Form 44 – Order following application to set aside finding

Rule 70(2)

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE
IN THE MATTER OF THE DEATH OF LOUISA IOANNIDIS

Court Reference: COR 2011 003854

ORDER FOLLOWING APPLICATION TO SET ASIDE FINDING

Section 77(2) of the *Coroners Act 2008* (Vic)

Order of:	Deputy State Coroner Paresa Antoniadis Spanos
Delivered on:	6 November 2025
Deceased:	LOUISA IOANNIDIS
Date of death of deceased:	On or about 2 October 2011
Applicant:	ANASTASIOS STOURAITIS
Date of application:	12 June 2025
Findings sought to be set aside:	Finding of Deputy State Coroner Paresa Antoniadis Spanos dated 30 January 2024

INTRODUCTION

1. Louisa Ioannidis was a 24-year-old woman who resided in public housing in Seston Street, Reservoir. Ms Ioannidis had been in a relationship with Youseff Asaad since she was 15 years old and they resided together at her address in the period immediately preceding her death. The relationship was volatile involving arguments and physical abuse, and substance use by both.

2. Ms Ioannidis was last seen alive by Mr Asaad in the late evening of 2 October 2011 running in the direction of nearby Darebin Creek. Earlier that day, neighbours had heard them arguing which was not an unusual occurrence.

CORONIAL INVESTIGATION & INQUEST

3. Ms Ioannidis' death was reported by police to the coroner on 11 October 2011 when the body of an unidentified female was found by a person walking near Darebin Creek, Reservoir, about 450 metres from her home. The body was decomposed, and identity was established by fingerprint analysis on 19 October 2011.

4. The coronial brief compiled by Detective Senior Constable Carla McIntyre (**DSC McIntyre**) was provided to the court under cover of memorandum dated 23 February 2012, runs to 437 pages and includes witness statements, photographs of the scene, the pathologist's autopsy report, the toxicologist's report, mobile phone records, details of intervention orders obtained by Ms Ioannidis and/or the police on her behalf, and the statement and record of interview of Mr Asaad.

5. During 2012, Anastasios (Tass) Stouraitis (**Mr Stouraitis**), the deceased's half-brother applied for and was given a copy of the coronial brief. In October 2012, in response to advice from the court that I intended to finalise the coronial investigation without an inquest, Mr Stouraitis lodged a Request for Inquest into Death (**Form 26**). For present purposes, suffice to say that he was concerned that Ms Ioannidis had died in suspicious circumstances and that Mr Asaad was involved in her death.

6. On 23 September 2013 I made a formal determination refusing this request and setting out my reasons (Decision by Coroner Whether or Not to Hold an Inquest into Death/Form 28). Due to an administrative error, the determination was not delivered to Mr Stouraitis at the time it was signed. When the oversight was brought to my attention on 29 October 2013, I

authorised re-dating of the determination to 29 October 2013 so as not to prejudice Mr Stouraitis' appeal rights.

7. Section 82 of the ***Coroners Act 2008*** **(the Act)** permits a person who is refused an inquest to appeal against the coroner's determination to the Supreme Court and must do so within three months unless the court grants leave to appeal out of time. Mr Stouraitis did not appeal the refusal of inquest.

8. As was the practice at that time, I allowed the appeal period to expire before delivering a Finding into Death Without Inquest (**Form 38**) into Ms Ioannidis' death. For convenience, that finding dated 30 January 2014 is attached to this determination as "Attachment 1" (**the finding**).

9. In format, the finding accorded with the Rules prescribed under the Act at the time. The finding was relatively succinct and was not published or distributed beyond the parties as was the general practice (both then and now) with findings following an investigation on the papers (without inquest) and in which no prevention-focused comments or recommendations are made.[1]

10. In summary, I found that the cause of Ms Ioannidis' death was *consistent with drowning*.[2] I noted a history of domestic violence between Ms Ioannidis and Mr Asaad, that they had argued that day and he had ostensibly moved out; and that Ms Ioannidis had been experiencing a number of other personal stressors in the months immediately preceding her death. I concluded that the available evidence did not enable me to determine whether Ms Ioannidis intentionally took her own life or had died from accident or misadventure and that the available evidence did not support a finding that any other person caused or contributed to her death.

11. Section 83 of the Act permits a person with a sufficient interest to appeal to the Supreme Court against the findings of a coroner in respect of a death after an investigation and must do so within 6 months unless the court grants leave to appeal out of time. Mr Stouraitis did not appeal the findings.

