey Street. He did not hear a splash or see any ripples on the water. He says the person was wailing for about 15 minutes and it stopped around 4:28am to 4:30am. He then saw a male walking towards the boats whereupon that person stopped and made a phone call on his mobile phone. Mr Birmingham then heard sirens.¹⁹
23. Ms Christine Davie was staying at the Hotel Grand Chancellor with her mother. After watching a movie they went to sleep at around midnight on 6 November 2019. As the room was a little stuffy they had the window open as far as it would go, which was about 20 cm, and the curtains were not covering the window so as to allow the breeze to come in. Ms Davey says she woke to the sound of moaning between 4:00am

¹⁷ Exhibit X29-affidavit of Detective Sergeant Michael Callinan.

¹⁸ Exhibit X19A-affidavit of Constable Nicholas Burke, exhibit X23- affidavit of Detective First-Class Constable Kellie Ladson and exhibit X29-affidavit of Detective Sergeant Michael Callinan.

¹⁹ Exhibit X9-affidavit of John Birmingham.

and 4:30am. Like Mr Birmingham she could not see anybody. Subsequently she heard a male voice calling for help. She then saw police vehicles parked near the dock. She did not see any ripples on the water.²⁰

24. On 7 November 2019 at approximately 4:30am Robert Carlisle was walking along Hunter Street as he does every day. He heard someone wailing from in or around the boats which were moored at Victoria Dock. He then saw a man hanging onto a timber wharf post. Mr Carlisle says that man appeared to be intoxicated. He immediately called 000. He says he was unable to get the man out of the water. He attempted to tell the man that someone was coming to help whereupon he observed the man let go of the timber wharf post and he went under the water. Approximately one minute later police arrived.²¹
25. Sergeant White, Constable Burk and Constable Suttor were on duty at the time Mr Carlisle contacted emergency services. At 4:38am they were tasked to attend Victoria Dock in response to Mr Carlisle's telephone call. On their arrival neither Constable Burk or Constable Suttor located the man observed by Mr Carlisle. The visibility into the water was poor and it was murky. Sergeant White then directed Constables Burk and Suttor to check each boat moored in the dock to see if there was anybody living on any of the boats. The result of these checks was negative. The search was also conducted to determine what type of CCTV footage might be available. In addition it was noted there were no signs of an altercation or a struggle. A further search for the man observed by Mr Carlisle was conducted but he was not located. Four taxi drivers on a nearby rank were spoken to but none of them saw or heard anything. At 4:45am Sergeant White requested the assistance of the Tasmania Police dive squad. Prior to the squad's arrival the three police officers continued their search of the wharf and surrounding boats however there was no sign of the male person. The dive squad arrived at 5:49am and at 6:09am a body was recovered from the water. The body was searched and a phone, wallet and cards in the name of Robert Xu were found. There were no attempts made to resuscitate Dr Xu as it was clear he was deceased. Police determined from staff at the Hotel Grand Chancellor that Dr Xu was a guest of that establishment who was in Hobart for a medical conference. Dr Xu was removed from the scene and taken to the mortuary at the Royal Hobart Hospital by Mr Anthony Cordwell who is a mortuary ambulance service officer.²²

²⁰ Exhibit X10-affidavit of Christine Davie.

²¹ Exhibit X8-affidavit of Robert Carlisle.

²² Exhibits X19, X20, and X21-affidavits of Constable Burk, Sergeant White and Constable Suttor.

Investigation - Dr Xu

26. Dr Xu's life was pronounced to be extinct by Dr Martin Watson at the Royal Hobart Hospital²³ and he was formally identified to police by Mr Christopher Cole²⁴ one of the conference organisers.
27. The police then conducted inquiries to ascertain Dr Xu's movements throughout the evening including identifying which venues he had attended. Affidavits were obtained from some of his colleagues and from people who were on duty at the various venues. CCTV footage was obtained from a number of businesses on the Hobart waterfront. From these inquiries police were able to rule out the involvement of any other people in Dr Xu's death. Various maps, diagrams and photographs of the waterfront were obtained. From investigations police were able to determine Dr Xu fell into the water at Victoria Dock at a point which was approximately 100 m from where he was discovered. He fell into the water at 1:35am and was not discovered by Mr Carlisle until approximately 4:30am. Police were also able to determine from their own observations and from visiting the scene on a subsequent occasion that there was a sufficient level of lighting, comprised of street and floodlighting, at the time of the incident.
28. Sophie Grace was, at the time she swore her affidavit²⁵, the Executive General Manager of Compliance, Safety and Sustainability at TasPorts. From documentation she collated dating back to 2001 she says the number of ladders which a person can use to climb out of Victoria Dock had not diminished since that time. In fact, since then the quality of all ladders has been upgraded and an additional ladder has been installed. In total there are 10 ladders situated in Victoria Dock which are evenly dispersed around its perimeter. There are also a number of life buoys erected on the walls of the dock. The ladders are not illuminated by light at night however they are all within distance of streetlights and floodlights from the road and nearby car parks and can be seen at night.
29. Jonathon Root is the Commissioner for Licensing appointed in accordance with s207 of the *Liquor Licensing Act 1990*. ("LLA") In this role he is provided with administrative support by the Liquor and Gaming Branch of the Department of Treasury and Finance. He also holds the positions of Deputy Secretary of Revenue, Gaming and Licensing in the Department of Treasury and Finance and Commissioner of State

²³ Exhibit X2-affidavit of Dr Watson.

²⁴ Exhibit X4-affidavit of Constable Suttor.

²⁵ Exhibit X18-affidavit of Sophie Grace.

Revenue. He is statutorily responsible for considering applications for liquor licences and liquor permits and where appropriate he can consider and take disciplinary action against a licensee or permit holder. Within the Liquor and Gaming Branch there are three units, one of which, comprises compliance inspectors who are appointed as authorised officers in accordance with s209 of the LLA.²⁶

30. On 7 November 2019 the Liquor and Gaming Branch received a complaint from Leigh Ferguson who owned a building in the vicinity of Mobius. The complaint alleged that a person, now known to be Dr Xu, was sold liquor while intoxicated and he was seen walking from Mobius on that date. Mr Ferguson provided CCTV footage which Mr Read SC says shows a male person unsteady on his feet who stumbled off and back on to the footpath and who was rubbing his hands on his face. Four days later Mr Root's staff formally requested the licensee of Mobius, Mr Ben Hickey, to provide surveillance footage from within the premises which showed Dr Xu and Dr Thakur enter the premises at approximately 12:48am. Mr Root is of the view Dr Xu did not appear to be intoxicated at the time the one drink he consumed in the premises was purchased or for the remainder of the time he remained at Mobius. However as he walked up the stairs to leave the premises he did appear to stumble when looking at his mobile phone. Mr Root's staff conducted an interview with Amy Fogarty on 7 January 2020. She was the bartender on duty at the time of Dr Xu's attendance and she has held a Responsible Service of Alcohol (RSA) qualification since February 2012. It is clear from that interview Ms Fogarty was a very experienced bartender and she formed the belief Dr Xu and his companion (Dr Thakur) had been drinking alcohol prior to their attendance at Mobius but they were not intoxicated. What she advised Mr Root's staff is consistent with her evidence set out in paragraph 48. She did think Dr Thakur showed a greater level of sobriety than Dr Xu. As a result of the investigation Mr Root was unable to identify any breaches of the LLA.²⁷
31. Mr Root says Mobius is a licensed premises that operates as a nightclub. An on-licence authorizes the sale of liquor –

“(a) between 5am and midnight on any day on the premises specified in the licence for consumption on those premises; and

(b) at any time to –

²⁶ Exhibit D49-affidavit of Jonathon Root.

²⁷ Exhibit D49-affidavit of Jonathon Root.

(i) a resident of the premises specified in the licence for consumption on those premises; or

(ii) a resident of any premises of which the premises specified in the licence form a part for consumption on those premises; and

(c) subject to any condition specified in the licence.”²⁸

32. The licensee of Mobius since 31 March 2003 has been Mr Ben Hickey. An out-of-hours permit permits the sale of liquor outside the on-licence hours, that is between midnight and 5:00am, for the hours specified in the permit.²⁹ In November 2018 Mr Root received a complaint from the operator of local accommodation premises regarding the conduct of people in the vicinity of Mobius. Information from this investigation was used in disciplinary action taken against Mr Hickey, as the licensee of Mobius, under the LLA. On 5 March 2019 after becoming aware of the death of Dr Stewart Williams, officers of the Liquor and Gaming Branch requested Tasmania Police to provide any information relating to contraventions of the LLA which may have occurred. That day Mr Root received a police liquor licensing report relevant to the death of Dr Williams and on receipt of that information he requested further information from Tasmania Police regarding instances of disorderly conduct at those premises or in the neighbourhood. On 8 March 2019 Mr Hickey was advised that on the basis of the information provided to Mr Root he was considering commencing disciplinary action against Mr Hickey under the LLA. Mr Hickey provided a written submission on the same day outlining the incident, the assistance he had provided to Tasmania Police in the investigation and that he would increase the number of crowd controllers at the premises to five. Four of them would be placed in stationary positions and a fifth crowd controller would move throughout the premises. Mr Root accepted those undertakings and that prevented him taking immediate action however Mr Hickey was advised disciplinary action would proceed.³⁰
33. On 15 March 2019 Mr Root wrote to Mr Hickey and advised him he had determined to vary the conditions of Mr Hickey’s out-of-hours permit and he required Mr Hickey to install recorded CCTV surveillance, bringing forward that requirement from 1 July 2019. That variation took effect on 29 March 2019. On 28 August 2019 Mr Root wrote to Mr Hickey advising him that as result of further complaints made to him and reports he had received from authorised officers under the LLA, he was aware there

²⁸ Section 8 LLA.

²⁹ Section 12 LLA.

³⁰ Exhibit D49-affidavit of Jonathon Root.

were instances of disorderly conduct in the neighbourhood of Mobius in the early hours of Saturday and Sunday mornings, including Dr Williams being struck at the premises. On the basis of the number of instances of disorderly conduct in the neighbourhood of those premises he was considering restricting the hours Mr Hickey was permitted to trade under the provisions of his licence.³¹

34. Mr Root instructed compliance inspectors of the Liquor and Gaming Branch to undertake remote surveillance of Despard Street from where patrons enter Mobius and Mobius itself and to assist in this process he requested a video camera be set up. In reviewing the footage he became aware of the attendance of Ambulance Tasmania at Mobius on 29 September 2019. He instructed compliance inspectors to obtain a report from Tasmania Police in relation to that matter.³²
35. On 8 November 2019 Mr Root wrote to Mr Hickey advising him that following the provision of further information he had determined not to proceed with the proposed action to restrict the trading hours but to take what he considered more serious action. Mr Root advised Mr Hickey he considered Mr Hickey had acted in a manner that had created a ground for disciplinary action in accordance with the LLA; specifically he had become aware that a serious assault had taken place inside Mobius on 29 September 2019.³³
36. On 12 December 2019 Mr Root took disciplinary action against Mr Hickey in accordance with s100(3) of the LLA for breaching s46C (Sale and consumption of liquor not to cause undue annoyance, disturbance or disorderly conduct) of the Act. As a result Mr Root amended Mr Hickey's out-of-hours permit by:
 - reducing the times authorising the sale liquor to between midnight and 4:00am on each day;³⁴ and
 - adding the following conditions:
 - no patrons are to enter or re-enter the premises after 3:30am;
 - water is to be free and made available during the permit hours;
 - promotions that may encourage excessive consumption of liquor, such as free alcoholic drinks, 2-for-1 alcoholic drinks offers, buy one get one free alcoholic drinks offers, or similar, must not be conducted during the permit hours; and

³¹ Exhibit D49-affidavit of Jonathon Root.

³² Exhibit D49-affidavit of Jonathon Root.

³³ Exhibit D49-affidavit of Jonathon Root.

³⁴ It had been until 5:00am since 31 March 2003.

- sufficient licensed crowd controllers are to be provided during the approved hours to ensure effective control of patrons.

Mr Hickey appealed Mr Root's decision to the Tasmanian Liquor and Gaming Commission and on 2 March 2020 the Commission confirmed Mr Root's decision.³⁵

37. On 15 November 2018 Mr Root received a joint complaint from the proprietors of four accommodation premises in the vicinity of Despard Street, Hobart regarding the out-of-hours permits issued to three licensed premises in that area namely the Telegraph Hotel, Mobius and the Lower House Bar and Restaurant. The complaint detailed the negative impact the noise, disturbance and antisocial behaviour was having on those accommodation businesses. As a result of the Hobart City Council ("the Council") convened a meeting of the Late-Night Precinct consultative group that was attended by representatives of the Council, Tasmania Police, Tasmania Hospitality Association, the Salvation Army which was representing the Street Teams Project, SL Security, the Taxi Council and members of the Liquor and Gaming Branch. On 7 December 2018 compliance inspectors of the Liquor and Gaming Branch were rostered to conduct a joint inspection with members of Tasmania Police. Mr Root instructed the compliance inspectors to conduct covert surveillance activities in Despard Street with particular focus on the areas of complaint. At a Late Night Precinct stakeholders meeting on 12 December 2018 the Council agreed to coordinate the provision of relevant evidence from its various divisions regarding any adverse activities connected to the licensed premises in the Despard Street area and provide that to Mr Root. It appears by October 2020 no such evidence had been received by the Liquor and Gaming Branch. On 13 December 2018 officers of the Liquor and Gaming Branch met with the licensees of the premises to discuss the subject of the complaint and undertakings were given by the licensees regarding the dispersal of patrons and cleaning the areas upon closing. Mr Root specifically requested each of the licensees to provide CCTV surveillance footage from the premises covering the times which formed the basis of the complaint. That footage was provided and assessed. CCTV surveillance footage was also obtained from the building owner of 15 Murray Street that has an access and frontage on Despard Street. In addition Mr Hickey provided a written submission on 23 January 2019 which advised he would close his premises earlier to ensure there is sufficient time to clean the area outside his premises and that the area is free of any of his patrons before neighbouring businesses begin their morning trade. Mr Root noted Daci and Daci, a bakery and café, commenced serving breakfast at 7:00am. Mr Hickey also advised he

³⁵ Exhibit D49-affidavit of Jonathon Root.

would operate a “stamps only” lockout policy from 4:00am and a full lockout from 5:00am with no re-entry after that time. It seems from evidence gathered antisocial behaviour was occurring in this area for in excess of 7 ½ years and was still occurring when local businesses commenced trade each morning.³⁶

38. On 27 February 2020 a compliance inspector of the Liquor and Gaming Branch undertook an inspection of Mobius with the licensee and determined two RSA certificates could not be produced. They were provided later that day.³⁷
39. From a review of the CCTV footage provided by the three licensees it appeared the street cleaning they undertook to commence upon closing was occurring. In addition Mr Root required compliance inspectors of the Liquor and Gaming Branch to provide him with observation reports when these premises are trading, including recorded footage on an ongoing basis. In addition he has instructed compliance inspectors to undertake a number of targeted compliance inspections of the premises in this area. Mr Root acknowledges he receives regular complaints from local business owners some of whom provide CCTV footage. Each time footage and/or a complaint is received he instructs compliance inspectors to review the footage with a view to investigating the complaint further. This has resulted in a number of requests for CCTV footage from licensed premises. In order to take disciplinary action though, Mr Root says he needs to be certain the allegations contained within the complaint are alcohol-related and that there is a connection to a particular licensed premises.
40. The forensic scientist Mr Neil McLachlan-Troup of Forensic Science Service Tasmania found, as a result of toxicological tests which were conducted on a blood sample taken at autopsy, that Dr Xu had a blood alcohol reading of 0.183 g of alcohol in 100 ml of blood. He says in his affidavit ethanol is a central nervous system (CNS) depressant and its effects on the CNS are proportional to its concentration in the blood. Cognitive, sensory and motor disturbances which include muscular incoordination, slow reaction times and visual impairment increase as the blood alcohol concentration increases. At higher concentrations there is a loss of critical judgement, incoordination, reduced perception and awareness, impaired balance, a decrease in activity leading to sedation and sleep, nausea and vomiting together with reduced responsiveness and impaired intellectual performance.³⁸ Generally speaking alcohol is metabolised at between 0.010 – 0.015 g of alcohol in 100 ml of blood per hour. Given Dr Xu had been in the water for approximately 3 hours prior to his

³⁶ Exhibit D49-affidavit of Jonathon Root.

³⁷ Exhibit D49-affidavit of Jonathon Root.

³⁸ Exhibit X6-affidavit of Mr McLachlan-Troup.

death his blood alcohol reading at the time he entered the water could have been as high 0.228 grams of alcohol in 100 ml of blood. I accept the opinion of Mr McLachlan-Troup.

41. The forensic pathologist Dr Baber conducted an autopsy on 8 November 2019. Dr Baber conducted both an external and internal examination of Dr Xu. She also considered the results of histology, toxicology and a full body CT scan. As a result of these investigations Dr Baber concluded Dr Xu's cause of death was drowning. She says drowning is essentially a diagnosis of exclusion and it has no typical features. What might be seen at an autopsy is a foam plume about the mouth, hyper-inflated lungs, pleural effusions, pulmonary oedema and water in the stomach although the absence of any or all of these features does not exclude drowning as a cause of death. In this case there was copious frothy pulmonary oedema rather than a typical foam plume and Dr Xu had hyper- inflated lungs. Dr Baber says there was no significant natural disease identified that may have caused death. She says there was no formal injury identified that may have caused or contributed to death. Although toxicology testing showed a high blood alcohol concentration Dr Baber says this does not change the cause of death but it is likely to have contributed to the circumstances due to impaired cognitive function.³⁹ I accept her opinion.

Evidence with respect to alcohol consumption-Dr Xu

42. At the trainees' dinner Dr Thakur saw Dr Xu was drinking beer. He, himself, was intoxicated. They then walked to the Evolve Spirits Bar where whiskey was consumed. Dr Thakur could not recall attending Mobius with Dr Xu at all.⁴⁰ He does not recall seeing Dr Xu after leaving the Evolve Spirits Bar. He considered his lack of memory was due to excessive alcohol consumption and intoxication. He believes Dr Xu would have consumed a similar amount of alcohol to himself.⁴¹
43. Dr Jurth, consumed red wine at the dinner and whiskey at the Evolve Spirits Bar. She has a very good recollection of the evening. Dr Jurth only observed Dr Xu drinking whiskey at the Evolve Spirits Bar. She says *"I think that Rob had a bit to drink. But he was not offensive nor saying anything that was inappropriate. We were all having a lot of laughs"*.⁴²

³⁹ Exhibit X5-affidavit of Dr Baber.

⁴⁰ Exhibit XI I-affidavit of Dr Sameer Thakur.

⁴¹ Transcript page 142 lines 32-42.

⁴² Exhibit XI2-affidavit of Dr Timea Jurth.

44. Dr Ross had a couple of glasses of wine at the dinner and 3 whiskeys. He says *“Robert appeared more drunk than us. He was slightly unsteady on his feet not excessively, not vomiting, a little slurred and [he] was slightly disinhibited. He asked us to keep drinking when we were getting ready to go at about 12:30am”*.⁴³
45. On 6 November 2019 Dylan Taylor was working at The Glass House. His duties included taking food and drink to guests including the surgical trainees attending the conference dinner. He says over about a 5 hour period Dr Xu would have consumed 6 to 7 glass of white wine. He thought all the guests at the dinner, including Dr Xu, were quite drunk and they were drinking at a pretty decent rate. Had Dr Xu ordered another drink he would have been refused service.⁴⁴
46. Enquiries made of staff at the Evolve Spirits Bar provided no useful evidence. However financial information provided by that organisation indicates Dr Xu spent \$400 while at that bar in three transactions. The records indicate Dr Xu purchased Lark Distillers Collection 30 ml at \$40 per serve. The alcohol content of this drink is 46%. The documentation indicates on 6 November 2019 at 11:45pm Dr Xu purchased four drinks in one transaction, 3 drinks at 12:09am on 7 November 2019 in the second transaction and 3 drinks at 12:19am on 7 November 2019 in the third transaction.⁴⁵ Dr Xu did not consume all these drinks on his own but was purchasing drinks for his colleagues. From my consideration of the relevant CCTV footage he has consumed in excess of half of the ten drinks he purchased.
47. George Fiddymment was the security on the door at Mobius at the time Dr Xu entered that establishment. He recalls two males entering the premises at approximately 12:30pm who were not regulars. He did not think they were intoxicated when they came in. He said it was a quiet night and Dr Xu did not appear to him to be overly intoxicated. On a scale of 1 – 10, with 10 being drunk, he thought both males were equally intoxicated at around 6 – 7.⁴⁶ Dr Thakur has confirmed from a screen shot of CCTV footage shown to him at the inquest from inside Mobius that he was the person with Dr Xu.⁴⁷
48. Amy Fogarty was the bar manager on duty when Drs Xu and Thakur attended Mobius. Dr Xu ordered a drink for himself and a drink for Dr Thakur which she thinks was a gin and tonic which are served with a standard 30 mL shot of alcohol. Dr Xu

⁴³ Exhibit X13-affidavit of Dr Jordan Ross.

