IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 3828

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Karina Anne BELL

Delivered On:	30 April 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	28 March 2013
Findings of:	Coroner Paresa Antoniadis SPANOS, CORONER
Representation:	Ms Jodie BURNS, Senior In-House Counsel, assisting the Coroner
	Mr John FERGUSON, the deceased's uncle, appeared in person to represent the family

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of KARINA ANNE BELL

AND having held an inquest in relation to this death on 28 March 2013

in the Coroners Court of Victoria at Melbourne

FIND that the identity of the deceased was KARINA ANNE BELL

born on 5 June 1987, aged 24

and that the death occurred on or about 10 October 2011

in the vicinity of a rear access lane behind 660 Glenhuntly Road, Caulfield South, Victoria 3162

from a cause which remains:

1 (a) UNASCERTAINED

in the following circumstances:

INTRODUCTION & PERSONAL CIRCUMSTANCES

1. Ms Bell was a 24 year old single woman who was born in Adelaide on 5 June 1987 to Marilyn Ferguson and David Bell. Her father died in a motor cycle accident when she was 18 months old and, thereafter, Ms Bell generally lived with her mother in various locations in Adelaide and Melbourne. According to her mother, Ms Bell started using cannabis when she was about twelve and living in Adelaide. At about 16 years of age, Ms Bell was admitted to hospital for the first time due to suspected psychosis. Thereafter, it appears Ms Bell medicated and self-medicated herself with a number of illicit substances and prescription medications.

2. Ms Bell was previously in a de facto relationship with Terry Widger and is survived by their son Tyler who was residing with his father in Tasmania at the time of her death, following a long history of involvement with the Department of Human Services Child Protection Service. In the period immediately preceding her death, Ms Bell was a resident of Hanover House, 52 Haig Street, Southbank.

3. At about 4.00am on 10 October 2011, Ms Bell's body was found in an access laneway at the rear of 660 Glen Huntly Road, Caulfield South, by the owner of the business at 662 Glen Huntly Road who was arriving to start work for the day. He called 000 and police and ambulance paramedics arrived shortly thereafter. Ambulance paramedics found no signs of life and police established a crime scene. They noted that Ms Bell had been lying face down

with what appeared to be blood coming from her mouth and nose. Her upper body clothing was pulled up around her neck and her pants were down around her knees exposing most of her trunk and upper legs. Following appraisal of the scene by the first police officers attending, officers from the Homicide Squad attended, as did crime scene examiners and photographers. Fingerprints were taken for identification purposes and Ms Bell's body was taken away and an autopsy performed.[1]

THE EVIDENCE

4. Appraised of the autopsy findings, officers from the Homicide Squad determined that there were no suspicious circumstances and, thereafter, the investigation of Ms Bell's death was undertaken by Detective Senior Constable Luke Walsh from the Glen Eira Crime Investigation Unit (CIU), with the assistance of Detective Senior Constable Bubb from the Homicide Squad. This finding is based on the totality of the material, the product of their investigation. That is, the inquest brief as compiled; the report and testimony of Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (VIFM) who testified at inquest; and the testimony of DSC Walsh himself who was the only other witness I required to testify at inquest. All this material, together with the inquest transcript, will remain on the coronial file.[2] In writing this finding, I do not purport to summarise all the material/evidence, but will refer to it only in such detail as appears to me warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

5. The purpose of a coronial investigation of a *reportable death*[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which

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[1] See paragraphs 15-22 below where the autopsy findings and medical cause of death are discussed.

[2] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[3] The *Coroners Act 2008*, like its predecessor the *Coroners Act 1985*, requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear *"to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury"* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986"*.

[4] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[5]

6. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[6] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[7] These are effectively the vehicles by which the prevention role may be advanced.[8]

7. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. However, given aspects of the circumstances in which Ms Bell died, it is important to stress that Coroners are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence. Somewhat paradoxically, this prohibition does not apply to prevent a Coroner from referring to a notification to the Director of Public Prosecutions. Such a notification is required to be made by the Principal Registrar of the Court, where the Coroner investigating the death *believes* an indictable offence *may* have been committed in connection with the death.[9]

CIRCUMSTANCES LEADING UP TO MS BELL'S DEATH

8. Police investigations established that Ms Bell was last seen at her residence at Hanover House at 2.00pm on Saturday 8 October 2011. CCTV footage also captured her there at this time.