[1] See section 67(3) of the Act for the power to make "comments" at large and section 72(2) for the power to make recommendations to any Minister, public statutory authority or entity.
[2] This formulation will be discussed below.

THE APPLICATION TO SET ASIDE FINDING

12. On or about 12 June 2025, the court received an Application to Set Aside Finding (**Form 43**) pursuant to section 77 of the Act from MJR Criminal Lawyers and Robinson Gill Lawyers on behalf of Mr Stouraitis.[3] The application was supported by:

    - Submissions from Carly Marcs, Counsel for Mr Stouriatis dated 12 June 2025;
    - Annexure A – entitled Water Levels Data;
    - Annexure B – entitled Professor Duflou Pathology Report;
    - Annexure C – Journal article regarding the significance of dry lungs in bodies found in water;
    - Annexure D – entitled Expert Opinion of Professor Kerry Carrington;

13. As section 77(7) of the Act requires the State Coroner to determine which coroner is to constitute the Coroners Court for the purposes of such applications, the Application was referred to the (then) State Coroner, Judge John Cain, who in due course determined that I should constitute the Coroners Court for the purposes of the Application. This is in accordance with a general practice that the investigating coroner considers such application unless they are no longer a coroner or are otherwise unavailable.

14. The application and documents referred to in paragraph 11 above will be referred to in combination as "the application" in this determination, except where otherwise indicated.

15. The application does not explicitly stipulate which findings of fact are sought to be set aside. However, having reviewed the application, the coronial brief and the finding, it is reasonable to infer that, taken at its highest, the application seeks to set aside all findings except the findings as to Ms Ioannidis' identity, date of birth/age, and the date of her death which I found to be "on or about 2 October 2011".

THE LEGISLATIVE FRAMEWORK

16. Section 77 of the Act allows a person to apply to the Court for an order that some or all of the findings of a coroner be set aside, whether or not an inquest has been held.

[3] The application proper (Form 43) was accompanied by an unsigned and undated statement from Mr Stouraitis which reiterated concerns he had previously raised, namely his belief that Ms Ioannidis died in suspicious circumstances and that Mr Asaad was involved in her death.

17. Section 77 was the subject of amendment in 2018. In the earlier version, the relevant test was in section 77(3) and had two discrete limbs, requiring the Court to be satisfied firstly that there are new facts and circumstances and then that it is appropriate to re-open the investigation.

18. In its current form, the section 77(2) empowers the Court to set aside some or all of the findings, with or without re-opening an investigation, if satisfied that there are "new facts and circumstances" that make it appropriate to do so. This limits the matters capable of providing a basis for the Court to exercise the discretion to set aside some or all of the findings with or without re-opening the investigation, to the new facts and circumstances "that make it appropriate to do so".

19. Whereas there has been judicial consideration of aspects of the earlier version of section 77 there has been little, if any, judicial consideration of the proper construction of the current version of section 77, in particular section 77(2). Nevertheless, the strong similarities between the current test in section 77(2) and the earlier version of the test in section 77(3), namely the retention of the new facts and circumstances test means that there is some guidance in the earlier case law.

20. The phrase "new facts and circumstances" was considered by Forrest J in the case of *Hecht v Coroners Court of Victoria*[4] where His Honour said as follows -

> *Mr and Mrs Hecht argue that the expression 'new facts and circumstances' ought to be given a broad, common-sense definition, consistent with the Explanatory Memorandum for the Coroners Bill 2008:*
>
> *The reference to new facts and circumstances encompasses facts and circumstances that are new to the investigation. These facts may have been known to people during the investigation, but there were not known to the coroner conducting the investigation.*[5]
>
> *This argument should be accepted.*

[4] [2016] VSC 635 at [43] and [44]
[5] This test is clearly distinguishable from the "fresh evidence" test in the criminal jurisdiction.