⁴⁴ Exhibit X17-affidavit of Dylan Taylor.

⁴⁵ Exhibit X30-affidavit of Matt Casey and annexures to that affidavit at exhibit X30A and exhibit X31 Dr Xu's Amex statement.

⁴⁶ Exhibit X14-affidavit of George Fiddymment.

⁴⁷ Transcript page 143 lines 16-36.

attempted to pay with his American Express card however that card is not accepted by Mobius. Dr Thakur ended up paying for those two drinks. No other drinks were purchased by either of them. Ms Fogarty would not have refused Dr Xu service had he ordered another drink but she could tell he had been drinking prior to attending Mobius.⁴⁸ This evidence conflicts with that of Mr Taylor. I accept the evidence of Mr Taylor in preference to that of Ms Fogarty given Dr Xu has consumed at least 9 to 10 drinks plus perhaps some beer before he arrived at Mobius and the fact that the CCTV footage of Dr Xu when he left Mobius shows him staggering and struggling to walk. I observed he was swaying from side to side during the walk. In addition the footage from inside Mobius showed Dr Xu to be disinhibited in that he had his arms around people, who were total strangers when talking to them in a very animated fashion.

Background - Mr Davies

49. Mr Davies was 27 years of age (date of birth 18 January 1993), single and he resided at Leongatha in Victoria with his parents Robert and Jill Davies. At the time of his death Mr Davies was employed as a cleaner in a family operated business. He was an aspiring professional diver.⁴⁹
50. Mr Davies was a qualified open water diving instructor with qualifications from the Professional Association of Diving Instructors and Scuba Schools International. He was also a qualified Emergency First Response Instructor (underwater) and a serving technician for Aqualung, Australia. He had been employed as a diver and had completed over 1000 dives, including “cave dives” and “wreck dives”. In addition Mr Davies had also managed a team of 10 to 15 employees at the “Intercontinental” and “South Sea Island” Resorts and he had worked as a diving instructor for Reef Safari Diving based at Airlie Beach in Queensland.⁵⁰
51. Medical records obtained from two medical practices indicate Mr Davies had a history of alcohol and polysubstance abuse together with mental health difficulties which included suicidal ideation up to approximately March 2017 and for which he received treatment. It appears from reports on file there had been suicidal ideation and a poly-pharmacy overdose in the context of alcohol intoxication and on a background of low mood and anxiety following a relationship breakdown. In addition he had been treated for a lacerated right forearm; an injury he sustained in Vietnam in September 2019

⁴⁸ Exhibit X15-affidavit of Amy Fogarty.

⁴⁹ Exhibit D1-Police Report of Death for the Coroner.

⁵⁰ Exhibit D59-statutory declaration of Robert Davies at paragraphs 2 and 3.

which required hospitalisation in that country and the administration of IV antibiotics. Mr Davies had fallen over and cut his arm on some glass which had been sutured in a local hospital but then became infected. He had further surgery under general anaesthetic to extract more glass. Mr Davies had undergone a liver function test in Vietnam and had been encouraged to follow this up on his return to Australia but his mother's belief is he had not done this.⁵¹ Mr Davies had also been prescribed medication for inguinal pain.⁵²

52. Mr Davies' father has indicated his son likes to party and when he does he "*drinks quite a lot*". He has also had problems with methamphetamine in the past which has impacted on his health. However at the time of Mr Davies' death his father believed he had not been taking drugs for a number of years. He had gained weight and his health had improved. In addition to his diving Mr Davies was a strong swimmer.⁵³

Circumstances Leading to Death - Mr Davies

53. Mr Davies flew to Launceston on 2 February 2020 to commence a Maritime Health and Safety course which was scheduled to conclude on 14 February 2020. The course was conducted by the University of Tasmania trading as the Australian Maritime College.⁵⁴ He had the weekend commencing on 8 February 2020 free so on Friday 7 February 2020, his father flew to Launceston to spend the weekend with him. That evening they had a counter meal together and went to bed at approximately 10:00pm. They drove to Hobart at approximately 10:00am the following day; arriving at approximately 12:30pm.⁵⁵
54. Upon their arrival they attempted to check into the Ibis Motel in Macquarie Street but it was too early. They therefore left the car and walked to the Welcome Stranger Hotel on the corner of Harrington Street and Davey Street for some lunch at which time they consumed two beers. They returned to the Ibis Motel at 2:00pm where they checked in and went for a swim in the pool. They then caught an Uber to Wrest Point casino where they consumed four beers each and played the poker machines. At 6:00pm they left and caught an Uber to the Telegraph Hotel where they had a counter meal for dinner and about four further beers each. They spent the evening watching the cricket

⁵¹ Exhibit D14-affidavit of Detective Senior Constable Martin White at paragraph 36.

⁵² Exhibit D7-Long Street Family Medicine records and exhibit D8-. Leongatha Healthcare records.

⁵³ Exhibit D11-statutory declaration of Robert Davies.

⁵⁴ Exhibit D54-course documentation obtained from the Australian Maritime College.

⁵⁵ Exhibit D59-statutory declaration of Robert Davies at paragraphs 2, and 5-7.

on television and playing snooker. Mr Davies senior estimates they each drank a total of ten schooners⁵⁶ of beer over a nine and a half hour period.⁵⁷

55. At approximately 10:00pm Mr Davies and his father caught a taxi back to the Ibis Motel. Mr Davies got changed and indicated to his father he was going back out. His father says when he left he did not appear to be intoxicated.⁵⁸
56. Mr Ian Vaughan is the managing director of Pub Banc Pty Ltd and Hotel Banc Pty Ltd and at the time of Mr Davies' death he was the licensee of the Telegraph Hotel situated at 19 Morrison Street Hobart, the Observatory Bar which is on the upper level of the building opposite the Telegraph Hotel, Jack Greene at 49 Salamanca Place, Cargo Bar and Pizza Lounge at 51 Salamanca Place, Post Street Social at 11 A Franklin Wharf Hobart and Tavern 42 Degrees South which is on the Elizabeth Street Pier at Hobart. The two companies are associated with the operation of the various venues of which Mr Vaughan is a licensee.⁵⁹ Mr Vaughan provided investigating police with documentation and CCTV footage from his venues.
57. As a result of reviewing CCTV footage and records Mr Vaughan says Mr Davies arrived in a taxi on Brooke Street at 10:16pm. Shortly thereafter he entered the Telegraph Hotel before exiting to have a cigarette. He re-entered a few minutes later. He left again at 10:44pm to have a cigarette before he re-entered five minutes later. He left the premises again at 11:19pm before he re-entered 5 minutes later. He left the Telegraph Hotel at 11:44pm with two other males who have not been identified by police.⁶⁰ His alcohol consumption while at the Telegraph Hotel will be discussed below.
58. Shortly thereafter Mr Davies is seen crossing Morrison Street into Post Street where he is screened by security before entering the Observatory Bar. While present in the bar he purchases a number of drinks and at 12:57am he is assaulted by a person later identified as Jared Spaulding. The assault consisted of a head butt to Mr Davies' forehead and upper nose area and then a left hand punch to the jaw of Mr Davies. As a result of the assault Mr Davies fell to the floor and Mr Spaulding immediately walked away.⁶¹
59. Beth Packer, one of the bar staff, motions crowd controllers towards Mr Davies as he stood up. The CCTV footage depicts Mr Davies as being unsteady on his feet and appearing disorientated immediately after the assault. He is approached by two crowd

⁵⁶ A schooner holds 425 mL of liquid.

⁵⁷ Exhibit D59-statutory declaration of Robert Davies at paragraphs 7-9.

⁵⁸ Exhibit D59-statutory declaration of Robert Davies at paragraph 10.

⁵⁹ Exhibits D28 and D31B-affidavits of Ian Vaughan.

⁶⁰ Exhibit D30-affidavit of Ian Vaughan and exhibits C14B and 14C-CCTV timeline and footage.

⁶¹ Exhibit 14C- CCTV footage.

controllers namely Mubin Ahmed and Tuese Vailepa. The footage depicts Mr James Barr, who had been in the company of Mr Davies when he was assaulted, speaking with both crowd controllers. Mr Ahmed then physically restrains Mr Davies after he attempted to move away. Mr Davies is then escorted from the venue by Mr Ahmed and Mr Vailepa. He is depicted on the CCTV footage staggering from the Observatory Bar diagonally across Post Street towards Morrison Street where he is last observed walking in the direction of Franklin wharf at approximately 12:59am. He is observed holding and nursing his right arm. The last person identified by police as seeing Mr Davies alive is the crowd controller positioned immediately outside the entrance to the Observatory Bar. That person is Eric Elford and the CCTV footage depicts Mr Elford pointing towards Mr Davies as he crosses Post Street which is consistent with Mr Elford advising another crowd controller, Alexander Hodge, of Mr Davies' departure. Mr Elford, Mr Ahmed, Mr Vailepa and Mr Barr do not recall any interaction they may have had with Mr Davies despite some of them being shown CCTV footage.⁶² As to the footage of Mr Davies being ejected Mr Elford says it was unremarkable and depicted one of countless incidents he has witnessed of a patron being ejected for being intoxicated.⁶³ Mr Barr also has no recollection of his discussion with Mr Ahmed and Mr Vailepa after the assault.⁶⁴

60. Mr Barr had been out at a party which started at the Welcome Stranger Hotel in Harrington Street. His group then went to the Mens Gallery in Collins Street and had a few drinks. He has no recollection of arriving at the Observatory Bar but he remembers talking to one of his friends he was with and he spoke to Mr Davies because Mr Davies told him he was not from Hobart and he was in town with his father. Mr Barr also gives a good description of Mr Davies. He is sure Mr Davies gave him his name but he does not recall it. He says "*we were all drunk*". He does not recall what time he arrived at the Observatory Bar, how long he was there for but he does know he got home at about 4-00am. Mr Barr says he would have been drunk prior to arriving at the Observatory Bar because it was their third or fourth stop. He contacted police the next day when he saw a social media post about a man who had fallen into the water who he recognised was the person he had been drinking with at the Observatory Bar; that is Mr Davies.⁶⁵

⁶² Exhibits D42, D40, D43 and D60-affidavits of Eric Elford, Tuese Vailepa, and James Barr and email from Mubin Ahmed.

⁶³ Exhibit D42-affidavit of Eric Elford.

⁶⁴ Exhibit D 43 – affidavit of James Barr.

⁶⁵ Exhibit D43-affidavit of James Barr.

61. Broden Barlow had been, on 8 February 2020, out with Mr Spaulding at Mr Spaulding's bucks party. He concedes he had been drinking alcohol heavily that evening. He does not recall any incident that occurred at the Observatory Bar and he does not recall leaving that venue. The only reason he believes he was there is because he had a stamp on his arm as a result of being admitted to that venue. He identifies being with Mr Davies in CCTV footage that police showed him but he has no recollection of any interaction with him.⁶⁶
62. Mr Spaulding confirms in his police record of interview that on 8 February 2020 he attended the Welcome Stranger Hotel, Ivory and then the Observatory Bar. It was his buck's night. Prior to attending the Welcome Stranger Hotel he and his friends went on a boat cruise and they may have gone to the Hanging Garden.⁶⁷ He had been drinking alcohol since 9:00am that morning and he could not remember much.⁶⁸ He could not recall entering the Observatory Bar that evening⁶⁹ and he could not recall anything after he arrived at that venue.⁷⁰ In addition to consuming alcohol Mr Spaulding had also consumed drugs.⁷¹
63. After leaving the Observatory Bar Mr Davies is next observed on CCTV footage near the bridge on Franklin Wharf that spans vessel access to Constitution Dock which is situated near the building occupied by Pennicott Wilderness Journeys. Further footage depicts Mr Davies walking from the bridge towards Elizabeth Street Pier and then along the pier past the restaurant known as Tavern 42 Degrees South at 1:12am. Mr Davies continues walking along the pier and it appears at one stage he is talking on a mobile phone before entering the Derwent River at the end of the pier at approximately 1:17am.⁷² Although the quality of the footage does not permit Mr Davies to be positively identified Senior Constable White believes the person on the footage is Mr Davies because phone records establish he was in that vicinity when he used his phone to call his father. In addition there is an absence of any other person being depicted on camera in the same location and subsequently Mr Davies' mobile phone and body were recovered from that area. I agree.
64. Call records establish that Mr Davies telephoned his father at 1:14am on 9 February 2020. The duration of the call was 220 seconds or about 3.6 minutes. The records indicate Mr Davies' phone was being used in the Franklin Wharf area. There was no

⁶⁶ Exhibit D45-affidavit of Broden Barlow.

⁶⁷ Exhibit D 44- police record of interview with Jared Spaulding at page 14.

⁶⁸ Exhibit D 44- police record of interview with Jared Spaulding at page 3.

⁶⁹ Exhibit D 44- police record of interview with Jared Spaulding at page 5.

⁷⁰ Exhibit D 44- police record of interview with Jared Spaulding at page 7.

⁷¹ Exhibit D 44- police record of interview with Jared Spaulding at page 19-20.

⁷² Exhibits C14B and 14C-CCTV timeline and footage.

outgoing communication from that phone after this telephone call. Records reflect Mr Davies' father called his son on multiple occasions from 1:21am.⁷³

65. Robert Davies says that during that telephone call his son was difficult to understand. He was not making any sense. He says Mr Davies was speaking a lot and sounded different. He had spoken to his son a number of times previously when he was intoxicated but on this occasion it was different. During the conversation Robert Davies says his son was speaking calmly although he was talking quickly and quietly but slurring his words as if he was making an effort to compose himself and get the words out properly. After the call Mr Robert Davies attempted to contact his son but he did not answer.⁷⁴
66. CCTV footage depicted the weather conditions were fine and unremarkable. This is corroborated by data obtained from the Bureau of Meteorology by Detective Senior Constable White.⁷⁵
67. On Monday 10 February 2020, Mr Davies' mobile phone was recovered by police divers from the floor of the Derwent River at the end of Elizabeth Street Pier in the area he was last observed on the CCTV footage. At 12:40pm the next day, Mr Davies' body was recovered by police divers and thereafter he was transferred to the mortuary at the Royal Hobart Hospital.

Investigation - Mr Davies

68. Mr Davies' life was pronounced to be extinct by Dr Sophie Parcell at the Royal Hobart Hospital on 11 February 2020⁷⁶ and he was formally identified by way of fingerprints which were analysed by the police fingerprint expert Tracey Tobin.⁷⁷
69. The police conducted inquiries to ascertain Mr Davies' movements since he arrived in Tasmania. Affidavits were obtained from his father, Mr Vaughan the licensee of the Observatory Bar, some of the patrons of that establishment and some of its staff. Mr Spaulding was interviewed by police about his assault of Mr Davies. Mr Vaughan also supplied staff records with respect to the RSA, the register of crowd controllers for the Observatory Bar, procedures and policies applicable to bar staff, security procedures and standard operating procedures of the Pub Banc Group. CCTV footage was obtained from the Telegraph Hotel and the Observatory Bar and a number of

⁷³ Exhibit D14-affidavit of Detective Senior Constable Martin White at paragraphs 24, 25 and 27.

⁷⁴ Exhibit D59-affidavit of Robert Davies at paragraphs 11, 13 and 14.

⁷⁵ Exhibit 14D-data from the Bureau of Meteorology.

⁷⁶ Exhibit D2-affidavit of Dr Sophie Parcell.

⁷⁷ Exhibit D4-affidavit of Tracey Tobin.

businesses or organisations which are based on the Hobart waterfront. Phone records, Mr Davies' medical records, financial and weather records and police forensics evidence including photographs were obtained. Further evidence was obtained from TasPorts, the Tasmania Police Licensing section and the Liquor and Gaming Branch of the Department of Treasury and Finance. Evidence was also obtained from TasTAFE, with respect to the RSA, and the Hobart City Council. Various maps, diagrams and photographs of the waterfront were obtained. From these inquiries police were able to rule out that Mr Davies fell into the water deliberately or the fall was directly caused by another person or that it was witnessed by anyone who may have rendered assistance. Police were also able to determine from their investigations that the Elizabeth Street Pier was well lit. There is a single life buoy mounted on the building wall on the corner facing Kings Pier Marina. There is a raised ledge running along the perimeter of the pier with no railing and there is no ladder at the end of the pier. The pier is accessible to the public 24 hours a day, 7 days a week, except for a locked gate to a jetty at the end which is depicted in site plans and scene photographs. Based on measurements made by Constable Gowen,⁷⁸ it is estimated Mr Davies fell a distance of between 2 and 2.5 m before hitting the water.

70. Evidence obtained from Lisa Gregg who was the Assistant Director – Risk Based Licensing for Consumer and Building and Occupational Services (CBOS), a unit of the Department of Justice, confirms Mr Vailepa had held a security licence since 2016 which had been renewed on 15 October 2019 for a period of 3 years. Mr Ahmed was issued a security licence on 30 October 2018 for a period of 3 years subject to a condition that all outstanding training qualifications be completed within 12 months of the date of issue. His licence was withdrawn on 30 October 2019 after notification to the effect the certificates with respect to the outstanding qualifications had not been submitted to CBOS. The outstanding certificates were not provided until 27 February 2020 but by that time the licence had been withdrawn for almost 4 months. He was advised he would have to reapply. He did so on 9 March 2020 and was issued with a new licence. He was therefore not licensed to work as a crowd controller on 8 or 9 February 2020 and therefore was arguably in breach of s4 of the *Security and Investigations Agents Act 2002*.⁷⁹
71. Anna Flower was, at the time of the deaths of Dr Xu and Mr Davies, the General Manager Risk and Resilience of TasPorts. In her affidavit she provides evidence with respect to two cameras which are housed in the Marine Board building. The cameras

⁷⁸ Exhibit D24-affidavit of Constable Jared Gowen and site plan.

⁷⁹ Exhibit D51-affidavit of Lisa Gregg together with the annexure is at exhibits D51A, D51B and D51C.

cover the Franklin Wharf/ Sullivan's Cove area and they sit in what is called a "home position" when not in use which gives an overview of activities occurring in the public space covered by the cameras. Scans of the cameras are conducted at 2 hour intervals to detect any unusual or suspicious activity. Where an event or incident is identified during those scans or an incident is reported to the TasPorts' operations centre the cameras will be placed on the area to monitor the situation. TasPorts do not employ guards to undertake patrols of the public area as they add little value in incident detection and management because guards cannot be in multiple places at once. In addition guards have no power to detain members of the public and they would also be potentially at risk by actions of the public towards them. Accordingly the area is monitored through the cameras and police are advised of any incident, concern or the like which is identified by staff.⁸⁰

72. Sophie Grace has also provided an affidavit in relation to this matter. At the time of these deaths she was the Executive General Manager Compliance, Safety and Sustainability at TasPorts. Ms Grace confirms Elizabeth Street Pier is well lit with pedestal and wall mounted lights. Routine lighting inspections are undertaken every 180 days and all lights were working on that Pier on 3 January 2020 and again at the next inspection which was conducted in mid-2020.⁸¹
73. In her supplementary affidavit Ms Grace indicates a review was conducted of property owned and managed by TasPorts after Mr Davies' death in order to identify whether any further improvements could be made to public safety in addition to the controls which were already in place. In January 2021 all existing life buoys in Sullivan's Cove were replaced and an additional 13 life buoys were installed. There are now 28 life buoys installed at various locations around Sullivan's Cove. The life buoy stands have been designed to hold a light above the life buoy to highlight the life buoy. The lighting was to be in place by 30 June 2021. In addition there was to be fencing placed around sculptures located between Victoria Dock and Macquarie Wharf which was also due to be completed by June 2021. An additional five ladders were also to be installed by May 2021 between Elizabeth and Brooke Street Piers. In addition TasPorts signed a memorandum of understanding with the Royal Lifesaving Society Tasmania in order to deliver key water safety education messages across the community. Some further initiatives were to be implemented as a result of discussions between those two bodies.⁸²

⁸⁰ Exhibits D47 and D47A- affidavit of Anna Flower and photographs depicting camera coverage.