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[5] This is the effect of the authorities – see for example *Harmsworth* v *The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[6] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act of the *Coroners Act 1985* where this role was generally accepted as "implicit".

[7] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[8] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[9] Sections 69 and 49(1).

Access to rooms is via a slage card, and the card allocated to Ms Bell had not been used since that time, nor was the card found on her person or recovered in the course of the investigation. A search of Ms Bell's room located her mobile phone and some notes, none of which shed any light on her movements in the hours immediately preceding her death.[10]

9. Shortly before 10.30pm on 8 October 2011, Ms Bell was in the company of her friend Mario Lekic when she was detained by a Security Officer outside the IGA Supermarket at 64 Fitzroy Street, St Kilda. She was later arrested by Constables from St Kilda Police and taken to St Kilda Police Station where she was interviewed in relation to an allegation of theft, charged and released on bail between 12.30-1.00am on Sunday 9 October 2011. Apart from an injury to her knee which she alleged had occurred when she was being arrested, Ms Bell did not appear to police to have any other injuries. While emotional at times and complaining of a headache, she appeared to the police to be fit for interview, and did not appear to be overly intoxicated by substances.[11]

10. Later than morning, around 4.00am on 9 October 2011, Ms Bell was seen by three police officers from the Cabool Unit[12] in Grey Street, St Kilda. She was in the company of Mr Lekic once again, and they appeared to be in dispute with another male. The police tried to sort out the dispute but were called away to attend a nearby brawl.[13] Later still, shortly before 5.00am, Ms Bell was seen by the same police officers in the vicinity of the 7Eleven store on Fitzroy Street, St Kilda, still in the company of Mr Lekic.[14]

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[10] Transcript pages 25-26. Note that Ms Bell's mobile phone would have been of little use as it had no credit.

[11] Variously described in the inquest brief as "still upset and showed me her knee...had a migraine at the moment and that she was not on any other drugs but was currently on methadone...did not appear to be affected by drugs or alcohol..." (Hargreaves); "appeared tired but after some conversation...determined that she would be fit for interview...Other than the graze injury to her knee, I didn't notice any other visible injuries...was coherent and answered all of the questions...and was co-operative the whole time...initially emotional and maintained her innocence..." (Pitzen); "She appeared to be mildly affected by medication of some description...She said "Yes, I have a graze on my knee from when I was arrested. I suffer from anxiety and Post Traumatic Stress Disorder and I take Xanax"..."(O'Toole). Also transcript at pages 35 and following.

[12] A unit of Victoria Police tasked to address public intoxication and general disorder associated with night club locations.

[13] Initially the police were under the impression that Ms Bell had performed sexual services for which the male refused to pay. However, his English was limited, and when he later made a statement, he explained that Ms Bell got into the passenger seat of his car, demanding that he pay her for sexual services. He refused and the dispute escalated to the point where he left his car when he saw the police (with Ms Bell in it and the keys in the ignition) and tried to report the matter but the police could not understand him. See statement of Meresa Sibhat in the inquest brief Exhibit C. See also transcript pages 27 and following.

[14] Statements of Sen Const Wallace, Const Cohen and Const Breckon in the inquest brief Exhibit C.

11. The investigation of Ms Bell's death did not shed any further light on her movements between this sighting at about 5.00am on 9 October 2011 in St Kilda and the finding of her body about 24 hours later. Mr Lekic was formally interviewed by the police on 11 October 2011, and a transcript of that interview is included in the inquest brief. Mr Lekic told police that he had been with Ms Bell until 5.00am on 9 October 2011 at which time he had caught a taxi home. Mr Lekic's housemate had not seen him since 12.45pm on Saturday 8 October 2011, but another witness from a neighbouring unit told police that Mr Lekic had stayed with him at his unit on 9 and 10 October 2011.[15]

12. Two additional pieces of evidence, possibly inter-related, were uncovered by the police investigation of Ms Bell's death. The first is a statement from a female resident of Bambra Road Caulfield South, close to where Ms Bell's body was found. This witness told police that at about 1.15am on 10 October 2011, she heard a motor vehicle revving from the direction of Glen Huntly Road, alternately accelerating hard and then stopping abruptly, before driving towards a nearby park and coming to a screeching halt. She then heard a male voice screaming a name that sounded like "Koorn" or "Koren" or similar, shortly after which she heard a single vehicle door slam and the vehicle drive off. At this time she looked at her watch and saw that it was 1.28am.[16]