21. This interpretation was adopted by the Court of Appeal in the case of *Mortimer v West*[6] where the Court stated that -

> *We adopt the broad understanding of 'new facts and circumstances' countenanced by J Forrest J. It is noteworthy that there is no requirement, for example, that the fact or circumstance not have been in existence at the time of the initial investigation or could not have been discovered with reasonable diligence. We acknowledge, however, that the identification of the 'new fact or circumstances' is occurring within the statutory context of the power to order that previous findings be set aside and an investigation be re-opened. This suggests that matters of no, or little, substance would be excluded from meeting the statutory test under section 77(3)(a) even if previously unknown to the coroner. It is otherwise sufficient that the fact of circumstances was not known to the coroner conducting the investigation.*

22. While the amendments to section 77 since these cases have altered the statutory context to some extent, it is significant that Parliament has retained the phrase "new facts and circumstances" following the interpretation sanctioned in these cases. In the absence of other case law to the contrary, I accept that the interpretation of "new facts and circumstances" in the current version of section 77(2) should be in accordance with the decisions in *Hecht* and *Mortimer v West.*

ARE THERE NEW FACTS AND CIRCUMSTANCES?

23. As outlined above the application comprises and relies on several inter-related tranches of material proffered as establishing new facts and circumstances that make it appropriate to set aside the findings made in relation to Ms Ioannidis' death. In these reasons, I will deal with each in turn, starting with the expert evidence of Professor Johan Duflou (**Prof Duflou**), a specialist forensic pathologist.

24. In his report, Prof Duflou has set out details of this formal qualifications, training and experience and has provided a formal curriculum vitae including details of his many publications. I have no hesitation in accepting him as an expert who is qualified to conduct a review of the material in the coronial investigation of Ms Ioannidis' death and in particular to review of Dr Michael Burke's autopsy report.

[6] [2018] VSCA 188 at [108].

25. Apart from threshold matters pertaining to his expertise, Prof Duflou's relevantly comprises three discrete sections – an outline of the material provided to him and the context in which his expert opinion is ought (paragraphs 4-6); a review of the material provided in the form of a summary (paragraphs 7-20); and the questions asked of him in a briefing letter dated 3 April 2025 together with his responses (paragraphs 21-35).

26. To state the obvious, it is only the third section of Prof Duflou's report which can possibly amount to new facts and circumstances in this case. In this determination, I have necessarily focused on those areas of difference or departure between his report and Dr Burke's autopsy report. However, it is fair to note that Prof Duflou is complimentary of Dr Burke's autopsy overall and describes his formulation of the cause of death as not unreasonable.[7] Prof Duflou's explanation of the meaning of "consistent with drowning" accords with my understanding of the expression and, I believe, with Dr Burke's intent.[8]

27. Without doing justice to Prof Duflou's detailed and reasoned responses to the questions asked of him, his main criticism is that Dr Burke appears to have overlooked the presence of haemorrhages in the neck and that these in turn may represent a physical altercation or actual or attempted strangulation. While Dr Burke describes an absence of injury on formal dissection of the neck, in Prof Duflou's opinion mortuary photos of the neck muscles appear to show haemorrhages within the musculature of the neck.[9]

28. An associated criticism of Dr Burke concerns his formulation of the cause of death as "consistent with drowning". While Prof Duflou states this is not unreasonable, he emphasises that "consistent with" does not imply that the cause of death is drowning but rather that the features are in keeping with drowning, and arguably, there is no other obvious cause of death. In this context, he repeats his opinion that the haemorrhages within the neck muscles do raise at least a possibility of neck compression at some time prior to death.[10]

29. Prof Duflou's opinion as to the *possibility* of evidence of neck compression having occurred at or prior to Ms Ioannidis death that was not apparent at the time I wrote my finding

[7] Paragraph 26 at page 39/76 of the application.
[8] Paragraph 27 at pages 39-40/76 of the application. See too his suggestion that it might have been more prudent to attribute death to "unascertained" (paragraph 33 at page 42/76, premised on the existence of a concern that another person caused the death) and his explanation of the difficulty of attributing a death to drowning on purely pathological grounds which is in keeping with my understanding.
[9] Note that Prof Duflou refers to photos 21 and 22 taken by SC Owen at page 194 of the brief, whereas the version of the coronial brief retrieved from archives at my request has these photos of the neck muscles at page 177 of the coronial brief. See paragraph 31(a) of Prof Duflou's report at page 41/76 of the application.
[10] Paragraph 27 at pages 39-40/76 of the application.

satisfies the new facts and circumstances threshold for the purposes of the first limb of section 77(2) of the Act.

30. The second tranche of evidence proffered as establishing new facts and circumstances is the water levels data at pages 3-30/76 of the application. This data appears to have been downloaded from a Melbourne Water website and provides flow rate and depth of water data from a site in Bundoora (in the vicinity of La Trobe University) and a site in Ivanhoe (in the vicinity of the Darebin Parklands).