⁸¹ Exhibit D48-affidavit of Sophie Grace and drawings and photographs which are exhibits D48A, D48B and D48C respectively.

⁸² Exhibit D4D8-supplementary affidavit of Sophie Grace and annexures.

74. David Dunn is the Education Manager of Tourism and Hospitality and Drysdale North for TasTAFE. He has supplied information with respect to the RSA course offered by TasTAFE. The course consists of one unit which is nationally accredited. It provides for performance outcomes, skills and knowledge required to responsibly sell or serve alcohol. The unit applies to all levels of sales personnel involved in the sale, service and promotional service of alcohol in licensed premises. It also applies to security staff who monitor customer behaviour and to the licensee who is ultimately responsible for the management of the RSA. The unit includes details under State and Territory liquor licensing laws and in some cases after completion of the unit a State or Territory authority may require candidates to complete a bridging course to address any specific differences in the laws between States and Territories.⁸³
75. Benjamin Granger worked on a casual basis as a crowd controller at the Observatory Bar in its previous location in Morrison Street near Princes Wharf (opposite Parliament House) between 17 October 2015 and 31 March 2018. He left that employment partly due to, what he says, were expectations of him by his employer that put him in danger. In this regard he says all guards received a memorandum in February 2018 where the policy in relation to calling police was changed. The policy had been police would be called in any instance where a patron loitered for more than 2 minutes after being removed or refused service. However moving forward crowd controllers were to use their mediation and negotiation skills to try and resolve and de-escalate potentially volatile situations and that police were only to be notified when a threat was apparent or all attempts to resolve or de-escalate the situation had failed or where the Security Manager, Venue Manager or any member of the Operations Team had directed the crowd controller to call police. He then gives two examples where he felt threatened by patrons and on the first occasion which occurred on 17 March 2018 he was specifically directed by Mr Vaughan not to call police. The second occasion occurred on 28 March 2018. He says there were more examples where he says in essence his safety was compromised but where the direction was not to call police.⁸⁴
76. In a subsequent affidavit Mr Granger says he had shifts at the Observatory Bar, Telegraph Hotel, Cargo and Jack Greene where a patron would regularly be able to order an excessive quantity of alcohol just prior closing time, purchase the drinks but then be told they would have to leave the venue before being given a reasonable time

⁸³ Exhibit D52-affidavit of David Dunn.

⁸⁴ Exhibit D46-affidavit of Benjamin Granger.

to consume them. This created difficulties because he would be called on to intervene which resulted in patrons being inevitably disgruntled when they were asked to leave. It frequently resulted in a patron having to be physically removed.⁸⁵

77. The Commissioner for Licensing says the Observatory Bar is a licensed venue which operates as a nightclub. Although the street address is 11A Franklin Wharf Hobart the entrance to the premises is located in Post Street. The venue was first granted an on-licence on 13 December 2018 with an effective date of 13 May 2019. Mr Vaughan had made an application for a licence on 16 October 2018 which followed the renovation of the building on Franklin Wharf and Mr Vaughan relocating the business from its previous location on Murray Street Pier where it had operated since 28 November 2012. The relocation necessitated an application for a liquor licence with respect to the new building. The Observatory Bar also operates under the provisions of an out-of-hours permit which permits the sale of liquor outside of the on licence hours, that is between midnight and 5:00am for the hours specified in the permit which between 13 May 2019 and 19 May 2023 was until 5:00am 7 days a week.⁸⁶
78. Mr Root says the Liquor and Gaming Branch received a complaint on 11 February 2020 with respect to Mr Davies when he was outside the Telegraph Hotel at 10:45pm on 8 February 2020. CCTV footage was provided with the complaint. The complaint noted Mr Davies had subsequently died. CCTV footage was requested from Mr Vaughan from both the Observatory Bar and the Telegraph Hotel. On 19 February 2020 officers of the Liquor and Gaming Branch requested police to advise if they became aware of any breach of the LLA occurring as a result of Mr Davies attending either venue. On 27 February 2020 the Liquor and Gaming Branch received a report from Tasmania Police that an assault had occurred at the Observatory Bar on 9 February 2020 at 12:57am. The report also advised an offence report had been generated and the defendant charged. There was no recommendation listed on the report due to the matter being investigated by my office. Accordingly Mr Root requested the Liquor and Gaming Branch not pursue any further investigations at this time.⁸⁷
79. Toxicological testing was conducted on the vitreous humour of Mr Davies which is the main fluid component of the eye. The result returned was 0.140 g of alcohol in 100 ml. Mr McLachlan-Troup says in his affidavit vitreous humour is least likely to be contaminated from visceral fluids or through post-mortem redistribution and it tends

⁸⁵ Exhibit D46B- affidavit of Benjamin Granger.

⁸⁶ Exhibit D49-affidavit of Jonathon Root.

⁸⁷ Exhibit D49-affidavit of Jonathon Root.

to be relatively preserved from bacterial attack. The concentration of alcohol in vitreous humour is expected to be higher than in an equal volume of whole blood by a factor of 1.2:1. In his affidavit Mr McLachlan-Troup repeats what he says, in paragraph 40, about alcohol being a CNS depressant.⁸⁸

80. In a subsequent affidavit,⁸⁹ Mr McLachlan-Troup calculates Mr Davies' blood alcohol concentration (BAC) from the vitreous alcohol concentration (VAC) using the factor in paragraph 79 of 1.2:1 and arrives at a BAC of 0.117 g/ 100 ml. However he says this factor applies to the elimination phase of alcohol metabolism; that is after all the alcohol has been absorbed and is then just being eliminated from the body. He suggests because Mr Davies had left the Observatory Bar approximately 20 minutes before entering the water it is likely that some of the alcohol he consumed at that bar was still being absorbed at the time of his death which means the BAC estimate would be an underestimate. In addition he says VACs, in a number of alcohol-related drownings, have been thought to be falsely low due to alcohol diffusing out of the eye with prolonged immersion in water. For these two reasons he thinks a BAC of 0.117 g/ 100 ml is probably an underestimate.
81. Mr McLachlan-Troup therefore proceeded to estimate Mr Davies' BAC at the time of his death from a drink pattern analysis of his weight and stature and what alcohol he consumed at Wrest Point Casino, the Telegraph Hotel on the two occasions he visited and the Observatory Bar and an alcohol metabolism or elimination rate of 0.020 g/100 ml/ hour. Based upon the information supplied to him and his estimates of what each drink consumed contained by way of alcohol he calculated a BAC at the time Mr Davies entered the water at approximately 1:17am at 0.236 g/100 ml. He says that this figure is likely to be an over estimate because it assumes Mr Davies had absorbed all the alcohol that he drank at the last venue. Having taken that into account he concludes the BAC at that time would have been approximately 0.20 g/100 ml. A BAC in that range would have placed Mr Davies in either the excitation stage (0.09 – 0.250 g/100 ml) or in the confusion stage (0.18 – 0.300 g/100ml) of alcohol intoxication. He says the confusion stage is characterised by dizziness, exaggerated emotional states, visual disturbances and muscular incoordination including a staggering gait. The calculations performed by Mr McLachlan-Troup probably underestimate Mr Davies BAC as they appear not to take into account all the alcohol consumed which is mentioned in paragraph 54.⁹⁰

⁸⁸ Exhibit D6A-affidavit of Neil McLachlan-Troup.

⁸⁹ Exhibit D6B-affidavit of Neil McLachlan-Troup.

⁹⁰ For example the beer consumed at the Welcome Stranger Hotel.

82. The forensic pathologist Dr Donald Ritchey performed an autopsy on Mr Davies on 12 February 2020. He conducted both an external and internal examination and he examined the results of histology and toxicology. As a result of those investigations he concluded the cause of death was undetermined due to the effects of decomposition and extensive scavenging by marine animals. Despite this he says investigation findings strongly suggest an accidental drowning while intoxicated.⁹¹ I accept Dr Ritchey's opinion.

Evidence with respect to alcohol consumption - Mr Davies

83. In addition to the alcohol referred to in paragraph 54 which was consumed by Mr Davies he purchased the following drinks at the Telegraph Hotel on 8 February 2020:

- 10:22pm 1 x Vodka Red Bull;
- 10:35pm 1 x Vodka Red Bull;
- 10:57pm 1 x Vodka Red Bull;
- 11:08pm 2 x Vodka Red bull and he consumes one of them;
- 11:10pm 1 x Vodka Red Bull;
- 11:15pm 2 x Vodka Red bull and he consumes one of them; and
- 11:34pm 1 x Vodka Red Bull.

He is served by four different bar staff one of whom serves him twice while another serves him three times.⁹²

84. At the Observatory Bar Mr Davies purchased the following drinks on 8 and 9 February 2020:

- 11:48pm 1 x Vodka Red Bull;
- 11:56pm 1 x Vodka Red Bull;
- 12:06am 3 x Johnny Walker Red Label whiskey and 1 x Vodka Red Bull;
- 12:20am 2 x Jager bombs (a mixture of a liqueur and Red Bull);
- 12:42am 4 x Vodka Red Bull; and
- 12:53am 3 x Vodka Red Bull.

⁹¹ Exhibit D5-affidavit of Dr Donald Ritchey.

⁹² Exhibit D30-affidavit of Ian Vaughan.

Where more than 2 drinks were purchased he has not consumed all the drinks but has given some of the drinks to the patrons he was with.⁹³ Mr Davies was served by five different bar staff one of whom served him twice at 11:56pm and 12:42am.⁹⁴

85. All bar staff mentioned in paragraphs 86 to 90 had RSA qualifications.⁹⁵ None of the bar staff recall serving Mr Davies even after being shown CCTV footage by Tasmania Police.⁹⁶ They also say the following.
86. Andrew Goss was on duty at the Observatory Bar on the evening of 8 February 2020 and morning of 9 February 2020. He obtained his RSA qualification in 2008 and also a qualification with respect to crowd control in Victoria in 2019. He also completed a bridging course in crowd control in Tasmania so that he can work as a crowd controller in this State. He had been employed at the Observatory Bar since about March 2018. He had worked in several bars and bottle shops since 2008 and performed management roles at a number of venues which included the supervision of bar staff. He was not employed as a supervisor at the Observatory Bar. He says when he commenced employment at that venue the induction process involves being handed a document titled 'standard operating procedures'. He had no difficulties with the contents of that document and was aware of his obligations under RSA. If a patron presented as intoxicated at the bar where he was working he would call security and have them removed after refusing service. He would call security because it was not unusual for a patron to wander off and attempt to be served at the other bar or have someone else get them a drink. Only in his capacity as a crowd controller did he have concerns relating to the lack of support for patrons that had been required to leave this venue due to their intoxication.⁹⁷
87. Jesse Crossin was on duty at the Observatory Bar on the evening of 8 February 2020 and morning of 9 February 2020. She obtained her RSA qualification in April 2018 and had been employed on a casual basis at the Observatory Bar from about May that year. She says she is fully aware of her RSA obligations and she would not have served alcohol to Mr Davies or any other person who appeared intoxicated.⁹⁸

⁹³ Exhibit D29-affidavit of Ian Vaughan.

⁹⁴ Exhibits D35, D36, D37, D38 and D39-affidavits of Andrew Goss, Jesse Crossin, Hayden Clark, Brianna Fenton and Anna Packer.

⁹⁵ Exhibit D27A-documentation supplied by Ian Vaughan.

⁹⁶ Exhibits D35, D36, D37, D38 and D39-affidavits of Andrew Goss, Jesse Crossin, Hayden Clark, Brianna Fenton and Anna Packer.

⁹⁷ Exhibit D35-affidavit of Andrew Goss.

⁹⁸ Exhibit D36-affidavit of Jesse Crossin.

88. Hayden Clark was on duty at the Observatory Bar on the evening of 8 February 2020 and morning of 9 February 2020. He obtained his RSA qualification in March 2019 online. He was employed on a casual basis at the Observatory Bar for about 10 months from August 2019. He does not remember anything significant occurring and he says patrons being thrown out for fighting is a regular occurrence. If a person seems highly intoxicated he would refuse service and if he was unsure he would ask the bar supervisor or senior bar staff for advice.⁹⁹
89. Brianna Fenton was on duty at the Observatory Bar on the evening of 8 February 2020 and morning of 9 February 2020. She obtained her RSA qualification in July 2018 and she has worked as a casual employee at the Observatory Bar since that time. She recalls other staff speaking about a fight which occurred during her shift however she could not recall the incident.¹⁰⁰
90. Anna Packer was on duty at the Observatory Bar on the evening of 8 February 2020 and morning of 9 February 2020. She obtained her RSA qualification in August 2016 while still at school. As at February 2020 she had been employed at the Observatory Bar for about 16 months and she had been a supervisor for about 3 months. She recalls her shift was a busy one. After being told that she had potentially witnessed an incident involving Mr Davies she recalled an assault and her calling security over. She did not see the assault but she heard a noise and looked up and saw a male person stumbling on the floor. She thought he was intoxicated so she called security. She flashed a torch and security came to her and she pointed to the male patron; ie Mr Davies. When she served Mr Davies which was at about 12:53am she also served him a glass of water. She could only confirm this after police showed her CCTV footage. She says she is fully aware of her RSA obligations and would not have served alcohol to anyone who appeared intoxicated.¹⁰¹
91. Alexander Hodge has been a licensed crowd controller for a period of in excess of 15 years. He has been employed as a crowd controller at the Observatory Bar for in excess of 10 years. He is the security team leader who supervises the licensed crowd controllers working at that venue. He says his team of crowd controllers have all formally acknowledged standard operating procedures and site orders relevant to their duties and responsibilities for the venue they are working at. He says it is a requirement that all crowd controllers sign on in the crowd controller register kept at a venue and sign off at the end of their shift with details of any incident that occurred.

⁹⁹ Exhibit D37-affidavit of Hayden Clark.

¹⁰⁰ Exhibit D38-affidavit of Brianna Fenton.

¹⁰¹ Exhibit D39-affidavit of Anna Packer.

They are provided with a notebook to record any incidents they encounter. Serious incidents should be logged on a separate incident report however there is no such document in relation to Mr Davies' removal. A serious incident is defined as including a death or if someone suffers a serious injury or illness that requires immediate hospitalisation or medical treatment, electric shock, fire or explosion, infrastructure collapse or chemical spill or leak. He was on duty at the venue between 8:50pm on 8 February 2020 through until 5:30am on 9 February 2020. He has no specific recollection of Mr Davies being escorted from the venue but has viewed the CCTV footage and identified the two crowd controllers who did remove him namely Mr Vailepa and Mr Ahmed. His duties required him to remain at the entrance to the Observatory Bar and he would move from this position only to respond to incidents at this venue and at Post Street Bar which is in the same building with the Observatory Bar occupying the top floor and Post Street Bar occupying the ground floor. He recorded in his notebook this was a particularly busy night with multiple incidents. On the evening in question he recalls Mr Spaulding entering the venue and then leaving for a period before the evidence shows he was readmitted.¹⁰²

92. Mr Kumar was working at the Observatory Bar in his capacity as a crowd controller on the evening of 8 February 2020 and morning of 9 February 2020. He has no direct recollection of dealing with Mr Davies although he has a recollection of speaking to a man in his late 50s who attended the Observatory Bar and spoke to him about his son who had gone missing a day earlier after his son had attended the Observatory Bar. I infer this person was Mr Robert Davies. On 15 July 2020 Mr Kumar viewed CCTV footage of he and Umar Khan screening patrons, including Mr Davies, as they entered the venue. He is depicted checking that Mr Davies met the dress code. Mr Kumar says at the same time he would have been assessing Mr Davies' level of intoxication. After viewing the footage he still has no recollection of interacting with Mr Davies. He says Mr Davies' gait walking up the ramp as depicted on CCTV is consistent with a person who is not intoxicated.¹⁰³
93. Umer Khan was working at the Observatory Bar in his capacity as a crowd controller on the evening of 8 February 2020 and morning of 9 February 2020. Like Mr Kumar Mr Khan has no recollection of any interaction he had with Mr Davies. He viewed the same footage as Mr Kumar and notes he is depicted talking to the person identified as Mr Davies. He says it looks like both he and Mr Kumar are checking whether Mr Davies complied with the dress code and his level of intoxication. He says if Mr Davies

¹⁰² Exhibit D41-affidavit of Alexander Hodge.

¹⁰³ Exhibit D33-affidavit of Vikas Kumar.

was too intoxicated he would have been denied entry. He believes the footage depicts a typical and unremarkable interaction with a patron. After viewing the footage he still had no recollection of his interaction with Mr Davies.¹⁰⁴

94. Mubin Ahmed was working at the Observatory Bar in his capacity as a crowd controller on the evening of 8 February 2020 and morning of 9 February 2020. His understanding of his duties are that he was to control the crowd and prevent any fighting among intoxicated people. At the commencement of a shift he registers himself in the crowd controllers' register as having commenced the shift and he has to write down all reports of incidents that occur during the shift in that register. If anyone is harassing another patron or being violent due to intoxication he is required to call the radio room to inform the security supervisor. That supervisor then assesses the situation before action is taken. He does not recall any specific incident involving Mr Davies or the fact that he was working with Mr Vailepa on the shift.¹⁰⁵
95. Tuese Vailepa was working at the Observatory Bar in his capacity as a crowd controller on the morning of 9 February 2020. He commenced his shift at 12:10am and concluded at 5:10am. He commenced working at the Observatory Bar in or about June 2019. When he commenced work he was inducted by a manager whose name he can no longer recall. As a result of the induction he understood his responsibilities were to use the minimum amount of force required to eject a patron due to their intoxication or behaviour. He recorded any incident that requires contact with a patron and their eviction from the venue in a notebook he carried. He then recorded those details in the crowd controller register that is kept at the venue. In that register he also records his start and finish times for the shift. He, like his colleagues, had no recollection of any incident that occurred during his shift. He did however record an incident in the register where he removed a patron who I infer was Mr Davies from the venue due to that patron's intoxication. As they were walking out Mr Davies tried to rush back to the bar and Mr Vailepa had to use what he describes as reasonable force to remove him. Mr Vailepa recorded another instance in the register which was unrelated to Mr Davies. Consideration of those entries did not assist his recollection of his interaction with Mr Davies that morning. He confirmed the first incident he recorded in the register, after viewing a CCTV clip shown to him by police, was he and Mr Ahmed removing Mr Davies from the main bar area a few minutes before 1:00am.¹⁰⁶

¹⁰⁴ Exhibit D34-affidavit of Umer Khan.

¹⁰⁵ Exhibit D60 email of Mubin Ahmed.

¹⁰⁶ Exhibit D40-affidavit of Tuese Vailepa.