13. The second piece of evidence is DNA analysis of swabs and microscope slides taken from a number of sights on Ms Bell's body. Two of these swabs indicated a mixture of DNA from two people, including Ms Bell as a possible contributor to the mixture, and an unidentified male contributor. Also, one spermatozoon was observed on the microscope slide taken from Ms Bell's mouth, indicating an unidentified male contributor. By comparison with existing and accessible databases of DNA, the police were unable to identify the male in whose company Ms Bell appears to have been a short time prior to her death.[17]

UNCONTENTIOUS MATTERS

14. It will be apparent that a number of the matters required to be ascertained by the coronial investigation of her death were uncontentious. These matters were the deceased's identity, and aspects of the circumstances in which she died, namely the approximate place and time of

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[15] Statements of Rosemarie Togonon and Gary Quinn in the inquest brief Exhibit C and transcript pages 29-30.

[16] Statement of Chrissy Erlich in the inquest brief Exhibit C.

[17] Statement of Forensic Officer Alexandra Nicole Bate dated 17 October 2012 in the inquest brief Exhibit C.

death. I formally find that the deceased was Karina Anne Bell, born on 5 June 1987, late of Hanover House, 52 Haig Street, Southbank, Victoria and that she died in the early hours of 10 October 2011 in the vicinity of a rear access lane behind 660 Glen Huntly Road, Caulfield South, Victoria 3162.[18]

MEDICAL CAUSE OF DEATH

15. The autopsy was performed by Dr Paul Bedford, an experienced Forensic Pathologist from the Victorian Institute of Forensic Medicine (VIFM). Dr Bedford attended the scene and was briefed there by police, reviewed the circumstances as reported by the police to the Coroner, post-mortem CT scanning of the whole body and the results of toxicological analysis of post-mortem samples, both undertaken at VIFM. Having done so, Dr Bedford provided a detailed written report containing his findings, his opinion as to the medical cause of death and relevant comments.[19]

16. Consistent with Ms Bell's relatively young age and known medical history, Dr Bedford found no significant natural disease, apart from steatosis or fatty change in the liver and noted, in particular, that there was no evidence of cardiac disease. He identified minor traumatic injuries in the form of bruises and abrasions over the elbows and knees; right anterior frontal scalp bruising, occipital scalp bruising but no skull fracture or intracerebral haemorrhage; recent haemorrhage in the right sternocleidomastoid muscle not associated with a hyoid bone fracture; and no genital injury.

17. Dr Bedford advised that the medical cause of Ms Bell's death remained unascertained despite a full postmortem examination or autopsy and ancillary investigations. In the concluding comments to his report, Dr Bedford advised that there were no overt signs of homicide, that none of the injuries in themselves suggested that death resulted from inflicted trauma and that the minor traumatic injuries were consistent with the hypothesis that Ms Bell had been dumped from a motor vehicle, that arose from other aspects of the evidence.[20]

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[18] As to time of death, see Dr Bedford's evidence at page 10 of the transcript – some time between about midnight and his attendance at the scene at about 0600 on 10 October 2011.

[19] Exhibit A was Dr Bedford's nine page autopsy report dated 12 April 2012 which includes his formal qualifications and experience in forensic pathology.

[20] Especially the statement of Ms Erlich in the inquest brief Exhibit C.

18. At inquest Dr Bedford expanded on this opinion, stressing that although he found no ligature mark or other overt signs of strangulation, he could not entirely exclude the possibility.[21] He also testified that the minor traumatic injuries he found, generally looked fresh as if they had been sustained within about 24 hours of death, or in the perimortem period. Moreover, as a generality, these injuries did not bear the hallmarks of defensive injuries, and were consistent with her positioning on the ground, and/or how she came to be there.[22]

19. According to Dr Bedford's autopsy report and testimony at inquest, the other possible cause of Ms Bell's death is combined drug toxicity. Toxicological analysis of post-mortem blood and urine samples undertaken at VIFM, revealed methadone and its metabolite EDDP; morphine, codeine and 6-monoacetylmorphine (6MAM) consistent with the recent use of heroin, that is within a few hours of death; mirtazapine ("Avanza" an antidepressant); paracetamol; and a number of benzodiazepines - alprazolam ("Xanax" a short-acting antidepressant and anxiolytic) and its metabolite, diazepam ("Valium" a sedative/hypnotic), temazpeam, oxazepam.[23]