31. It is an understatement to say that the data is not self-explanatory. Apart from the data emanating from monitoring sites some distance from where Ms Ioannidis' body was found,[11] without expert analysis from an appropriately qualified person, it is not apparent whether the data speaks to any of the findings made about Ms Ioannidis's death or adds to the material already in the coronial brief which is limited to rainfall data.[12]

32. Nevertheless, taken at face value, the water level data provided satisfies the new facts and circumstances threshold for the purposes of the first limb of section 77(2) of the Act.

33. The third and final tranche of material relied on in the application as establishing new facts and circumstances relates to domestic violence.

34. It comprises the opinion of Professor Kerry Carrington (**Prof Carrington**) entitled "Expert Report on the significance of domestic violence as a risk factor in the death of Louisa Ioannidi [sic] Case No 3854/2011". This is a three-page report dated 29 May 2025, accompanied by a curriculum vitae and details of Prof Carrington's formal qualifications, research interests with a particular focus on gender, gendered violence and criminology and her experience in having testified in two inquests in Queensland.[13] Based on Prof

[11] Noting that the precise place where Ms Ioannidis entered the creek and/or came to grief is unknown, except that if Mr Asaad is to be believed, it was likely upstream and closer to her residence than the place from where her body was recovered, about 450m from her home.

[12] This is referred to the DSC McIntyre's statement, however, I have been unable to find it in the coronial brief retrieved from archives. In DSC McIntyre's statement at page 133 of the coronial brief, in a paragraph beginning "On the 20 October", DSC McIntyre states "I then conducted further enquiries with the Bureau of Metrology [sic] in relation to rainfall around the 3 October 2011. I found that there had been significant rainfall in the area. ***I produce the rainfall charts in the Reservoir area for the months of September 2011 to October 2011.*** I observed that on the 29 September 2011 the Reservoir area received over 40ml, followed by further constant rainfall until the 3 October 2011."

[13] Prof Carrington's report is at pages 70-72/76 of the application and her curriculum vitae at pages 73-76/76.

Carrington's curriculum vitae, I am satisfied that she has expertise regarding domestic violence research and risk factors.[14]

35. In her brief report, Prof Carrington reiterates and summarises aspects of the various witness statements in the coronial brief which provide evidence of domestic violence between Mr Asaad and Ms Ioannidis.[15] It is apparent that this aspect of her report merely repeats evidence included in the coronial brief and available to me coroner at the material time. Nor does its incorporation into counsel's submission transform what was part of the coronial investigation into new facts and circumstances for the purposes of section 77(2) of the Act.

36. In her report, Prof Carrington goes on to posit risk factors that were present and exacerbated the likelihood of lethal domestic violence in Ms Ioannidis' case; and to state that domestic violence risk is highest at the point of actual or pending separation.[16] This is new information in the sense that Prof Carrington's report was not available to me at the timexpert evidence along the same lines.

37. The risks of domestic violence identified by Prof Carrington in her report are not controversial, certainly not by today's standards. What my precise understanding was at the time I wrote the finding into Ms Ioannidis death is difficult to reconstruct. When I delivered the finding into Ms Ioannidis' death in January 2014, I had been a Magistrate for 11 years, involved in hearing applications for intervention orders and breaches of intervention orders throughout that time, as well as sitting in the criminal jurisdiction more broadly. And I had been a coroner for over eight years involved in the investigation of the spectrum of reportable deaths including deaths found to be suicides, drug related deaths both accidental and intentional, and deaths involving intentional trauma and homicide.

38. Prof Carrington criticises the police investigation in the following terms – *"Given the history of domestic violence and the fact that Louisa had attempted to leave her partner (unsuccessfully) just prior to her death, the motives and* movements *of Mr Asaad on the night of her death warrant further scrutiny. Yet, it appears, the police relied solely on the evidence of Mr Asaad, a potential suspect in what could be a suspicious death."*

[14] Page 70/76 of the application, under the heading "My Expertise" Prof Carrington stated "I have 3 decades of experience in research and evaluation. I am globally recognized for my research on preventing domestic violence and enhancing police responses to gender violence survivors."
[15] See "History of Domestic Violence" and "Summary" on page 71/76. I note that Prof Carrington incorrectly states that "On 3 October 2011 Louisa was found dead in creek at the end of the street 450 metres from where she had lived and was last seen alive by Joe (Mr Asaad)." This should read 11 October.
[16] Page 71/76 under the heading "Risk Factors of Lethal Domestic Violence"