Evidence from the Commissioner for Licensing relevant to both deaths

96. The LLA stipulates a person is qualified to be granted a liquor licence if, amongst other things, that person has successfully completed an approved course in the service of liquor. An approved course means a course or traineeship in the service of liquor approved by the Commissioner for Licensing.¹⁰⁷ Successful completion of an approved RSA course therefore forms part of the Commissioner's consideration as to whether a liquor licence should be granted.¹⁰⁸
97. Mr Root says a licensee's compliance with his or her obligations under the LLA is verified through compliance audits undertaken by the Compliance Unit of the Liquor and Gaming Branch. Compliance inspectors undertake audits and inspections of licensed premises, both individually and jointly. When a joint inspection takes place the inspection is conducted by representatives of Tasmania Police, local government and Tasmania Fire Service and representatives of WorkSafe Tasmania have also been included. In addition, Mr Root says targeted inspections and surveillance operations are carried out to ensure obligations under the Act are being met by licensees. He actively reviews intelligence gathered by inspectors and police officers and will investigate further if evidence suggests that a breach of the LLA has occurred.¹⁰⁹
98. Mr Root says the process of taking disciplinary action under the LLA is an administrative process. Unlike Tasmania Police he does not have the power to issue infringement notices under the LLA. In order to take disciplinary action, he says evidence gathered on his behalf must identify a connection between the conduct of the person and a particular licensed premises.¹¹⁰
99. The Liquor and Gaming Branch has six compliance inspectors who undertake inspections in southern Tasmania. Of those six, three are employed under an industrial agreement that enables regular inspections undertaken outside of normal business hours. The inspections undertaken include gaming premises, as well as liquor licensed and permitted premises. Mr Root says in 2020 there were 1092 licensed premises in the south of the State that are inspected according to a schedule which is regularly reviewed and amended in response to emerging issues and risks.¹¹¹

¹⁰⁷ Section 22(1)(d) LLA.

¹⁰⁸ Exhibit D49-affidavit of Jonathon Root.

¹⁰⁹ Exhibit D49-affidavit of Jonathon Root.

¹¹⁰ Exhibit D49-affidavit of Jonathon Root.

¹¹¹ Exhibit D49-affidavit of Jonathon Root.

100. In November 2018 Mr Root determined he would approve a set of technical standards for CCTV, and in accordance with s34B of the LLA, to vary conditions of existing out-of-hours permits to require any licensed premises operating anywhere within Tasmania which traded after 2:00am to install CCTV which met the technical standards. This he says formalised a previously ad hoc practice of including conditions relating to CCTV surveillance on out-of-hours permits. In making this determination he considered a higher amount of antisocial behaviour occurs in licensed premises that trade after midnight than those that trade before midnight. He also considers premises that trade after 2:00am are at a high risk of being located where this antisocial behaviour occurs and such premises attract persons who may be intoxicated and disruptive in the neighbourhood of the premises when turned away by door staff. He considered it to be in the interest of the community for this condition to be put in place as it may deter patrons from causing annoyance, disturbance or disorderly conduct either in the premises or in the vicinity of those premises. He also considered that if antisocial incidents occur police might be able to obtain CCTV footage from a venue to assist in any investigation of such an incident. To give existing permit holders sufficient time to meet the technical standards Mr Root imposed a commencement date of 1 March 2019 by which time compliance was mandatory. Any new permit issued from 1 December 2019 required compliance with the technical standards by 1 March 2019. In addition he determined the following standard conditions were to be included in all out-of-hours permits that exceeded 2:00am:

- CCTV surveillance standards CFLRS002 are to be met;
- All recorded CCTV surveillance is to be retained for a minimum of 14 days;
- and
- Access to and/or a copy of CCTV surveillance is to be provided upon request to a Police Officer or the Commissioner for Licensing.

101. On 15 June 2019 compliance inspectors of the Liquor and Gaming Branch were instructed to undertake a targeted review of CCTV systems installed in premises in Hobart including Mobius. This inspection was to ensure these premises met the CCTV surveillance standards. Mobius was found to be compliant.¹¹²

102. The Commissioner has a range of powers under the LLA to address disorderly conduct, annoyance and disturbance where that behaviour can be linked to a licensed venue. These powers include applying conditions to licences and permits to reduce the risk of poor behaviour in and around licensed premises.¹¹³ Such a condition might

¹¹² Exhibit D49-affidavit of Jonathon Root.

¹¹³ See s39 of the LLA for example.

include one that specifies no patrons are to enter or re-enter a licensed venue after a certain time. Where there is sufficient evidence the Commissioner also has powers to cancel, suspend or vary a license or permit. Grounds for disciplinary action are specified in the LLA and include contravening a licence or permit condition, contravening a provision of the LLA or where the sale of liquor on the licensed or permitted premises is causing undue annoyance or disturbance or is causing the occurrence of disorderly conduct.¹¹⁴

Evidence from Tasmania Police relevant to both deaths

103. Sergeant Peter Andricopoulos is attached to the Southern Licensing Section of Tasmania Police. That section consisted, at the time of the deaths of Dr Xu and Mr Davies, of one sergeant and three constables. The core function of that section is to police the LLA, liaise with the Liquor and Gaming Branch and hold licensees and/or permit holders and patrons to account in order to promote safety. The section therefore investigates breaches of the LLA. He says this is achieved by physically attending venues and conducted checks while venues are operating. His officers also conduct investigations by obtaining surveillance and point of sale records from licensed venues where appropriate. Details were provided of infringement notices issued by police under that legislation for the period from 1 July 2017 until 6 August 2020. During that time the majority of offences related to patrons who refused to leave licensed premises when required to do so or who have behaved in a violent, quarrelsome or disorderly manner on those premises. In these cases police have assisted licensees and all staff to remove those people from the premises.¹¹⁵

104. Analysis of the infringements reveals the following:

- 514 were detected during the period 1 July 2017 to 6 August 2020;
- Of those 195 or 37.93% were found to be against licensees; and
- Of those 178 or 91.28% were found to be against licensees in the south of Tasmania;

Of the 195 infringements detected against licensees:

1. 163 or 83.6% were dealt with by caution;
2. 11 or 5.6% were revoked; and
3. 21 or 10.8% were actually issued and/or fines were paid.

¹¹⁴ See s99 of the LLA for these and other grounds.

¹¹⁵ Exhibit D26-affidavit of Sergeant Peter Andricopoulos.

Of the total number of infringements (514) only 4.1% were issued or resulted in fines against licensees.¹¹⁶

105. Sergeant Andricopoulos was appointed to lead the Southern Licensing Service of Tasmania Police in 2019. At the commencement of that service the team consisted of 3 other police officers who would be predominantly rostered onto afternoon or night shifts. On some shifts the four of them would be rostered together or he would roster two police officers on the afternoon shift and two officers on the night shift. That service still supported other divisions of the Southern District of Tasmania Police. When there was a restructure in 2022 the number of officers in the Southern Licensing Service was reduced to two but it is supported by general uniform police officers when required.¹¹⁷
106. There is a protocol between the Department of Police Fire and Emergency Management and the Department of Treasury and Finance with respect to information sharing between those departments for the purpose of administering the LLA.¹¹⁸ This means each day Southern Licensing Services receive an email from the Liquor and Gaming Branch with a spreadsheet which details all licensed premises in the State and the conditions attached to the respective licences. Southern Licensing Services then attend licensed premises at random and check compliance with the conditions of the licence. If there are any issues, as authorised officers, the police officers can issue cautions or cause infringement notices to be issued. Records relevant to Dr Xu's death indicate no member of Southern Licensing Services attended the Evolve Spirits Bar or Mobius on the day in question and no member of Southern Licensing Services was on duty at the time of Mr Davies' death as two members were on annual leave and the other two had a shift change and were required to work dayshift on 9 February 2020 at the Hobart Cup.¹¹⁹
107. Southern Licensing Services is under the command of Assistant Police Commissioner Adrian Bodnar. He says that Service is responsible for enforcing compliance with the LLA. He confirmed Southern Licensing Services currently consists of one Sergeant and a Senior Constable who are appointed as authorised officers for the purposes of s209 of the LLA. At the time of these two deaths Southern Licensing Services comprised a team of four which included a Sergeant, a Senior Constable and two constables. That service is supported by general uniform police officers and it supports general uniform

¹¹⁶ Exhibits D26A and D26C-details of Police infringement notices.

¹¹⁷ Exhibit C3- affidavit of Sergeant Peter Andricopoulos.

¹¹⁸ See Exhibit D26B.

¹¹⁹ Exhibit C3- affidavit of Sergeant Peter Andricopoulos.

officers as and when required. He says in accordance with s93 of the *Police Service Act* 2003, Part 2.14 of the Tasmania Police Manual contains orders, directions, procedures and instructions issued by the Commissioner of Police which specifically relate to liquor licensing. That manual is available to all serving police officers.¹²⁰

108. After giving evidence and pursuant to my request, Assistant Commissioner Bodnar made enquiries as to what, if any, information sharing mechanisms exist between Tasmania Police and the Department of Justice or CBOS who are the agencies responsible for training and licensing crowd controllers in Tasmania. He advised, to the best of his knowledge, there are no formal information sharing arrangements in place. There is however an obligation under s7 of the *Security and Investigations Agents Act* 2002 that the Commissioner of Police must inquire into and report to the Director of Consumer Affairs and Fair Trading on any matters concerning an application for a crowd controller licence at the request of the Director.¹²¹

Evidence from the Hobart City Council relevant to both deaths

109. Mark Anderson, the Manager Surveying Services at the Hobart City Council (HCC), has provided documentary evidence that the registered proprietor of the entirety of Victoria Dock, including the place at which Dr Xu fell into the water, at the date of Dr Xu's death was TasPorts. That company has been the registered proprietor of that property since 11 April 2006. In addition he says TasPorts has been the registered proprietor of the Elizabeth Street Pier, from which Mr Davies entered the water, since 11 April 2006 and it was the registered proprietor of that property on the date Mr Davies was last seen.¹²² Although the HCC was initially represented in this matter at the CMC it was not, after the provision of Mr Anderson's affidavit on 16 May 2023, represented and nor did the HCC wish to be heard at this inquest because that entity did not own or control land relevant to the deaths of both men.

Evidence from TasPorts relevant to both deaths

110. Prudence Cunningham is the manager of operations in Southern Tasmania for TasPorts. Since Ms Grace provided evidence as to the installation of additional life buoys a further two life buoys have been installed which means a total of 15 additional life buoys have been installed since these deaths. There are now 31 life buoys in Sullivans Cove. They have all now had lighting installed which operates between dusk

¹²⁰ Exhibit C2-affidavit of Assistant Commissioner Adrian Bodnar.

¹²¹ Exhibit C2-affidavit of Assistant Commissioner Adrian Bodnar and s7(3) of the *Security and Investigations Agents Act* 2002.

¹²² Exhibit C4-affidavit of Mark Anderson.

and dawn. In addition fencing has been installed where the fall height is greater 1.5 m and where there is no over wharf operational requirements for a fence in that area. This fencing has been installed near the Bernacchi Tribute Sculptures which are located on Franklin Wharf near MACq01 Hotel just west of Victoria Dock Bridge. In addition in June 2021, TasPorts installed fencing along the lower steps of Waterman's Dock and in May 2022, anti-slip materials were installed over the existing concrete.¹²³

111. Since the deaths of Dr Xu and Mr Davies, TasPorts has installed an additional 12 safety ladders in Sullivans Cove which brings the total number of ladders to 42. All safety ladders are also equipped with safety lighting which operates between dusk and dawn. In addition TasPorts works with the Royal Lifesaving Society Tasmania (RLST) to improve safety across the Hobart waterfront. As part of this association Royal Lifesaving Society Australia conducted an aquatic safety assessment which included a risk assessment and treatment plan which made a number of recommendations relevant to water safety at the Port of Hobart. Where relevant, TasPorts is implementing those recommendations which include the provision of water safety signage. In addition TasPorts has designed instructional lifesaving signage to be installed on each lifebuoy and it is working with RLST to create an instructional film which explains the use of lifesaving equipment on the waterfront which can be accessed via a QR code installed on each lifebuoy. In January 2023 line marking on Franklin Wharf was added to improve pedestrian safety. In addition, TasPorts is planning to implement zebra crossings in multiple areas between the Elizabeth Street Pier and Victoria Dock Bridge. In so far as the Hobart waterfront is concerned, Ms Cunningham says her organisation undertakes continuous monitoring, regular risk assessments and regular internal safety reviews which include regular safety walks and weekly safety meetings. Stakeholders are also regularly consulted to discuss relevant changes and upgrades around the waterfront.¹²⁴
112. In a supplementary affidavit Ms Cunningham advised that Mr Vaughan, on behalf of Pub Banc Pty Ltd and Hotel Banc Pty Ltd, requested on 9 and 22 March 2022 that TasPorts consider a lifebuoy and ladder be installed on the northern side of Murray Street Pier. After consideration a ladder was requested from the manufacturer and it was installed on 1 June 2023. The life buoy was installed on 26 August 2022.¹²⁵

¹²³ Exhibit C1-affidvit of Prudence Cunningham.

¹²⁴ Exhibit C1-affidvit of Prudence Cunningham.

¹²⁵ Exhibit C1A-affidvit of Prudence Cunningham.

Discussion

I. The service of alcohol to Dr Xu and Mr Davies on the evening before each died and the extent to which that service might be characterised as causing or as a cause of the death of either Dr Xu or Mr Davies.

113. No counsel apart from Counsel Assisting, Mr Read SC, and Mr Jackson SC, on behalf of Mr Vaughan, made submissions on this issue.
114. Dr Xu, according to Mr Taylor, had reached a point where Mr Taylor would have refused service if Dr Xu had asked for more alcohol. Two of his colleagues, Drs Jurth and Ross, say Dr Xu was drunk with Dr Ross saying his speech was slurred and he was disinhibited. Dr Xu purchased 10 drinks of whiskey in 3 transactions from the Evolve Spirits Bar. While he clearly purchased some of those drinks for his colleagues, I am satisfied from considering the CCTV footage he consumed at least 3 of those drinks himself. He has his arm around two of his colleagues while conversing with them at this bar. He consumed another alcoholic drink at Mobius. Dr Ross says Dr Xu wanted to keep drinking alcohol when others in their group wanted to go to bed. While at Mobius Mr Fiddymment and Ms Fogarty say Dr Xu was not intoxicated. That is however not supported by the CCTV footage which depicts a very disinhibited man in animated conversation with, and an arm around, people he did not even know. He appears uncoordinated and has impaired balance. Consistent with this is the fact that Dr Thakur has no memory of even being at Mobius with Dr Xu; his loss of memory he concedes was due to the extent of his alcohol consumption. When Dr Xu leaves Mobius the CCTV footage shows him staggering and he is struggling to walk. During the walk he was swaying from side to side and I observed one of his feet slip off the footpath into the gutter during which time he temporarily loses his balance. The fact Dr Xu walked off the footpath over the ledge and into Victoria Dock is indicative of a loss of judgement, visual impairment and/or a reduction in his powers of perception and awareness caused by excessive alcohol consumption. I am satisfied to the requisite standard his inability to extricate himself from the dock within a short time of entering the water is also indicative of his level of intoxication which is confirmed by toxicology analysis which showed a level of intoxication of nearly 4 times the legal limit. This is estimated to be in excess of 4.5 times the legal limit at the time Dr Xu entered the water. Accordingly I find that the excessive service of alcohol was a cause of Dr Xu's death.

115. Mr Jackson SC, on behalf of Mr Vaughan, contests the proposition that there is any causative link between the service of alcohol to Mr Davies at the Observatory Bar and his entry into the water and it is not possible to conclude that service of alcohol to him at the Observatory Bar made any material contribution to his death. I note Mr Jackson SC confines this submission to service of alcohol to Mr Davies at the Observatory Bar on the basis of Counsel Assisting's submissions and the manner in which the inquest was conducted. He points out that service of alcohol to Mr Davies does not mean he consumed that alcohol. He notes Detective Constable White says, after reviewing the CCTV footage, Mr Davies supplied other people with alcohol and Detective Constable White could not discern Mr Davies' level of intoxication until the penultimate transaction at which point he says he could discern Mr Davies was "moderately" intoxicated. He says he was better able to assess Mr Davies demeanour and intoxication by viewing the CCTV footage than the bar staff who served him. In addition Mr Jackson SC submits no meaning has been ascribed to the word "excessive" and it is not open for me to find an excessive level of alcohol was supplied to Mr Davies whatever that term might mean. He also submits the financial records are not a reliable source of evidence as to how many alcoholic drinks Mr Davies consumed as those records include drinks he may not have drunk himself but left on the bar and those he bought for others. There were also submissions made about preloading that is the practice of some patrons who consume alcohol at home and then come to the Hobart waterfront already intoxicated. Mr Jackson SC submits this is not something staff at the Observatory Bar could have reasonably suspected. In addition, he submitted there is no evidence to establish how Mr Davies entered the water so it cannot be said, as submitted by Counsel Assisting, Mr Davies walked from the dock into the water without any third-party involvement and that excessive service of alcohol was a cause. Mr Jackson SC submitted it was quite plausible Mr Davies simply walked, tripped or slipped off the end of the pier while distracted by his telephone discussion with his father and was then unable to get out of the water.
116. There is no magic in the meaning of the term "excessive". The concise Oxford Dictionary definition of that word is "*overstepping of due limits; intemperance in eating or drinking*"; an apt definition given the circumstances of this case. Other definitions include too much or too many or more or higher than is necessary, reasonable or appropriate.
117. While Counsel Assisting's submissions might be limited to the service of alcohol to Mr Davies at the Observatory Bar and Mr Jackson SC's impression that it was so limited because of the manner in which the inquest was run, it is evident this ignores

the alcohol which Mr Davies purchased at the Telegraph Hotel of which Mr Vaughan was also the licensee. That evidence cannot be ignored.

118. As to preloading it is clear from the evidence of Mr Vaughan that his security staff “*would be very onto that*” and that his staff had to be “*very, very mindful of people preloading and pulling up in taxis and Ubers*”. At the end of the night staff cleaned up around his premises which included cleaning up “*all the stuff that was being bought in from the suburbs*.” Security would also be checking bags and “*numerous times... confiscating hip flasks or cans of something, or bottles of something.*”¹²⁶ Mr Goss was aware of the practice of preloading and says it was a significant problem because when a patron turned up at the venue they might appear sober when they are trying to get in and then the alcohol would hit them once they were already in the venue and that causes a range of problems.¹²⁷ Given this evidence I do not accept the submission preloading was not something staff at the Observatory Bar could have reasonably suspected.
119. I agree with Mr Jackson SC that the service of alcohol to Mr Davies does not mean he consumed all the alcohol he was served. Detective Constable White says he did not or was unable to form an opinion as to whether or not Mr Davies was intoxicated until the fifth of six transactions whereby Mr Davies purchased alcohol at the Observatory Bar. Mr Davies consumes his last alcoholic drink at about 12:48am and he is assaulted by Mr Spaulding at about 12:57am. Ms Crossin, who served Mr Davies when he purchased alcohol on the second and fifth occasion and Mr Goss who served Mr Davies when he first purchased alcohol at the Observatory Bar were asked about the RSA. Ms Crossin said she would refuse service “*[i]f they can’t really talk properly, if they’re staggering, just knowing when someone’s had too much.*” She would therefore be looking to see whether the patron was staggering or exhibiting slurred speech.¹²⁸ Ms Crossin made an assessment of Mr Davies’ level of intoxication and said Mr Davies was not intoxicated so that is why she served him.¹²⁹ Mr Goss also made an assessment of Mr Davies’ level of intoxication and determined he was not intoxicated but said “*we don’t always um get as much time as we’d like to assess people*”.¹³⁰ This evidence is corroborated by the CCTV footage when Ms Crossin serves Mr Davies at 11:55pm and 55 seconds. She only ever takes any notice of Mr Davies when she takes his order which takes her about 2 seconds. That is the only

¹²⁶ Transcript page 66 lines 1-8.

¹²⁷ Transcript page 244 lines 1-6.

¹²⁸ Transcript page 210 lines 26-43.

¹²⁹ Transcript page 215 lines 9-13.

¹³⁰ Transcript page 239 lines 18-19.

time she can be assessing his sobriety because thereafter she is concentrating on preparing the drink he has ordered and then arranging for him to pay. Any assessment of a patron's level of intoxication is therefore, in my view, fleeting.