20. Although Department of Health records indicated that, as at the date of her death, there was an extant permit to treat Ms Bell with either methadone and/or buprenorphine for opioid dependence, the last recorded dosing attributable to this permit was 40mg on 11 and on 12 February 2011 with no take-away doses being supplied. According to the toxicologist's report, the concurrent use of other drugs such as benzodiazepines and opiates that depress the central nervous system, including respiration, *may* contribute to the toxicity of methadone, which is also a central nervous system depressant.[24]

21. Dr Bedford noted the toxicology results and, in his autopsy report, commented that *"The cause of death appears to relate to the multitude of drugs which include opioids and*

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[21] Transcript pages 11-13.

[22] This was a reference to the hypothesis that Ms Bell was dumped (or dragged) from a motor vehicle. See transcript page 16-17 "Clearly when there's any sorts of injuries that doesn't mean that they're not related to some sort of self-defence or trauma, but my general impression was that there was not strong evidence that injuries were not related to the fact of her positioning on the ground and how she got there, and – and the like... Well, it's especially the position on the body, so in particular hands are prominently used as a defensive mechanism...they're prominent positions on the body the knees and the elbows related in particular I would think in this case to movement of the body on the ground, on that bitumen, again without the protection of clothing...(and possibly related to a fall)..."

[23] According to the toxicologist's report, the benzodiazepines temazepam and oxazepam, which were detected in urine only and not in blood, may derive from the metabolism of diazepam and temazepam respectively. See toxicologist's eight page report in the inquest brief Exhibit C.

[24] Toxicologist's report in the inquest brief Exhibit C.

benzodiazepines. Both of these groups of drugs are known to cause respiratory depression."[25] He did not, however, see fit to attribute Ms Bell's death to combined drug toxicity, explaining at inquest that it was always difficult to extrapolate the effect of drugs on an individual from levels found in post-mortem samples, particularly for an individual who was known to use drugs and could be anticipated to have developed a level of tolerance to their effects and where, as in Ms Bell's case, the detected levels were not at recognised excessive or toxic levels.[26]

22. Based on the above, I find that the medical cause of Ms Bell's death remains unascertained despite a full post-mortem examination or autopsy performed by Dr Bedford, ancillary investigations undertaken either by him or at his behest and routine post-mortem toxicological analysis.

CONTENTIOUS CIRCUMSTANCES – CONCLUSION

23. Apart from the lack of a clear medical cause of death, the focus of the investigation of Ms Bell's death was on her movements in the 24 hour period immediately preceding her death and, in particular, the identification of anyone who spent time with her and/or who may have caused or contributed to her death. The evidence does not allow me to make a positive coronial finding about what happened to her in that 24 hour period.

24. However, a hypothesis has been formulated which finds its genesis in Ms Bell's lifestyle, Dr Bedford's autopsy findings, Ms Erlich's observations in the early hours of 10 October 2011 and the DNA analysis mentioned in paragraphs 12 and 13 above. That hypothesis is, that in the early hours of 10 October 2011, Ms Bell was probably in the company of an unidentified male or males, that she was performing sexual services possibly in a motor vehicle, became unconscious, possibly as a result of combined drug toxicity and/or appeared to her companions to be deceased, and that he/they panicked and ejected her from the vehicle in the laneway where she was found at about 4.00am.

25. Although this is the hypothesis of "best fit" with the available evidence, on my assessment, the available evidence does not support a positive coronial finding that this hypothesis

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[25] Page 9 of Exhibit A.

[26] Transcript pages 7-9. I note that Dr Bedford excluded mirtazapine as a major contributor to any hypothetical combined drug toxicity.

represents the circumstances in which Ms Bell actually died. There is a dearth of direct evidence about Ms Bell's movements in the 24 hour period immediately preceding her death, and about the company which she kept. Such evidence as there is allows a number of possibilities, ranging from an accidental drug-related death at the higher end of the spectrum of possibilities, to a suspicious death involving an unidentified person/s at the other.

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

The family of Ms Bell

Detective Senior Constable Luke Walsh (#32123) c/o O.I.C. Glen Eira C.I.U.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: **30 April 2013**