39. The criticism was extended to the coronial finding in the following terms – *"Moreover, the conclusions of the Coroner's report relied extensively on a police investigation which accepted at face value Mr Asaad's claims about his whereabouts and actions that night, and failed to take into account the history of serious domestic violence in the relationship where the risk of lethal violence would have peaked on the night of the death of Ms Louisa Ioannidis."*

40. With all due respect, Prof Carrington has over-simplified and mis-represented the investigation undertaken by DSC McIntyre and misrepresented the coronial finding in which I explicitly acknowledged the domestic violence context in which Ms Ioannidis' death occurred.

41. Beyond that, it does not do to conflate what researchers know about the risk of domestic violence, even lethal domestic violence, from an epidemiological perspective, with what can be established by evidence to the standard applicable (even) in a coronial investigation that an individual caused or contributed to a death.

42. Nevertheless, Prof Carrington's opinion about the domestic violence risk for Ms Ioannidis around the time of her death does satisfy the new facts and circumstances threshold for the purposes of section 77(2) of the Act.

43. The balance of material relating to domestic violence relied on in the submissions of Counsel is and was part of the coronial brief available to me at the material time. This material does not satisfy the new facts and circumstances threshold even on the broad interpretation given in the *Hecht* and *Mortimer v West* decisions.

DO THE NEW FACTS AND CIRCUMSTANCES MAKE IT APPROPRIATE TO GRANT THE APPLICATION

44. The next consideration is the second limb of section 77(2) of the Act. This requires a consideration of whether the new facts and circumstances make it appropriate to set aside some or all of the findings without or without re-opening the investigation. However, apart from the legislative framework mentioned above, there is a need to consider the **broader legislative context within with all coronial determinations are made.**

45. When exercising a function under the Act, I must have regard to its preamble, purposes and objectives. The preamble recognises the important role the coronial system plays in Victorian society, a role that involves - finding the causes of deaths; contributing to the

reduction of the number of preventable deaths; and promoting public health and safety and the administration of justice.

46. The purposes of the Act include, relevantly, to require the reporting of certain deaths; to provide for coroners to investigate deaths in certain circumstances; to contribute to the reduction of the number of preventable deaths; and to establish the Coroners Court of Victoria as a specialist inquisitorial court.

47. Part 2 of the Act sets out the objectives intended to give guidance in the administration and interpretation of the Act. Section 8 sets out factors that a person should have regard to when exercising a function under the Act, including that that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death; that there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information; and the desirability of promoting public health and safety and the administration of justice. Section 9 requires that *"The coronial system should operate in a fair and efficient manner."*

48. Another feature of the coronial system established by the Act is the coroner's amenability to review of decisions made during the course of an investigation. The Act provides for – reconsideration of an autopsy direction (section 26); an appeal against a decision that a death is not reportable (section 78); an appeal against an autopsy direction (section 79); an appeal against order to release a body (section 85); an appeal against an exhumation or refusal of exhumation (section 81); an appeal against determination not to hold an inquest (section 82); an appeal against findings of coroner whether following an investigation or an inquest (section 83); and an appeal on a question of law (section 87).

49. At the risk of labouring the point, the substance of the application before me seems better suited to an appeal against the findings of a coroner (section 83) rather than an application to set aside the finding based on new facts and circumstances.

50. Apart from directions or determinations that are intrinsically exigent, generous appeal periods are allowed for appeals to the Supreme Court. Three months in the case of a refusal of exhumation and a determination not to hold an inquest, 90 days in respect of an appeal against a refusal to re-open an investigation, and six months in the case of an appeal against

a finding with provision for leave to be granted by the Supreme Court to appeal out of time in appropriate circumstances.[17]

51. There has been some judicial consideration touching on whether the new facts and circumstances make it appropriate to grant the application.