120. What is known in so far as alcohol purchases and consumption is concerned is Mr Davies consumed about ten schooners of beer over a nine-and-a-half-hour period.¹³¹ At the Telegraph Hotel Mr Davies purchased nine spirit drinks over a period of 72 minutes. Two of them are purchased for another person and on the 2 occasions he purchases 2 drinks he consumes one of them.¹³² In those circumstances it is not unreasonable to infer Mr Davies has consumed 7 drinks in just over an hour. Even if he only consumed just over half the drinks he purchased, that is 4 out of the 7 which were available to him, he has consumed 14 alcoholic drinks in a period of about ten and a half hours. He then purchases a further 14 drinks at the Observatory Bar in 65 minutes.¹³³ Using the same reasoning I infer he has consumed a minimum of 21 drinks (14 prior to the Observatory Bar and seven at that venue) over a period of about 11 ³/₄ hours. It was probably more. It is also known Mr Barlow has no recollection of even being present at the Observatory Bar let alone a recollection of what actually occurred. Likewise, Mr Spaulding remembers nothing of his attendance at the Observatory Bar. Their lack of memory is due to their excessive consumption of alcohol and in Mr Spaulding's case, illicit drugs.¹³⁴ Mr Barr's recollection is a little better in that he remembers being at that venue and speaking to Mr Davies, but he too concedes he was intoxicated. The extent of his intoxication must have been extreme because he accepts he is depicted on the CCTV footage watching Mr Spaulding assault Mr Davies but he has no recollection of that occurring.¹³⁵
121. I have considered the CCTV footage depicting Mr Davies very carefully. The footage confirms there are five bar staff working the main bar at the Observatory Bar and the venue is crowded. It was a busy night's trading. A number of patrons including Mr Davies, Mr Barlow, Mr Spaulding and Mr Barr display disinhibiting behaviour and appear to be, at times, unsteady on their feet. In so far as the 6 transactions involving Mr Davies at the Observatory Bar are concerned the CCTV footage depicts the following:

Transaction 1: Mr Davies approaches the main bar and orders one drink from Mr Goss and pays by way of an EFTPOS transaction at about 11:48pm. Prior to

¹³¹ See paragraph 54.

¹³² See paragraph 83.

¹³³ See paragraph 84.

¹³⁴ See paragraphs 61 and 62.

¹³⁵ Transcript page 453 lines 37-39.

receiving his drink he is dancing on his own at the bar, looking around, he appears to be singing and he appears unsteady on his feet. When he pays for the drink, he tries to pay by tapping his card before Mr Goss has the EFTPOS machine ready. Mr Goss pushes Mr Davies hand holding the card in it away until the machine is ready. Mr Davies' coordination is affected because he has difficulty putting his card back into his wallet.

Transaction 2: On this occasion Mr Davies approaches the main bar and orders a drink from Ms Crossin. Again he uses the EFTPOS to pay. This transaction takes place at approximately 11:56pm. He walks away from the bar with his drink and commences to drink it. Prior to purchasing the drink he is observed to be dancing on his own as he comes to the bar. He then reads what appears to be a drinks menu before he drops it and then picks it up. He again attempted to pay for his drink before Ms Crossin is ready for him to tap his card on the EFTPOS machine. She has to pull the machine away until she is ready for him to pay.

Transaction 3: At approximately 12:03am Mr Davies approaches the main bar and interacts with two other male patrons standing at the bar. He orders four drinks which include 3 glasses of whiskey two of which he gives to the two other males. He is served by Mr Clark. He then sculls the whiskey as do the other two patrons. He walks off with the other drink. During his interaction with the other two patrons there is a prolonged shaking of hands with each of them and he taps one of them on the chest. He appears to be very familiar with two people he does not know. Again there are some difficulties in paying for the drinks using the EFTPOS machine.

Transaction 4: At approximately 12:18am Mr Davies approaches the main bar with one other male person who is a different person to the people he was with at the time of the third transaction. He purchases two drinks from Ms Fenton and gives one to the person he is with, and he sculls his drink. The person he is with then buys Mr Davies a drink which he consumes. Mr Davies is unsteady on his feet. He has difficulty removing his wallet from his pocket. At one stage both men have their arms around one another, high-fiving and shaking each other's hands. He puts his arm around a female. At one stage Mr Davies makes contact with the rear of the male's left shoulder with his left elbow. After consuming both drinks Mr Davies pulls his male friend away from the bar and they leave. Again he appears to be very familiar with two people he does

not know which I infer from the fact that he does not reside in Tasmania and he was a visitor to Hobart.

Transaction 5: At approximately 12:38am Mr Davies approaches the main bar and stands behind another male patron with whom he interacts. A second male patron approaches them and shortly thereafter Mr Davies is served by Ms Crossin at which time he orders four drinks. He passes two of the drinks to the other two patrons. He is unsteady on his feet and has difficulty removing his wallet from his trouser pocket. He drinks one of the drinks quickly. Detective Constable White goes on to explain that one of the other two patrons appears to secrete the fourth drink. This is incorrect. Mr Davies is observed for a period with two drinks in his hand before he drinks one of them and puts the other one back on the bar. He knocks that second drink over.¹³⁶ On this occasion he is with different males to those he was with previously. While at the bar he is unsteady on his feet. He pushes a third male person away who puts an empty glass on the bar. He grabs one of the other two males by the shoulder from the rear and pats him on the shoulder and ruffles his hair. He is talking in that male's ear. There is high-fiving of one another and hugging. Mr Davies then engages in some play wrestling with one of the males. At one stage Mr Davies and one of the males have their arms around each other. He has trouble finding his wallet in order to pay. At one stage he takes three glasses from a tray while reaching over to the service side of the bar and he places those three glasses on that side of the bar. One of the two males Mr Davies is with gives him a drink which he sculls. They are shaking hands and cuddling. They are pushing their heads against one another. He is observed to be dancing and speaking to himself. Detective Constable Davies formed the view that by this stage Mr Davies appeared to be moderately intoxicated. I disagree. From what I have observed on the CCTV footage it is my view that by this stage Mr Davies is extremely intoxicated. Given the behaviour exhibited by Mr Davies prior to first being served at the Observatory Bar it is my view he was intoxicated at that point in time and his level of intoxication only increased over the next 65 minutes.

Transaction 6: Mr Davies remains at the bar with the same two males and at approximately 12:50am he holds up three fingers to Ms Packer who serves him three drinks. He hands two of those drinks to the other male patrons. Ms Packer also appears to pour Mr Davies a glass of water which he drinks before

¹³⁶ At 12:45:56am.

picking up the third drink which he had just purchased. He did not consume that drink because he was assaulted by Mr Spaulding shortly thereafter. His interaction with Mr Spaulding before the assault, as depicted on the CCTV footage, depicts two very intoxicated individuals.

122. Mr Davies' demeanour having left the Observatory Bar will be discussed below. I do not however accept Mr Jackson SC's submission it was quite plausible Mr Davies simply walked, tripped or slipped off the end of the pier while distracted by his telephone discussion with his father and was then unable to get out of the water. This is because his father's evidence is his son ended the conversation by hanging up.¹³⁷ As a matter of common sense given the objective evidence set out above the extent of Mr Davies' intoxication contributed to him either walking, tripping or slipping off the end of the pier and the level of intoxication was such as to render him incapable of extracting himself from the water. He was after all a very experienced open water diving instructor and he was a strong swimmer.¹³⁸ Had he not consumed an excessive amount of alcohol one would, in those circumstances, expect him to be able to extricate himself from the water. I therefore conclude that the excessive service of alcohol was a cause of Mr Davies' death.
123. The level of Mr Davies' intoxication from toxicology analysis was determined to be 0.140 g of alcohol in 100 mL of blood.¹³⁹ In his proof of evidence,¹⁴⁰ Mr McLachlan-Troup explains that in this case the only sample available for alcohol analysis was from Mr Davies' vitreous humour which is taken from his eye. There was no blood available for testing. He goes on to say the blood alcohol concentration is estimated from the vitreous alcohol concentration however there have been reports of alcohol-related drownings cases where the measured vitreous alcohol concentration is thought to be falsely low due to alcohol diffusing out of the eye with prolonged immersion in water. Because of this and the variability that can occur when a blood alcohol concentration is estimated from the vitreous alcohol concentration Mr McLachlan-Troup says it would be useful to estimate Mr Davies blood alcohol concentration at the time of his death from his drink consumption history. He uses a history of drinking from 2:00pm through to 12:57am the next day during which time Mr Davies consumes 8 beers, 7

¹³⁷ Exhibit D59- statutory declaration of Mr Robert Davies at paragraph 12. Mr Davies was cross examined by Mr Jackson about this at pages 138 and 139 of the transcript. Their conversation did not end in the normal way by either of them saying goodbye. Mr Davies said "*ambo ambo here Dad. Got to go*", and he hung up on his father.

¹³⁸ Exhibit D59- statutory declaration of Mr Robert Davies at paragraphs 3-4 and exhibit D11- statutory declaration of Mr Robert Davies page 2 second last paragraph.

¹³⁹ Exhibit D6A-affidavit of Neil McLachlan – Troup.

¹⁴⁰ Exhibit D6B-proof of evidence of Neil McLachlan – Troup.

Vodka Red Bulls, a further 4 Vodka Red Bull drinks, two Jagerbombs and one whiskey. This estimate is not too different to the estimate I have made in paragraph 120. From that drink pattern and using the amount of alcohol in each drink and after deducting the population average metabolism rate of 0.020 g of alcohol in 100 mL of blood per hour, Mr McLachlan-Troupe calculated Mr Davies' estimated blood alcohol level at the time of entering the water. He noted his calculation is likely to be an over estimate because it assumes Mr Davies had absorbed all the alcohol that he drank at the last venue. After reducing his calculation for this last fact he settled on an estimate of 0.200 g of alcohol in 100 mL of blood.

2. In respect of Mr Davies did the assault and/or the care afforded to him thereafter cause or contribute to his death.

124. No counsel apart from Counsel Assisting, Mr Read SC, and Mr Jackson SC, on behalf of Mr Vaughan, made submissions on this issue.
125. Mr Read SC submits as a result of the assault Mr Davies was concussed and that contributed to his death. In addition, he submitted a finding should be made that the care afforded to Mr Davies by Observatory Bar staff after he was assaulted fell well short of that which ought to have been provided and as a result that lack of care was a cause of his death. Mr Jackson SC submits there is no causative link between the assault of Mr Davies and his death and further, no finding should be made that the care afforded to Mr Davies by Observatory Bar staff after he was assaulted fell well short of that which ought to have been provided and as a result, that lack of care was a cause of Mr Davies' death.
126. Mr Jackson SC submits evidence on the CCTV footage suggests after the assault, Mr Davies' appearance, movements, gait and general demeanour are essentially unchanged and that after being assaulted he stood back up immediately unassisted. He submits there was no gross observable incoordination after Mr Davies was ejected from the Observatory Bar. Further, there was the evidence of Dr Bell that he could not determine from the CCTV footage that Mr Davies had suffered a concussion rather than him exhibiting the effects of being intoxicated. In addition, he submits the fact Mr Davies walked in the opposite direction to his accommodation after he was evicted did not support an inference being drawn that he was disorientated. Further the evidence of Mr Robert Davies that his conversation with his son sounded a lot different to when he had spoken to him previously while his son was intoxicated did also not support the inference that his son was concussed. There is no first-hand witness evidence of anything that suggests a concussion.

127. As to whether there was a lack of care, Mr Jackson SC submitted that is not something that could reasonably be found was, or ought to have been, known by any of the staff at the Observatory Bar. He also submitted it was neither practical or realistic to expect security guards and bar staff to recognise and identify signs of concussion as distinct from intoxication as that task was difficult enough for trained medical professionals let alone the Observatory Bar staff who were not trained medical professionals. Further he submitted there was no evidence that had the standard operating procedures in this case been followed, the result would have been any different.
128. As to the standard operating procedures Mr Vaughan said once somebody is refused service they are not necessarily removed from the venue. It depended on the situation. He indicated *“we also look after customers, if they are intoxicated.”* They might be taken to the first aid room which is also used if a person is injured. They *“may need to go and get some fresh air or take some time out before they leave the premises.”* If a person was mildly intoxicated they would be asked to leave and be provided with a bottle of water or staff will offer water before they leave the premises, and staff will always provide a free bottle of water when people left.¹⁴¹
129. The standard operating procedures for the Observatory Bar¹⁴² and the Telegraph Hotel¹⁴³ contained the following provision:

RSA & CUTTING OFF CUSTOMERS

- Customers are only to be served 2 drinks per person at any time.
- If you think a customer is intoxicated and should not be served you **MUST** approach a supervisor/manager for a second opinion.
- Offer a bottle of water.
- You will then be asked to notify security if the customer is cut off from drink service as the customer will then be required to leave the venue.
- Security will then ask the customer to leave and get some fresh air and they will escort the customer from the venue.
- They will be offered a free bottle of water at the entry/exit by Security.
- Remember – R.S.A. – customers should not be at the point of needing to be cut off, remember to offer free water if in doubt.

¹⁴¹ Transcript page 38 line 38 to page 39 line 3, page 39 lines 24-25 and page 40 lines 15-19.

¹⁴² Exhibit D27A annexure 4.

¹⁴³ Exhibit D27A annexure 8.

130. None of the bar staff thought Mr Davies was intoxicated on the six occasions he was served alcohol at the Observatory Bar. Similarly, there is no evidence any of the bar staff or any of the crowd controllers saw the assault. Ms Packer says *"I recall looking up and seeing the guy stumbling on the floor after I heard a loud noise, but not actually seeing what had happened. The noise sounded like someone being punched or falling over. I just recall seeing what looked to be an intoxicated guy having a bit of trouble and then calling security. I usually have a torch with me. I think I flashed a torch at security, and they came to me, I recall pointing towards the guy on the ground and the security staff member approaching him."*¹⁴⁴ I note Ms Packer did not think Mr Davies was intoxicated when she served him alcohol about seven minutes prior to the assault. The fast-paced working environment to which she refers, and which is obvious from the CCTV footage means bar staff have little time to assess the sobriety of a patron. It was much easier to determine this when, as Detective Constable White says, he had the advantage of considering the CCTV footage which the bar staff did not have. He had a number of angles he could view so he had a clear line of sight, and he was not distracted by other patrons, nor was he distracted by having to serve them.¹⁴⁵
131. The CCTV footage shows Mr Davies speaking to one patron after being pushed by that patron. That patron then calls Mr Spaulding over by using a right arm signal. Mr Spaulding grabs Mr Davies hand and speaks to Mr Davies and then pushes his head away. Mr Davies resumes his conversation with the other patron. Mr Spaulding is dancing and clapping his hands. Both Mr Davies and Mr Spaulding are unsteady on their feet. Mr Davies reaches out towards Mr Spaulding with his hands, and they speak further. Mr Davies then pushes Mr Spaulding slightly. Mr Spaulding then grabs Mr Davies' head with both hands and pulls him close to his head. They are both holding one another. While Mr Spaulding has hold of Mr Davies' head their foreheads are touching. They release hold of one another, and they are in animated discussion. Mr Davies then pushes Mr Spaulding and continues speaking to Mr Spaulding in the latter's ear as Mr Spaulding is leaning forward towards Mr Davies. Again, their foreheads are touching. Mr Spaulding then holds his finger up at Mr Davies and their heads come together. Mr Spaulding then head butts Mr Davies and follows this up with a punch with his left clenched fist to Mr Davies face. Mr Davies falls to the floor and Mr Spaulding walks away.

¹⁴⁴ Exhibit D39-affidavit of Anna Packer.

¹⁴⁵ Transcript page 27 lines 22-43.

132. Mr Davies takes approximately 4 seconds to get up off the floor unassisted. His head is down. He does not appear to speak to the male patron next to him who has been identified as Mr Barr. At the time Mr Davies gets up off the floor Ms Packer is looking away from Mr Davies whereas she is looking in his direction as he is falling. This confirms she has heard the noise of the assault and has looked towards the noise as Mr Davies has fallen to the floor. Before he is up off the floor she is shining her torch towards security and then she points in the direction towards Mr Davies without speaking to security or Mr Davies. Ms Packer confirmed in cross-examination she heard a noise and the assault, she did not see it nor him fall to the floor but she saw him on the floor. She confirmed he was having trouble that is he was struggling by which she meant he was having difficulty getting up.¹⁴⁶ Ms Packer said she did not know Mr Davies had been assaulted but she suspected that was so and that he was in trouble and that she contacted the security guard. She says she knew the security guards would remove him. When it was put to her whether or not she considered talking to the security guards to tell them about her suspicions of an assault she said *"[i]t's a very fast paced environment and in most situations we don't necessarily have the opportunity to talk to security guards about things."* She conceded she did not have the time to do so.¹⁴⁷
133. Mr Davies also does not appear to speak to the security guards although they are speaking to him. I infer that they were telling him that he was to be removed from the premises. When Mr Davies gets up off the floor he appeared to me to be less steady on his feet than he was prior to the assault. He appears to be disorientated as he turns away from the security guards before they move him towards the exit. Mr Davies does not engage in conversation with anybody like he was prior to the assault. He then turns back towards the bar before he is grabbed by both arms by the crowd controllers and is ushered out. As he is escorted out his head is down and he is very unsteady on his feet. A crowd controller is positioned on each side of him and they each have hold of one of Mr Davies' arms. At one stage he is almost being dragged out by the crowd controllers. At the entrance to the venue he is pointed towards the southern side of Post Street and he negotiates the four steps down to the foot path and while doing so he almost falls. He heads north on Post Street holding in his right arm which may have been injured when he was removed from the premises and/or when he fell after being assaulted given there is no sign of any difficulty with his right arm prior to the assault. There is no conversation with anybody like there was prior to the assault. Mr Elford was at the front door of the Observatory Bar when Mr

¹⁴⁶ Transcript page 442 lines 14-37.

¹⁴⁷ Transcript page 444 lines 10-18 and lines 38-44.

Davies was escorted out of the premises by the two crowd controllers. He was shown the footage of the incident and he says it was *“unremarkable and depicted one of countless incidents I have witnessed of a patron being ejected for intoxication”*.¹⁴⁸

134. As he walks towards the north-east corner of Post Street where it intersects with Morrison Street, Mr Davies almost falls on the footpath near the last window of a building prior to the intersection which is on the opposite side of Post Street to the Observatory Bar; that is the eastern side. He hits the corner of that building before turning right onto Morrison Street. He is next observed walking on Elizabeth Street Pier where he jogs for a very short distance of about 5 steps outside the restaurant known as Tavern 42 Degrees South. About halfway down Elizabeth Street Pier he doubles back a short distance before moving off about 20 seconds later. This footage appears to be taken from a significant distance and as a result Mr Davies' movements are not clearly depicted.
135. Dr Anthony Bell is the medical advisor to the coroner's office. He is a very experienced medical practitioner having graduated with a Bachelor of Medicine and a Bachelor of Surgery from the University of Melbourne in 1975. He became a fellow of the Royal Australian College of Physicians in 1985 and a Doctor of Medicine in 1994. In 2010 Dr Bell became a fellow of the College of Intensive Care Medicine. He has worked at the Royal Hobart Hospital, at two hospitals in Canada, one in the United States and at the Alfred and Austin hospitals in Melbourne. He was for 15 years until January 2007 the Director of the Department of Critical Care Medicine at the Royal Hobart Hospital before becoming the Deputy Director of Medical Services at that hospital and then Chief Medical Officer for almost 4 years until July 2012. He has published a number of papers, held a number of academic appointments and positions on the Board of the Australian and New Zealand Intensive Care Society including that of President.¹⁴⁹
136. Dr Bell has provided a report¹⁵⁰ in this case. In that report he provides some background information on mild traumatic brain injury. He says the following:

“Mild traumatic brain injury (TBI) is common and, while typically benign, has a risk of serious short and long term sequelae. TBI occurs with head injury, usually due to contact. Mild TBI is typically defined as mild by a Glasgow Coma Scale (GCS) score of 13 to 15, measured at approximately 30 minutes after the injury. The term

¹⁴⁸ Exhibit D42-affidavit of Eric Elford; last paragraph on page 2.

¹⁴⁹ Exhibit D10A-CV of Anthony James Bell.

¹⁵⁰ Exhibit D10-report of Dr Anthony Bell.

'concussion' is often used in the medical literature as a synonym for mild TBI, but is used more specifically to describe the characteristic symptoms and signs that an individual may experience after a mild TBI. The Quality Standards Subcommittee of the American Academy of Neurology defines concussion as a trauma-induced alteration in mental status that may or may not involve loss of consciousness.

The annual incidence of mild head injury per 100,000 population has been estimated to be 749 for Auckland, New Zealand. However, the incidence of mild head injury may be significantly higher, as many cases go unreported. Assaults cause 5 to 17% of TBI.

Mild TBI results from direct external contact forces or from the brain being slapped against intracranial surfaces with acceleration/deceleration trauma. Concussion may result in neuropathologic changes, but the acute clinical symptoms are believed to reflect a disturbance of function rather than structural injury.

The hallmark symptoms of concussion are confusion and amnesia, sometimes with, but often without, preceding loss of consciousness. These symptoms may be apparent immediately after the head injury or may appear several minutes later. It is important to emphasise that the alteration in mental status characteristic of concussion can occur without loss of consciousness. In fact, the majority of concussions in sports occur without loss of consciousness and are often unrecognized.

The amnesia almost always involves loss of memory for the traumatic event and frequently includes loss of recall for events immediately before (retrograde amnesia) and after (anterograde amnesia) the head trauma. Amnesia also may be evidenced by the patient repeatedly asking a question that has already been answered.

Other early symptoms of concussion include headache, dizziness (vertigo or imbalance), lack of awareness of surroundings, and nausea and vomiting; these may immediately follow the head trauma or evolve gradually over several minutes to hours. Over the next hours and days, patients may also complain of mood and cognitive disturbances, sensitivity to light and noise, and sleep disturbances.

While many concussions occur without observed findings, signs observed in someone with a concussion may include:

- *Grossly observable incoordination (stumbling, inability to walk tandem/straight line)*

As well as neuropsychiatric impairments, including:

- Vacant stare (befuddled facial expression)
- Delayed verbal expression (slower to answer questions or follow instructions)
- Inability to focus attention (easily distracted and unable to follow through with normal activities)
- Disorientation (walking in the wrong direction, unaware of time, date, place)
- Slurred or incoherent speech (making disjointed or incomprehensible statements)
- Emotionality out of proportion to circumstances (appearing distraught, crying for no apparent reason)
- Memory deficits (exhibited by patient repeatedly asking the same question that has already been answered or inability to recall three of three words after five minutes).

It is important to note that mild TBI and concussion may be unrecognized by both the injured and nonmedically trained observers, particularly if there is no loss of consciousness. Some surveys have found that more than 80% of individuals with a past concussion did not recognize it as such.”

137. Dr Bell considered the CCTV footage noting the assault and the behaviour of Mr Davies after the assault. He also noted the evidence of Mr Robert Davies with respect to the nature of his conversation with his son.¹⁵¹ Dr Bell says this evidence suggests Mr Davies suffered a TBI or concussion. Dr Bell says Mr Davies was intoxicated, was assaulted and then suffered a TBI or concussion. He was removed from the premises without consideration of a concussive injury which Dr Bell says leads to an increased risk from alcohol intoxication and a concussive injury.
138. Under cross-examination by Mr Jackson SC Dr Bell conceded a formal diagnosis of concussion or a TBI could not be made and “*the only way to really formally diagnose is to observe the patient for a minimum of 15 minutes... – and to really watch and see if clinical signs develop*”.¹⁵² Dr Bell also agreed with the proposition that it is almost impossible to arrive at any diagnosis without a clinical examination involving subjective history from the patient because so many of the symptoms of concussion are subjective to the patient. He said his evidence was based on his opinion watching the CCTV footage and Mr Davies leaving that venue. He was questioned whether it was possible to determine as a matter of probability that Mr Davies suffered a concussion. He

¹⁵¹ See paragraph 65.

¹⁵² Transcript 11 October 2023 page 6 lines 28-33.

repeated it was not possible to make a formal diagnosis because of the absence of an examination but he went on to say given what he observed *“I think it’s more likely than not there was a traumatic brain injury. But it certainly cannot be proved”*.¹⁵³ Dr Bell was pressed about what he saw on the CCTV of the footage that led him to that conclusion. He replied by saying that after the assault Mr Davies looked different from prior to the assault when he was *“lively, he was active, he was trying to communicate, um and then after the assault, he certainly appeared not to be trying to communicate and not to have that buzz that he seemed to have before”*.¹⁵⁴ The cross examination of Dr Bell concluded with the following exchange:

“Um the short point Dr Bell is this is it not, you you just can’t express any reasoned opinion – any reasoned opinion derived objectively observably from the CCTV footage that Mr Davies had suffered a TBI rather than – as opposed to just high level of intoxication? You can’t separate them out?..... Correct”.¹⁵⁵

139. Despite Dr Bell’s concession that you cannot determine from the CCTV footage whether Mr Davies was displaying the effects of being highly intoxicated as opposed to the effects of a concussion, Dr Bell favoured the latter because from his observations after the assault Mr Davies looked more unsteady, more befuddled¹⁵⁶, he looked different¹⁵⁷ and he had an unusual conversation with his father.¹⁵⁸ In addition Dr Bell says Mr Davies seemed *“a little isolated from what was happening when he was being ejected from the premises”*¹⁵⁹ and Mr Davies did appear to be compliant.¹⁶⁰ Dr Bell thought Mr Davies’ behaviour - who seemed to be a little isolated from his surroundings, was not perceiving well and appeared to be compliant when ejected - could have been caused by the assault. I note Dr Bell was well qualified to give this opinion given his decades of experience as a doctor, in addition to him spending many years looking at head trauma and damage. He was also involved for a period in research about mild traumatic head injury which included going through all the medical literature.¹⁶¹

140. In addition to Dr Bell’s opinion there is the following further objective evidence which supports a finding that concussion resulted from the assault:

¹⁵³ Transcript 11 October 2023 page 7 lines 8-15.

¹⁵⁴ Transcript 11 October 2023 page 8 lines 1-5.

¹⁵⁵ Transcript 11 October 2023 page 14 lines 19-23.

¹⁵⁶ Transcript 11 October 2023 page 7 line 33.

¹⁵⁷ Transcript 11 October 2023 page 7 lines 43-44.

¹⁵⁸ Transcript 11 October 2023 page 10 lines 17-19.

¹⁵⁹ Transcript 11 October 2023 page 13 lines 7-8.

¹⁶⁰ Transcript 11 October 2023 page 13 line 35.

¹⁶¹ Transcript 11 October 2023 page 23-27.

The nature and apparent force of the blows which are capable of causing a concussive injury; and signs of a concussive injury which include:

- The grossly observable incoordination seen immediately after Mr Davies was ejected from the Observatory Bar;
- Dr Bell's observations from the CCTV that post assault Mr Davies ceased trying to communicate and had lost the buzz that he had had;
- That Mr Davies walked in the opposite direction to his accommodation after eviction; supporting an inference of disorientation; and
- Mr Robert Davies' evidence that his conversation with his son was "*difficult to understand and not making any sense*". His son was speaking a lot and sounded different. His evidence was that he had spoken to his son a number of times when he was intoxicated in the past, but this was different.

141. In relation to the first point in paragraph 140, that the nature and apparent force of the blows were capable of causing a concussive injury, Mr Jackson SC submits that contention ignores the clear evidence of what actually occurred. Mr Jackson SC says once Mr Davies is back on his feet, up until the time he is last seen on the pier, his appearance, movements, gait and general demeanour are essentially unchanged. I disagree because of the evidence set out in paragraphs 132 to 134. In addition, the head butt and punch were very forceful and their force propelled Mr Davies backwards and to the ground.
142. As to the second point in paragraph 140, that there were signs of a concussive injury and the contention that Mr Davies exhibited grossly observable incoordination after he was ejected, Mr Jackson SC submits what is observable at that point is no different from what is observable for some time before. Again, I disagree when one compares the evidence set out in paragraph 121 with the evidence set out in paragraphs 132-134. As to the next contention about Dr Bell's observations from the CCTV footage, Mr Jackson SC submits those observations lose whatever force they might have had given Dr Bell's concession that what he observed may have been caused by a higher level of intoxication as opposed to concussion. Despite that concession Dr Bell was, on balance, of the view that what he observed after the assault was caused by the assault on a person who was already highly intoxicated. As to drawing an inference of disorientation because Mr Davies walked in the opposite direction to his accommodation after eviction, Mr Jackson SC says the route Mr Davies took might quite simply indicate he had not finished with his night out and that he knew where he was because when he spoke to his father, he said he was on a pier. In addition, Mr Jackson SC says Mr Davies said nothing to his father which indicated he was lost, or

that he did not know where their hotel was or how to get there from where he was. As to the first submission, it is clear from the CCTV footage that Mr Davies was not in any fit state to continue on with his night. The fact that he told his father he was on a pier and did not indicate he was lost does not mean he knew where he was, given he was a visitor to Hobart and knew nobody here. Robert Davies says his son was difficult to understand and he told his father that his arm had been cut off and an ambulance was on its way. Clearly this was not the case. After being evicted he has walked in the opposite direction to his accommodation and had ended up on a pier which from the footage appears to be deserted. He then spoke to his father in a manner which his father had not encountered before when he had spoken to his son when intoxicated. This suggests to me that Mr Davies was disorientated. As to Robert Davies' interpretation of his conversation with his son, Mr Jackson SC says that evidence is not capable of effective rebuttal by cross-examination, but it has to be critically weighed against all the other objective evidence and cannot be taken at face value. He then submitted the conversation is just as consistent with a moderately intoxicated person as it might be with a person who has suffered some degree of concussion. While I agree with that submission in general terms, the difference here is that is not something Robert Davies agrees with because on this occasion, his son sounded different.

143. When Dr Bell's opinion is added to the objective facts set out in paragraph 140, I find, on the balance of probabilities, Mr Davies was concussed as a result of the assault and this occurred in a person who was already extremely intoxicated.
144. Ms Packer concluded after she saw Mr Davies get up off the floor he was intoxicated.¹⁶² She did not comply with the procedure in paragraph 129¹⁶³ in that no second opinion was sought from a supervisor or manager and no bottle of water was offered to Mr Davies. She skipped to the next step which is notifying security, but she did not speak to the crowd controllers who then of their own accord, removed Mr Davies from the venue. No bottle of water was then offered by the crowd controllers on Mr Davies' exit. Mr Davies was not looked after in the manner contended by Mr Vaughan in paragraph 128. Mr Vaughan indicated security staff provide first-aid to patrons in a number of circumstances which include somebody slipping over, someone cutting themselves accidentally or someone having been assaulted. Assistance is also provided when someone may have overdosed, had a seizure or consumed too many

¹⁶² Ms Packer did not think Mr Davies was overly intoxicated when she served him only 7 minutes prior to the assault. See paragraphs 90 and 161.

¹⁶³ Mr Vaughan confirmed this procedure at page 38 of the transcript lines 13-22.

drinks.¹⁶⁴ He confirmed a patron who is incapable of looking after themselves because they have been assaulted is not treated any differently to a person who is incapable of looking after themselves because they are intoxicated.¹⁶⁵ In the case of an assault such as this one, the security team leader who supervises the licensed crowd controllers at the Observatory Bar, Mr Hodge, would have expected the crowd controllers to ask the male if he was okay and if he needed assistance or treatment. Beyond that, if the patron was conscious and able-bodied, Mr Hodge says there was nothing further they could do. First aid cannot be forced upon somebody.¹⁶⁶ That did not occur in this case because there is no evidence any staff member witnessed the assault. The highest it gets is Ms Packer's suspicion but then she does not investigate any further because of what she terms is a fast-paced working environment. As a result of this and the failure to follow the procedure set out in paragraph 129 it was not discovered that Mr Davies had been assaulted and it was not considered by staff whether he needed to be taken to the first aid area for observation, or that he might need time out, or he might need an ambulance. Had the procedure been followed and had it been determined Mr Davies had been assaulted, I am not able to determine, on the evidence before me, whether he would have been detained and provided with medical treatment or evicted from the premises.

145. Mr Kumar indicated it was normally the case security guards were alerted to intoxicated patrons by bar staff and there is nobody at the premises who views the CCTV footage in real time. CCTV footage can be reviewed when staff do not know who the aggressor is in an altercation between patrons.¹⁶⁷ Sergeant Andricopoulos says in his inspections of licensed premises over the last few years, he has seen staff monitoring CCTV in real-time. He says Wrest Point casino has a person manning the surveillance on a full-time basis and he believed the venue known as Grape in Salamanca Place was doing something similar. He agreed that such a system promotes both public and patron safety.¹⁶⁸
146. **In order to reduce the risk of a situation like this occurring again, I recommend the Commissioner for Licensing give consideration to attaching a condition to a venue's out-of-hours permit requiring the implementation of real-time CCTV monitoring.** I accept each venue would have to be considered on a case-by-case basis. However in my view, such a condition

¹⁶⁴ Transcript page 59 lines 5-10.

¹⁶⁵ Transcript page 61 lines 4-11.

¹⁶⁶ Transcript page 103 lines 4-10.

¹⁶⁷ Transcript page 416 line 30-page 417 line 9.

¹⁶⁸ Transcript page 291 line 32-page 292 line 23.

ought be placed on venues which are open to the early hours of the morning and are very busy, resulting in bar staff working in a very fast paced environment with little opportunity to talk to security guards. Such monitoring would also enable the proper assessment of the sobriety of patrons which did not occur in this case.

3. *What conditions were specified in the licences issued to each of the premises – ss.7, 8, 9, Liquor Licensing Act 1990.*¹⁶⁹

147. Only Counsel Assisting provided any submissions on this issue. Each of the premises, namely the Evolve Spirits Bar, Mobius and the Observatory Bar were licensed under the LLA and each had out-of-hours permits operative at the relevant times of service of alcohol to Dr Xu and Mr Davies. The conditions were generic. With respect to Mobius the following conditions were imposed:

- Trading was permitted until 5:00am 7 days a week until 12 December 2019.
- Trading was permitted until 4:00am 7 days a week from 13 December 2019 until 21 August 2021.
- No liquor is to be removed from the licensed premises during the hours specified in the permit.

¹⁶⁹ **Section 7. General licence**

A general licence authorizes the sale of liquor—

(a) between 5 a.m. and midnight on any day on the premises specified in the licence for consumption on or off those premises; and

(b) at any time to a resident of the premises specified in the licence and any premises of which those premises form a part; and

(c) subject to any condition specified in the licence.

Section 8. On-licence

An on-licence authorizes the sale of liquor –

(a) between 5 a.m. and midnight on any day on the premises specified in the licence for consumption on those premises; and

(b) at any time to –

(i) a resident of the premises specified in the licence for consumption on those premises; or

(ii) a resident of any premises of which the premises specified in the licence form a part for consumption on those premises; and

(c) subject to any condition specified in the licence.

Section 9. Off-licence

An off-licence authorizes the sale of liquor between 5 a.m. and midnight, on any day on the premises specified in the licence, for consumption off those premises, subject to any condition specified in the licence.

- Sound levels and frequencies produced by the sound system within the premises must be recorded for the duration of the hours provided for the out-of-hours permit.
- The recorded data must include the correct date and time.
- The recorded data is to be held for a minimum of 14 days and must be provided to officers of the Liquor and Gaming Branch or members of Tasmania Police upon request.
- CCTV recorded surveillance that meets the Commissioner for Licensing's Technical Standards for Recorded CCTV Surveillance is to be in operation at all times that the premises is trading under the authority of the permit.
- CCTV surveillance in operation must be recorded and retained for a minimum of 14 days.
- Recorded surveillance is to cover the entrance to the premises together with the footpath area in front of the entrance, the liquor sales point (bar serveries) and the outside smoking area; and
- Access to and/or a copy of the recorded surveillance data is to be provided upon request to a Police Officer or an authorised officer of the LLA, within 7 days of the request.

148. The following conditions were added from 13 December 2019:

- No patrons are to enter or re-enter the premises after 3:30am.
- Sufficient licensed crowd controllers are to be provided during the approved hours to ensure effective control of patrons.
- Water is to be free and made available during the permit hours; and
- Promotions that encourage excessive consumption of liquor, such as free alcoholic drinks, 2-for-1 alcoholic drinks offers, buy one get one free alcoholic drinks offers, or similar, must not be conducted during the permit hours.

149. With respect to the Observatory Bar the following conditions were imposed:

- Trading was permitted until 5:00am 7 days a week from 13 May 2019 until 19 May 2023.
- No liquor is to be removed from the licensed premises during the hours specified in the permit.
- Water is to be free and made available during the permit hours.
- Promotions that encourage excessive consumption of liquor, such as free alcoholic drinks, 2-for-1 alcoholic drinks offers, buy one get one free alcoholic drinks offers, or similar, must not be conducted during the permit hours.

- Sufficient licensed crowd controllers are to be provided during the approved hours to ensure effective control of patrons.
- CCTV recorded surveillance that meets the Commissioner for Licensing's Technical Standards for Recorded CCTV Surveillance is to be in operation at all times that the premises is trading under the authority of the permit.
- All CCTV recorded surveillance must be retained for a minimum of 14 days; and
- Access to and/or a copy of the recorded surveillance data is to be provided upon request to a Police Officer or an authorised officer of the LLA, within 7 days of the request.

150. Given that alcohol was served well before the end of the licence period no comments or recommendations are made as to any shortcomings with the conditions.

151. The condition that *"CCTV recorded surveillance that meets the Commissioner for Licensing's Technical Standards for Recorded CCTV Surveillance is to be in operation at all times that the premises is trading under the authority of the permit"* has assisted the inquest in obtaining the best evidence of what occurred on the nights in question.

4. *Whether the service of alcohol to Mr Xu and Mr Davies was in accord with the Liquor Licensing Act 1990 and any conditions specified in the licence of the premises concerned.*

152. In the LLA, s78, makes it an offence to *"sell or serve liquor on licensed premises or permit premises to a person who is intoxicated"*. For the purposes of the LLA a person is intoxicated if-

"(a) the person's speech, balance, coordination or behaviour is noticeably affected; and

(b) it is reasonable in the circumstances to believe that the affected speech, balance, coordination or behaviour is the result of the consumption of liquor or other substances".¹⁷⁰

153. Service did not contravene any condition of the licence or permit in place since the licences and permits did not separately deal with service of liquor to intoxicated persons.

154. Given the evidence discussed in detail above by the time liquor was served to Dr Xu at Mobius he was already extremely intoxicated.

¹⁷⁰ S3B LLA.

155 Mr Jackson SC relies on the opinion of Detective Senior Constable White as to what Mr Davies consumed at the Observatory Bar. He submits it is not possible from the evidence to identify any point within the hour that Mr Davies consumed alcohol in the Observatory Bar that he was served liquor in contravention of s78. We of course cannot determine what Mr Davies' speech was like from the CCTV footage. However as described in paragraph 121, at the time of the first transaction Mr Davies is unsteady on his feet, he is singing and dancing on his own and his coordination is affected. He is noticeably affected when you compare his behaviour at this point in time to others around him at the bar. Further in the circumstances, given his drinking with his father that afternoon and then after 10:00pm when he attended the Telegraph Hotel on his own, it is reasonable to conclude that behaviour is the result of the consumption of liquor. Accordingly, it is my view at the time liquor was first served to Mr Davies at the Observatory Bar he was intoxicated. Given what appears in the CCTV footage, after the first drink is purchased Mr Davies' intoxication increases.

5. Whether (and if so what) recommendations should be made, with a view to preventing further deaths in like circumstances, as to conditions that ought to be generically specified in out-of-hours permits issued pursuant to s12 of the Liquor Licensing Act 1990.

156 Counsel for Mr Vaughan agreed with Counsel Assisting's position on this issue. No other party made any submissions. I also agree with that position. Counsel Assisting submitted that as liquor was relevantly served well before the end of the licence period in each of the two deaths being investigated at this inquest no submissions were made as to the existence of any shortcomings with the conditions attached to the out-of-hours permits attached to each venue. In addition, the provisions of s78 of the LLA are applicable to out-of-hours permits.¹⁷¹

¹⁷¹ **Section 78. Liquor not to be sold or served to intoxicated people**

(1) A person must not sell or serve liquor on licensed premises or permit premises to a person who is intoxicated.

Penalty: Fine not exceeding 50 penalty units.

(2) A licensee or permit holder is guilty of an offence if a person authorized by the licensee or permit holder to sell or serve liquor on the licensed premises or permit premises sells or serves liquor to a person who is intoxicated.

Penalty: Fine not exceeding 100 penalty units.

(Currently one penalty unit is equivalent to \$195).

157 In relation to the issues listed under point 6 in paragraph 11, which are discussed below, Mr Jackson SC agreed with Counsel Assisting's submissions with respect to paragraph 6(a). He made submissions in relation to paragraph 6(b) and he made no submissions with respect to paragraphs 6 (c)-(i) as those matters did not concern Mr Vaughan. Mr Stevens made submissions with respect to paragraphs 6(c), (g) and (i).

6 (a) Whether procedures in place at the Observatory Bar on 9 February 2020 to ensure compliance with conditions specified in its out-of-hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies' death.

158. The procedures in place were sufficient to ensure compliance with the conditions in the out-of-hours permit. They were followed.

(b) Whether procedures in place at the Observatory Bar on 9 February 2020 to ensure compliance with relevant provisions in Division 5 of Part 2 of the Liquor Licensing Act 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Mr Davies' death.

159. Division 5 of Part 2 of the LLA contains s46 and 46A. Section 46 requires the licensee to carry on its business in such a way that the licensee can exercise effective control over the sale and any consumption of liquor on the licensed premises. Section 46A provides a licensee must not allow a person to sell or serve liquor at the licensed premises unless the person has successfully completed an approved course or in other circumstances which are not relevant to this case. An approved course means a course of instruction or training in the service of liquor, approved by the Commissioner for Licensing.

160. The bar staff on duty, namely Mr Goss, Ms Crossin, Mr Clark, Ms Fenton and Ms Packer all say:

- They each had a responsible service of alcohol qualification; that is the approved course referred to in s46A of the LLA.
- They each were fully aware of their obligations with respect to the responsible service of alcohol and they took those obligations seriously.
- They each indicated they were required to assess a patron's level of intoxication before they served the patron.

161. Mr Goss, Ms Crossin, Ms Fenton and Ms Packer all say they assessed Mr Davies and the first three say he was not intoxicated whereas Ms Packer says he was not overly intoxicated because she would not have served him if he was overly intoxicated.¹⁷²
162. While I accept each of the bar staff were properly qualified and they believed Mr Davies was not intoxicated when they served him this was not the case. It is clear from the evidence in this case that the procedures designed to ensure effective control over the sale and consumption of liquor were not followed. That evidence is as follows:
- a. The evidence that Mr Davies consumed at least 6 drinks on the premises.
 - b. The contradictory evidence of the Register (showing fights and evictions).
 - c. Mr Vailepa who concluded he evicted Mr Davies because he was drunk.¹⁷³
 - d. Mr Barr, who the CCTV shows witnessed the assault on Mr Davies but was so drunk he could not remember it.¹⁷⁴ He is seen on the CCTV with drink in hand.
 - e. Mr Barlow and Mr Spaulding who were drunk on arrival and likely served alcohol once inside.
 - f. Neither Mr Barr nor Mr Barlow were cross examined with a view to suggesting they had been responsibly served liquor at the Observatory Bar.
 - g. Mr Vaughan's evidence was that if anyone was in that state (Barr, Spaulding or Barlow) they would not have been admitted to the venue, or they would have been removed from the venue. Clearly, they were admitted and there is no evidence of removal. The policies Mr Vaughan expected to be enforced failed.¹⁷⁵
163. The facts set out in paragraph 162 demonstrate that the procedures designed to ensure effective control was exercised were not followed. As to adequacy of the procedures, Mr Vaughan's evidence is that management relied on individual staff members to monitor liquor service.¹⁷⁶ The Register would have told anyone that this reliance was not working. Detective Senior Constable White's evidence provides an explanation – the staff relied on (to make the decision) did not have a sufficient

¹⁷² See the evidence of Mr Clark at transcript pages 396-398, Ms Crossin at transcript pages 238-239, Mr Clark at transcript pages 177-178, Ms Fenton at transcript pages 396-398 and Ms Packer at transcript pages 435-437.

¹⁷³ Transcript page 252 lines 1-15.

¹⁷⁴ Transcript 454 lines 5-25.

¹⁷⁵ Transcript page 41 lines 18-20.

¹⁷⁶ Transcript page 38 lines 13-23.

vantage point to form a subjective opinion on sobriety. For reasons previously stated the failure to follow procedures and their inadequacy were a cause of Mr Davies' death.

(c) Whether any failure on the part of any police officer or of any authorised officer under s209 of the Liquor Licensing Act 1990 to take steps to enforce compliance by the licensee of the Observatory Bar on 9 February 2020 with conditions specified in its out-of-hours permit, or with relevant provisions in Division 5 of Part 2 of the Liquor Licensing Act 1990, resulted in non-compliance that caused or contributed to Mr Davies' death.

- I 64. The evidence establishes there was no failure on the part of any police officer or of any authorised officer under s209 of the LLA.
- I 65. However, one of the employed security, Mr Ahmad, did not have a Security Licence. Had police or an authorised officer visited the Observatory Bar they would not have been able to discover the lack of a licence as Mr Vaughan was not aware that Mr Ahmad's licence had lapsed. The absence of Mr Ahmed's licence was not in any way a cause of the death of Mr Davies.
- I 66. However, the evidence points to a need for change in procedures to prevent an unlicensed person from being employed to undertake crowd control duties. Guidelines for information sharing between the Liquor and Gaming Branch and Tasmania Police are in evidence illustrating a formal process for the exchange of information in relation to persons licensed to serve liquor. Assistant Commissioner Bodnar advised there are no formal information sharing arrangements in place between the Department of Justice/Consumer Building and Occupational Services ("CBOS") and Tasmania Police.¹⁷⁷ Mr Stevens has indicated the Commissioner of Police accepts such a recommendation.¹⁷⁸
- I 67. **Although formal arrangements might not have overcome the problem with Mr Ahmad's lapsed licence, I think it is reasonable to recommend formal guidelines be developed and implemented for information sharing between CBOS and Tasmania Police. I therefore make that recommendation.**

¹⁷⁷ Exhibit C5-affidavit of Assistant Commissioner Bodnar.

¹⁷⁸ Submissions of Mr Stevens at paragraph 19.

168. Counsel Assisting also submitted the evidence suggests that lack of compliance checks has led to a situation where alcohol is served contrary to s78 of the Act. At the very least, it can be concluded that had compliance checks been regular, the factual matrix set out in paragraph 162 would have been much less likely to have occurred. The lack of sufficient compliance checks leaves compliance a matter of self-regulation which in the case of the Observatory Bar and for the reasons stated above, failed, at least on the night of Mr Davies' death but probably on most nights given the content of the crowd controller register.

169. Mr Stevens submitted there is no evidence of a lack of compliance checks and therefore the conclusion in the last paragraph cannot be drawn. The evidence is:

- only in southern Tasmania is there a dedicated liquor licensing unit within Tasmania Police; that is there are no such units in the north or northwest Tasmania.
- the current staffing of the dedicated unit in southern Tasmania is two police officers.
- those officers are supported by general uniform police officers when required.
- in addition, all members, in accordance with the Tasmania Police Manual, should regularly enter and check licensed and permit premises.¹⁷⁹
- as at 30 June 2023 there were 1064 licensed premises in southern Tasmania.¹⁸⁰
- it is reasonable to infer that there were a similar number of licensed premises at the time of these two deaths and there were and are many more in the north and northwest of Tasmania.
- quite evidently, as Mr Stevens submitted, it is not possible to check every venue every day; and
- in the period from 1 July 2017 to 6 August 2020, which covers the period when these two deaths occurred, there was less than one police infringement detected every 2 days. In so far as licensees are concerned, this fell to less than one infringement every 6 days whereas only one infringement in every 53 days against a licensee was actually issued and/or a fine paid.¹⁸¹

170. The evidence in the last bullet point suggests to me there is evidence of a lack of compliance checks and this, in addition to the clear facts of these cases, has led to a

¹⁷⁹ Exhibit C2A- section 2.14 Liquor Licensing.

¹⁸⁰ Transcript page 274 line 30.

¹⁸¹ These figures are derived from those set out in paragraph 104.

situation where alcohol is served contrary to s78 of the Act. Had compliance checks and the issuing of infringements been more frequent, then the factual matrix in paragraph 162 would be much less likely to occur. It seems therefore compliance is a matter of self-regulation which in the case of the Observatory Bar failed at least on the night of Mr Davies' death but probably on many other nights given the content of the crowd controller register.

(d) Whether procedures in place at the Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 to ensure compliance with conditions specified in its out-of-hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

171. The evidence discloses the Evolve Spirits Bar is a much different establishment to the Observatory Bar. The pace is slower, the clientele less likely to resort to violence or otherwise behave in such a way that might require the attention of staff after consuming liquor. Profit is not sought from the bar but rather the associated accommodation. Mr Casey gave evidence that *"normally people are taking quite some time, relaxing – it's not designed to be a venue where we get maximum people in, in fact the venue itself could probably only comfortably take 60 people or so at a time... It's high class so it's quiet"*.¹⁸² No crowd controllers were employed.

172. Mr Casey gave evidence of procedures as to safe service of alcohol. Dr Xu in one transaction purchased 4 whiskies at \$40 each. When asked about procedures to ensure these drinks were shared and not all consumed by Dr Xu, Mr Casey's answer, which follows, suggested the need for tighter procedures:

*"Oh that that would be basically binge drinking you know if it was an individual it would – it would be binge drinking and I would like to think – although I have no proof of it on the night, we we wouldn't serve that person alcohol."*¹⁸³

173. Mr Casey added that it would be an anomaly for a person to consume 10 whiskies while at the Evolve Spirits Bar.¹⁸⁴

¹⁸² Transcript page 367 lines 28-31 and page 368 line 17.

¹⁸³ Transcript page 365 lines 19-23.

¹⁸⁴ Transcript page 365 lines 28-33.

174. I therefore recommend the Evolve Spirits Bar review its procedures so that bar staff ensure that where a patron purchases multiple drinks those drinks are being shared and not all consumed by the purchaser.

(e) Whether procedures in place at the Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 to ensure compliance with relevant provisions in Division 5 of Part 2 of the Liquor Licensing Act 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

175. The evidence suggests that the majority of the liquor consumed by Dr Xu on the night of his death was consumed at the Evolve Spirits Bar. Clearly intoxication was a cause of his death. Dr Xu's consumption of liquor at the Evolve Spirits Bar was in excess of consumption consistent with responsible service. Dr Thakur's evidence strongly corroborates that.

176. While the procedures in place might well have enabled compliance with Division 5 of Part 2 of the *Liquor Licensing Act 1990*, there is a high likelihood that they were not followed. However, I am unable to make any finding about this because Dr Xu had attended a sponsored "open bar" dinner before arriving at Evolve and his level of intoxication on arrival might not have been sufficient for him to have been refused service particularly given the nature of the establishment.

(f) Whether any failure on the part of any police officer or any authorised officer under s209 of the Liquor Licensing Act 1990 to take steps to enforce compliance by the licensee of Evolve Spirits Bar at MACq01 Hotel on 7 November 2019 with conditions specified in its out-of-hours permit, or with relevant provisions in Division 5 of Part 2 of the Liquor Licensing Act 1990, resulted in non-compliance that caused or contributed to Dr Xu's death.

177. The evidence does not disclose there was any failure on the part of any police officer or of any authorised officer under s209 of the LLA. I repeat my comments in paragraphs 168-170 with respect to compliance checks.

(g) Whether procedures in place at Mobius Lounge Bar on 7 November 2019 to ensure compliance with conditions specified in its out-of-hours permit were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu's death.

178. Mobius Lounge Bar stands in complete contrast to the "high class" nature of the Evolve Spirits Bar. The evidence given by its licensee Mr Hickey was extremely unimpressive. He was argumentative and often nonresponsive to questions put to him.

Mr Hickey refused to accept the finding of the Commissioner for Licensing that “the sale and consumption of liquor on your licensed premises has caused the occurrence of disorderly conduct in the premises and in the neighbourhood of the premises”¹⁸⁵ when the facts underpinning that finding clearly indicated it to be correct.

179. The Register of crowd controllers required to be kept by s35B of the *Security and Investigation Agents Act 2002* was completely inadequate particularly in relation to the “bad patch” of which Mr Hickey spoke.¹⁸⁶ It is apparent that crowd controller numbers were either not increased as Mr Hickey had undertaken to the Commissioner for Licensing to increase or were increased but not recorded in the Register. Given the failure of the Register to record other known occurrences that require recording, the former is the likely situation – the numbers were not increased: the undertaking or promise Mr Hickey gave was not fulfilled.

(h) Whether procedures in place at Mobius Lounge Bar on 7 November 2019 to ensure compliance with relevant provisions in Division 5 of Part 2 of the Liquor Licensing Act 1990 were inadequate, or were not followed, resulting in non-compliance that caused or contributed to Dr Xu’s death.

180. Notwithstanding the considerable shortcomings in relation to Mobius, none were causative of Dr Xu’s death. That is because he consumed, at most, one drink at this establishment. When Dr Xu and Dr Thakur arrived at Mobius they were already in a state of considerable intoxication. Rather than extra alcohol being a cause of what transpired it is likely it was the effluxion of time that led to the alcohol consumed at the Evolve Spirits Bar and the dinner earlier having its full and fatal effect.

(i) Whether any failure on the part of any police officer or any authorised officer under s209 of the Liquor Licensing Act 1990 to take steps to enforce compliance by the licensee of Mobius Lounge Bar with conditions specified in its out-of-hours permit, or with relevant provisions in Division 5 of Part 2 of the Liquor Licensing Act 1990, resulted in non-compliance that caused or contributed to Dr Xu’s death.

181. I refer to my comments on this question relating to the Observatory Bar. The evidence of considerable shortcomings set out above suggests that a culture of

¹⁸⁵ Exhibit D49-affidavit of Jonathon Root at attachment 6.

¹⁸⁶ The “bad patch” occurred in 2019 when there were a number of assaults at the venue or just outside which included the one punch assault of Dr Stewart Williams that resulted in his death.

complacency existed at Mobius. Self-regulation is a path to a breach of the LLA. A regular system of spot checks with an adequate response in the event of a breach is needed to avoid the type of outcome described by Mr Hickey, in his very significant understatement, that he had a “*bad patch*”.

182. In addition, guidelines for information sharing between CBOS and Tasmania Police would have enabled the police on their visits to Mobius to be aware of the undertaking or promise made by Mr Hickey to increase crowd controller numbers and to check to ensure the undertaking was being complied with. That undertaking was not complied with on the night Dr Xu attended Mobius.

7. Whether recommendations should be made as to procedures to ensure compliance with the Liquor Licensing Act 1990 and conditions specified in the licences.

183. The LLA does not need to be amended and nor do the conditions specified in the licences. While it is of potential concern that an out-of-hours permit to 5:00am permits, in effect, 24 hour a day trading, because the events relevant to these inquests related to the earlier hours of the evening, this concern was not the subject of evidence.

184. I have made comments about the lack of compliance visits which has led to a culture of complacency and in effect resulted in a very lax regime of self-regulation. Counsel Assisting submitted in those circumstances it was appropriate for me to recommend:

That there be improved communication between Tasmania Police and the Office of the Commissioner for Licensing with respect to potential breaches of the Act and that there be a joint initiative so that regular, random spot checks of licensed premises are conducted, any potential breaches are fully investigated and prosecuted, and any appropriate disciplinary action is then taken against the licensee.

185. Mr Vaughan took no issue with paragraph 183 and made no submissions with respect to Counsel Assisting’s recommendation in paragraph 184.

186. The Commissioner of Police also took no issue with paragraph 183. As to paragraph 184, she noted I made a similar recommendation in the matter of Jethro Wolf Douglas.¹⁸⁷ Mr Stevens, on behalf of the Commissioner of Police, advised Assistant

¹⁸⁷ (2023) TASCD 560.

Commissioner Bodnar had instructed him that procedures have been put in place in accordance with that recommendation. Unfortunately, I was not told what those procedures are and when they were put in place apart from the fact that “[d]irect lines of communication have been established between the Commissioner for Licensing and each of the Tasmania Police districts”.¹⁸⁸

187. Consistent with my knowledge of what has taken place since the decision in Mr Douglas’ death, Mr Stevens advised a joint operation between Tasmania Police and staff from the Liquor and Gaming Branch took place in November 2023 with 26 venues in and around the Hobart waterfront inspected, resulting in 6 infringement notices being issued.¹⁸⁹
188. In addition a joint operation between Tasmania Police and staff from CBOS was conducted on 8 December 2023 with 25 venues in Sandy Bay, Hobart and the Hobart waterfront inspected and 57 security guards checked. Five security guards were cautioned for incorrect identification documents and that it was intended that joint operations continue.¹⁹⁰ I recall seeing reports of these two operations in the local media. Unfortunately, I have not heard that anything further has occurred on this front this year. Such operations may have occurred but if they have I do not believe they have been publicised. Publication of such operations would, in my view, enhance their deterrent effect.
189. I said the following in the investigation of the death of Mr Douglas:

“As mentioned above one of the objects of the Liquor Licensing Act 1990 is to regulate the sale, supply, promotion and consumption of liquor so as to minimise harm arising from its misuse. One of the methods by which s2A says the minimisation of harm is achieved is through encouraging a culture of responsible consumption of liquor. Clearly Mr Douglas did not responsibly consume alcohol while present at the Hotel on the 30 April and 1 May 2021. There has been an absence of such a culture in a number of other cases I have examined as a Coroner. Relying on any licensee and his or her staff “to do the right thing” in circumstances where the licensee has a direct financial interest in selling as much liquor as possible does not encourage the responsible service or consumption of liquor. In my view the only way this can be achieved is for there to be regular, random spot checks of licensed premises to ensure that alcohol is being served responsibly, and where there is evidence of a breach in this

¹⁸⁸ Submissions of the Commissioner of Police at paragraphs 26 and 27.

¹⁸⁹ Submissions of the Commissioner of Police at paragraph 28.

¹⁹⁰ Submissions of the Commissioner of Police at paragraphs 29 and 30.

regard then that breach is fully investigated, and if appropriate, proceedings against a licensee are instituted. Where a breach is established either by an infringement notice being accepted by the licensee or by a subsequent complaint being proved then disciplinary proceedings should be instituted by the Commissioner for Licensing.

I therefore recommend there be improved communication between Tasmania Police and the Office of the Commissioner for Licensing with respect to potential breaches of the Act and that there be a joint initiative so that regular, random spot checks of licensed premises are conducted, any potential breaches are fully investigated and prosecuted, and any appropriate disciplinary action is then taken against the licensee. Should this not occur then I expect there will continue to be deaths in similar circumstances to that of Mr Douglas in the future because there appears to be nothing which deters a licensee to not comply with his or her obligations under the Act.”

190. While I accept what Assistant Commissioner Bodnar has advised in paragraphs 186 to 188, my view is, given the number of deaths I have examined arising out of an absence of a culture which encourages the responsible consumption of liquor, that unless there are random but regular spot checks of licensed premises and unless any potential breaches are fully investigated and prosecuted and any appropriate disciplinary action is taken against a licensee, then there is nothing that will encourage licensees to comply with his or her obligations under the LLA; that is there is no deterrent if a licensee does not comply. Without such a regime one of the objects of the LLA which is mentioned in paragraph 189 will not be achieved. **I therefore recommend there be joint initiatives between Tasmania Police and the Liquor and Gaming Branch and Tasmania Police and CBOS so that regular, random spot checks of licensed premises are conducted, any potential breaches are fully investigated and if appropriate prosecuted and any proper disciplinary action is then taken against the licensee under the Liquor Licensing Act 1990 or against the licensee or crowd controller under the Security and Investigations Agents Act 2002.**

8. *The safety features of the Hobart waterfront and the extent to which the layout of the Hobart waterfront ought be characterised as causing or as a cause of the death of either Dr Xu or Mr Davies.*

191. This issue was not relevant to Mr Vaughan and the Commissioner of Police and so neither party made any submissions with respect to it. Counsel for TasPorts submitted “*the layout of the waterfront in no way caused or contributed to the death of*

either Dr Xu or Mr Davies.” While I acknowledge Dr Xu died when he walked off Victoria Dock and fell into the water while intoxicated and Mr Davies, while intoxicated, ended up in the water at the end of Elizabeth Pier and died the fact is the Hobart waterfront is a working port. Fencing is therefore not practical. The approach taken by TasPorts, providing life-saving devices for those in the water rather than attempting the impractical exercise of preventing any entry to the water is the correct approach.

192. As the evidence set out above demonstrates, TasPorts has continued to update its management plans and continues to apply funds to enhance waterfront safety. Since the deaths the subject of this inquest, additional ladders and lifebuoys have been provided and instructional lifesaving signage has been installed on each individual lifebuoy.

193. Ms Cunningham’s evidence, the accuracy of which was not questioned, was “*the waterfront is subject to continuous monitoring, risk assessments, internal safety reviews, regular safety walks, weekly safety meetings, regular stakeholder consultations and regular monitoring and maintenance of assets. It is also addressed by way of ad hoc requests...*”.¹⁹¹

9. Whether recommendations should be made for improvement of safety features of the Hobart waterfront

194. I agree with the submission of Counsel for TasPorts that for the reasons expressed in paragraph 191 no recommendations are warranted.

Formal Findings

195. On the basis of the evidence tendered at the inquest I make the following formal findings pursuant to section 28(1) of the Act with respect to Dr Xu:

- a. The identity of the deceased is Robert Bo Xu;
- b. Dr Xu died in the circumstances set out in paragraphs 17 to 25;
- c. the cause of Dr Xu’s death was drowning; and
- d. Dr Xu died on 7 November 2019 when he walked off the footpath, in the Mures car park near the intersection of Campbell and Davey Streets Hobart in Tasmania, and into Victoria Dock.

¹⁹¹ Exhibit CIA-affidavit of Prudence Cunningham.

196. On the basis of the evidence tendered at the inquest I make the following formal findings pursuant to section 28(1) of the Act with respect to Mr Davies:
- a. The identity of the deceased is Jarrod Robert Davies;
 - b. Mr Davies died in the circumstances set out in paragraphs 53 to 67;
 - c. The cause of Mr Davies' death was undetermined however what the forensic pathologist found strongly suggested the cause of death was accidental drowning while intoxicated; and
 - d. Mr Davies died between when he was last seen on 9 February 2020 and when he was found on 11 February 2020. I am however satisfied Mr Davies died soon after he left the eastern side of the Elizabeth Street Pier at its southern end at Hobart in Tasmania, at which time, he entered the Derwent River.

Comments and Recommendations

197. Both Dr Xu and Mr Davies died after being served, and after consuming, too much alcohol to the extent that both men were incapable of looking after themselves. In addition, Mr Davies was concussed as a result of a vicious assault at the hands of Mr Spaulding in the Observatory Bar after which he was evicted from those premises.
198. I note since the hearing of this matter the Observatory Bar has changed its name to Muse which on its website is described as Hobart's newest nightclub. The Liquor and Gaming Branch has advised Muse operates from the same premises as the Observatory Bar used to operate from. There is no obligation on a licensee to advise the Commissioner for Licensing of a change of name under the LLA. As far as the Commissioner is concerned the licensee is still Mr Vaughan and the venue still operates on the same licence and out-of-hours permit as it did prior to the change of name.
199. For the reasons outlined above I repeat the **recommendations** made in paragraphs **146, 167, 174 and 190.**
200. I acknowledge and thank Detective Senior Constable White for his very thorough investigation of Mr Davies' death.
201. I thank all counsel namely Mr Read SC, Mr Jackson SC, Ms Sluiter, Mr Cox, Mr Hilliard, Mr Stevens and Ms Chen for their assistance and their submissions in these matters.

202. I convey my sincere condolences to Dr Xu's family and loved ones.

203. I convey my sincere condolences to the family and loved ones of Mr Davies.

Dated: 13 June 2024 at Hobart in the State of Tasmania.

Magistrate Robert Webster
Coroner

Annexure A – Exhibits – Dr Xu

No.	TYPE OF EXHIBIT	NAME OF WITNESS
X1	POLICE REPORT OF DEATH FOR THE CORONER	Constable Nicholas Burk
X2	LIFE EXTINGUISHED AFFIDAVIT	Dr Martin Watson
X3	AFFIDAVIT OF IDENTIFICATION	Anthony Cordwell
X4	AFFIDAVIT OF IDENTIFICATION	Constable Brett Suttor
X5	AUTOPSY REPORT	Dr Yeliena Baber
X6	TOXICOLOGY REPORT	Neil McLachlan-Troup
X7	AFFIDAVIT	Ruojun Xu, Father & SNOK
X8	AFFIDAVIT	Robert Carlisle, Scene witness
X9	AFFIDAVIT	John Birmingham, Grand Chancellor guest
X10	AFFIDAVIT	Christine Davie, Grand Chancellor guest
X11	AFFIDAVIT	Sameer Thakur, Cardiac Surgeon Trainee
X12	AFFIDAVIT	Timea Jurth, Cardiac Surgeon Trainee
X13	AFFIDAVIT	Jordan Ross, Surgical Registrar
X14	AFFIDAVIT	George Fiddymment, Mobius Lounge Bar Security Supervisor
X14A	ANNEXURE	George Fiddymment
X15	AFFIDAVIT	Amy Fogarty, Mobius Lounge Bar Bartender
X16	AFFIDAVIT	Benjamin Hickey, Mobius Lounge Bar Licensee & Manager
X16A	STANDARD OPERATING PROCEDURES	Benjamin Hickey, Mobius Lounge Bar Licensee & Manager
X16B	CROWD CONTROL REGISTER	Benjamin Hickey, Mobius Lounge Bar Licensee & Manager
X17	AFFIDAVIT	Dylan Taylor, Glass House Waiter
X18	AFFIDAVIT	Sophie Grace, TasPorts Tasmania
X18A	ANNEXURE – MAP OF WHARF	Sophie Grace, TasPorts Tasmania
X19	AFFIDAVIT DATED 21.12.2019	Constable Nicholas Burk

X19A	SUPPLEMENTARY AFFIDAVIT DATED 12.09.2020	Constable Nicholas Burk
X19B	ANNEXURE – WATERFRONT PHOTOGRAPHS	Constable Nicholas Burk
X19C	ANNEXURE – CCTV COMPILATION OF VARIOUS VENUES	Constable Nicholas Burk
X19D	ANNEXURE – BWC FOOTAGE	Constable Nicholas Burk
X20	AFFIDAVIT	Sergeant Gavin White
X20A	ANNEXURE – BWC FOOTAGE	Sergeant Gavin White
X21	AFFIDAVIT	Constable Brett Suttor
X22	AFFIDAVIT	Detective I/Constable Sharee Maksimovic
X23	AFFIDAVIT	Constable Kellie Ladson
X24	AFFIDAVIT	Detective S/Constable Jamie Hart
X24A	ANNEXURE – ATLAS RUNNING LOG	Detective S/Constable Jamie Hart
X25	AFFIDAVIT	S/Constable Sally Swifte
X26	AFFIDAVIT	Detective S/Constable Cameron Brown
X27	AFFIDAVIT	Constable Connor Young
X28	PHOTOGRAPHS & AFFIDAVIT	I/Constable Angela Ghedini
X29	AFFIDAVIT	Detective Sergeant Michael Callinan
X29A	ANNEXURE – PHOTOGRAPHS	Detective Sergeant Michael Callinan
X29B	ANNEXURE – VIDEO FOOTAGE	Detective Sergeant Michael Callinan
X29C	ANNEXURE – VIDEO FOOTAGE	Detective Sergeant Michael Callinan
X30	AFFIDAVIT	Matt Casey, MACq I & Henry Jones Art Hotel General Manager
X30A	ANNEXURE – TAX INVOICES	Matt Casey, MACq I & Henry Jones Art Hotel General Manager
X31	BANK STATEMENT	AMEX
X32	EYE REPORT	OPSM
X33	ANNEXURE	Martin Kerr

Annexure B – Exhibits – Mr Davies

No.	TYPE OF EXHIBIT	NAME OF WITNESS
D1	REPORT OF DEATH	Detective Senior Constable Chloe Carr
D2	LIFE EXTINGUISHED AFFIDAVIT	Dr Sophie Parcell
D3	AFFIDAVIT OF IDENTIFICATION	Anthony Cordwell, Mortuary Ambulance
D4	AFFIDAVIT OF IDENTIFICATION	Tracey Tobin (Fingerprint ID)
D5	AUTOPSY REPORT	Dr Donald Ritchey
D6A	TOXICOLOGY REPORT	Neil McLachlan-Troup (FSST)
D6B	TOXICOLOGY REPORT (PROOF OF EVIDENCE)	Neil McLachlan-Troup (FSST)
D7	MEDICAL RECORDS	Long Street Family Medicine
D8	MEDICAL RECORDS	Leongatha Healthcare Pty Ltd
D9	MEDICAL RECORDS	Vinmec International Hospital
D10	MEDICAL REPORT ON CONCUSSIONS	Dr Anthony J Bell, Coronial Medical Consultant
D10 A	Resume	Dr Anthony J Bell, Coronial Medical Consultant
D11	STATUTORY DECLARATION 9 February 2020	Robert Davies, Father & SNOK
D11A	SCREENSHOTS OF JARROD DAVIES OF THE NIGHT	CCTV FOOTAGE
D12	AFFIDAVIT- Initial attendance	Constable Josh Thorpe
D12A	BWC FOOTAGE (OBAR CCTV)	Constable Josh Thorpe
D13	AFFIDAVIT - ATLAS Records	Detective Senior Constable Jamie Hart
D14	AFFIDAVIT	Detective Senior Constable Martin White, Investigator (CIB)
D14A	ANNEXURE A (Map)	Detective Senior Constable Martin White, Investigator (CIB)
D14B	ANNEXURE B (CCTV index)	Detective Senior Constable Martin

		White, Investigator (CIB)
D14C	CCTV FOOTAGE (HOBART WATERFRONT)	Detective Senior Constable Martin White, Investigator (CIB)
D14D	ANNEXURE D (BOM)	Detective Senior Constable Martin White, Investigator (CIB)
D14E	ANNEXURE E (tides)	Detective Senior Constable Martin White, Investigator (CIB)
D14F	ANNEXURE F (financial purchases)	Detective Senior Constable Martin White, Investigator (CIB)
D14G	AFFIDAVIT (OUTLINING ATTACHMENTS)	Detective Senior Constable Martin White, Investigator (CIB)
D14H	ATTACHMENT 1 – INSTRUMENT OF APPOINTMENT	Detective Senior Constable Martin White, Investigator (CIB)
D14I	ATTACHMENT 2 – RSA CERTIFICATE	Detective Senior Constable Martin White, Investigator (CIB)
D14J	ATTACHMENT 3 – CROWD CONTROLLER LIST	Detective Senior Constable Martin White, Investigator (CIB)
D14J (A)	ATTACHMENT 4- CROWD CONTROLLER LIST	
D14K	ATTACHMENT 4 – SMS TEXT MESSAGES	Detective Senior Constable Martin White, Investigator (CIB)
D14L	ATTACHMENT 5 – SCREENSHOT OF MAP	Detective Senior Constable Martin White, Investigator (CIB)
D14M	ATTACHMENT 6 – BANK TRANSACTIONS	Detective Senior Constable Martin White, Investigator (CIB)
D14N	ATTACHMENT 7 – MUBIN AHMAD EMAILS	Detective Senior Constable Martin

		White, Investigator (CIB)
D15	AFFIDAVIT	Detective Senior Constable Mark Wilby, Investigator (CIB)
D16	AFFIDAVIT	Constable Leighton Beer, Police Diver
D17	AFFIDAVIT	Detective Constable Francis Aboud, Investigator (CIB)
D18	AFFIDAVIT	Constable Ysanne Harper, Police Diver
D18A	Diving Footage (Warning Graphic)	Constable Ysanne Harper, Police Diver
C18B	Dive Footage	Constable Ysanne Harper, Police Diver
D19	AFFIDAVIT	Senior Constable Christopher Williams, Marine & Rescue
D20	AFFIDAVIT	Sergeant Bernard Peters, Marine & Rescue
D21	AFFIDAVIT	Senior Constable Paul Johns, Marine & Rescue
D22	AFFIDAVIT	Constable Melissa Bartulovic, Forensics, DNA
D23	AFFIDAVIT	Sergeant Scott Kregor, Forensics
D23A	FORENSIC PHOTOGRAPHS	Sergeant Scott Kregor, Forensics
D24	AFFIDAVIT – CIS / Site Plan of Elizabeth Street Pier	Constable Jared Gowen
D25	AFFIDAVIT	Constable Nicholas Monk, Forensics
D25A	ANNEXURE (WATERFRONT PHOTOGRAPHS)	Constable Nicholas Monk, Forensics
D26	AFFIDAVIT	Sergeant Peter Andricopoulos, Police Licensing
D26A	ANNEXURE A	Sergeant Peter Andricopoulos, Police Licensing
D26B	ANNEXURE B	Sergeant Peter Andricopoulos, Police Licensing
D26C	ANNEXURE C	Sergeant Peter Andricopoulos, Police Licensing

D27	AFFIDAVIT	Constable Armando Pasa
D27A	ANNEXURES 1-9 – Pub & Hotel Banc Group Documents	Constable Armando Pasa
D28	AFFIDAVIT 24 April 2020	Ian Vaughan, Obar Licensee
D28A	ANNEXURE – Obar Staff List	Ian Vaughan, Obar Licensee
D29	AFFIDAVIT 16 July 2020(Transaction History at Obar)	Ian Vaughan, Obar Licensee
D30	AFFIDAVIT 4 August 2020 (Transaction history at Telegraph Hotel)	Ian Vaughan, Obar Licensee
D31	AFFIDAVIT 31 August 2020	Ian Vaughan, Obar Licensee
D31A	ANNEXURE (M Ahmad Contract)	Ian Vaughan, Obar Licensee
D31B	AFFIDAVIT	Ian Vaughan, Obar Licensee
D32	AFFIDAVIT	Jacob Brown, Observatory Bar Operations Manager
D32A	ANNEXURES	Jacob Brown, Observatory Bar Operations Manager
D33	AFFIDAVIT	Vikas Kumar, Crowd Controller
D33A	ANNEXURE	Vikas Kumar
D34	AFFIDAVIT	Umer Khan, Crowd Controller
D35	AFFIDAVIT	Andrew Goss, Bar Staff
D35A	ANNEXURES	Andrew Goss, Bar Staff
D36	AFFIDAVIT	Jesses Crossin, Bar Staff
D36A	ANNEXURES	Jesses Crossin, Bar Staff
D37	AFFIDAVIT	Hayden Clark, Bar Staff
D37A	ANNEXURES	Hayden Clark, Bar Staff
D38	AFFIDAVIT	Brianna Fenton, Bar Staff
D38A	ANNEXURES	Brianna Fenton, Bar Staff
D39	AFFIDAVIT	Anna Packer, Bar Staff
D39A	ANNEXURES	Anna Packer, Bar Staff
D39B	PHOTOGRAPHS x2	Observatory Bar

D39C	PHOTOGRAPHS BUNDLE x20	Observatory Bar
D40	AFFIDAVIT	Tuese Vailepa, Crowd Controller
D40A	ANNEXURES	Tuese Vailepa, Crowd Controller
D40B	ANNEXURES	Register
D40C	ANNEXURES	Tuese Vailepa
D41	AFFIDAVIT	Alexander Hodge, Crowd Controller Team Leader)
D41A	ANNEXURES	Alexander Hodge, Crowd Controller Team Leader)
D41B	ANNEXURES	Alexander Hodge
D41C	BUNDLE OF CORRESPONDENCE	Alexander Hodge
D42	AFFIDAVIT	Eric Elford, Crowd Controller
D42A	ANNEXURE	Eric Elford
D43	AFFIDAVIT	James Barr, Observatory Bar patron
D43A	ANNEXURE	James Barr, Observatory Bar patron
D44	NO EXHIBIT	
D45	AFFIDAVIT	Broden Barlow, Patron at Obar
D46	AFFIDAVIT 6 August 2020	Benjamin Granger, Ex Hotel & Pub Banc Group Employee
D46A	ANNEXURE	Benjamin Granger, Ex Hotel & Pub Banc Group Employee
D46B	SUPPLEMENTARY AFFIDAVIT 13 April 2021	Benjamin Granger, Ex Hotel & Pub Banc Group Employee
D46C	ANNEXURE	Benjamin Granger
D47	AFFIDAVIT	Anna Flower, TasPorts
D47A	ANNEXURE A	Anna Flower, TasPorts
D48	AFFIDAVIT 1 October 2020	Sophie Grace, TasPorts
D48A	ANNEXURE A	Sophie Grace, TasPorts
D48B	ANNEXURE B	Sophie Grace, TasPorts
D48C	ANNEXURE C	Sophie Grace, TasPorts
D48D	SUPPLEMENTARY AFFIDAVIT (& attachments) 28 April 2021	Sophie Grace, TasPorts

D49	AFFIDAVIT	Jonathan Root, LAGB
D49A	ANNEXURE	Jonathan Root, LAGB
D50	NO EXHIBIT	
D51	AFFIDAVIT	Lisa Gregg, A/Director, Risk Based Licensing (DOJ)
D51A	ANNEXURE A	Lisa Gregg, A/Director, Risk Based Licensing (DOJ)
D51B	ANNEXURE B	Lisa Gregg, A/Director, Risk Based Licensing (DOJ)
D51C	ANNEXURE C	Lisa Gregg, A/Director, Risk Based Licensing (DOJ)
D52	AFFIDAVIT	David Dunn, TasTAFE re RSA
D53	AFFIDAVIT	Robert McLaren, Hobart City Council
D53A	ANNEXURE A	Robert McLaren, Hobart City Council
D53B	ANNEXURE B	Robert McLaren, Hobart City Council
D54	AMCS Documents Relating to Sea Safety Course	Dean COOK
D55	COURT BRIEF & OUTCOME OF JARED SPAULING	Magistrates Court of Tasmania, Hobart
D56	BANK RECORDS	CBA
D57	AFFIDAVIT	Jared Spaulding
D57A	ANNEXURE A	Jared Spaulding
D58	TELCO RECORDS & DISC	
D59	AFFIDAVIT 22 June 2023	Robert Davies
D60	EMAIL 11 June 2023	Mubin Ahmed
D60A	CERTIFICATE	Mubin Ahmed
D60B	CERTIFICATE	Mubin Ahmed
D60C	CERTIFICATE	Mubin Ahmed
D60D	ANNEXURE	Mubin Ahmed
D61	FOOTAGE (USB)	Ian Vaughan
D62A	Out-Of-Hours Permit 13 May 2019	Johnathan Root
D62B	Out-Of-Hours Permit 19 May 2020	Johnathan Root

Annexure C – Exhibits – General

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	Affidavit	Prudence Cunningham
C1A	Affidavit	Prudence Cunningham
C2	Affidavit	Assistant Commissioner Bodnar
C2A	2.14 Licensed Premises	Policy
C3	Affidavit	Sergeant Peter Andricopoulos
C4	Affidavit	Mark Anderson
C5	Affidavit	Assistant Commissioner Bodnar