52. In *Mortimer v West,* MacAulay J agreed with the decision of Forrest J in *Hecht* that there is no warrant to qualify the words appearing in section 77(3)(a) by reference to the capacity of the new facts and circumstances to change the original finding. Adding –

> *Apart from that qualification being a significant gloss on otherwise plain words, the presence of the second limb of the test, s77(3)(b), suggests that the second limb is the intended mechanism by which the coroner may consider, among other things, the potential for the new facts and circumstances to impact upon the original finding.* [18]
>
> *The power to re-open in s77(2), expressed or amplified in s77(3), is unlikely to be intended to be exercised merely because a new fact or circumstance has arisen. For instance, it would be unusual if a new fact that entirely supported and reinforced the original finding could be a ground to set aside the finding and re-open the investigation. Additionally, even if a new fact had a potential to bear upon the original finding, the extent of that impact could be anywhere on the scale between negligible and overwhelming. So, it seems logical that the likely impact of a new fact and circumstance on the original finding should be a relevant consideration when assessing whether any investigation should be re-opened. The chief error in Hecht, it seems to me, was the stage at which the coroner considered the impact of the new fact and circumstances within the two-tiered test, that is, at the first tier. Additionally, the test for measuring the 'impact' of the new fact and circumstance may have been too rigid.*[19]

53. MacAulay J was considering the previous iteration of section 77, when he noted that the expression 'appropriate to re-open the investigation' had been given little if any analysis in

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[17] Section 86 provides that the Supreme Court may grant leave to appeal out of time under section 78, 80, 81(3), 82, 83 or 84 if the Supreme Court (a) is of the opinion that the failure to institute the appeal within the specified period was due to exceptional circumstances; and (b) is satisfied that granting leave is desirable in the interests of justice.
[18] [2017] VSC 293 at [46]
[19] [2017] VSC 293 at [47]. Referred to as the "unsustainability test" the test applied by the coroners in *Hecht* and *Mortimer v West and impugned in the appellate decisions* was recorded by Forrest J as *"The new facts of circumstances must be such that a previously accepted fact, material to findings regarding the identity of the deceased, the cause of death and/or pertinent circumstances surrounding the death under investigation, is so altered that the relative finding may be unsustainable."*

the cases. His Honour went on to say that the first limb of section 77(3) having been satisfied, the second limb requires the coroner to determine whether, in light of those new facts and circumstances, it is 'appropriate to re-open the investigation'. He referred to the dictionary definitions of the word 'appropriate' being, relevantly, 'suitable or fitting for a particular purpose' or 'proper, fitting'.

54. MacAulay J characterised the test in the second limb as inherently broad with its application being deliberately left to the judgement of the decision-maker, noting that –

> *The legislature can be taken to expect the coroner to have specialist knowledge and experience and to have consciously entrusted him or her to make judgments as to what is required or desirable by way of investigation to achieve the purposes of the Act as applied to a particular death or event.*[20]

55. Further consideration to the correct interpretation of section 77 was given by the Court of Appeal in the *Mortimer v West (in his capacity as Deputy State Coroner)*. In a joint judgement, the Court noted with approval that MacAulay J accepted that Forrest J was correct in finding that it would be unfaithful to the statutory language in section 77(3)(a) to apply the unsustainability test, but also that he went further in finding it would be unfaithful to the statutory language in section 77(3)(b) to apply the unsustainability test.[21] The Court went on to say –

> *In our view, it would be an error of law for the unsustainability test to be used in the application of either the first or second limb of s 77(3). For the reasons given by J Forrest J in Hecht the identification of 'new facts and circumstances' does not require that those facts and circumstances would cause a previously accepted fact to be so altered that a relevant finding may be unsustainable. Similarly for the reasons given by the judge below, the assessment of whether it is 'appropriate' to re-open an investigation does not depend on a finding that a previously accepted fact would be so altered that a relevant finding may be unsustainable. The language of what is 'appropriate' is inherently broad and properly to be informed by a multitude of considerations, some of which may be competing. In our view, neither of the criteria under s77(3) are restricted by their capacity to give rise to conclusions about the unsustainability of previously accepted facts, and it would be contrary to the statutory language to confine the criteria in this way.*

[20] [2017] VSC 293 at [49]. See also [50-51]
[21] [[2018] VSCA 188 at [75-76]

That is not to deny (and it was not in dispute) that the impact of a new fact or circumstances on the original findings of a coroner may well be relevant in assessment the appropriateness of re-opening an investigation.[22]

56. As set out above, following the amendments to section 77, a coroner's decision to set aside some or all of the findings with or without re-opening the investigation can only be based on the established new facts and circumstances that make it appropriate to do so. In my view, the amendments make an explicit causal connection between the two limbs of the test where one was previously implied and do not detract from the applicability of the Court of Appeal's decision in *Mortimer v West* in terms of the guidance it gives to coroners making such determinations.

57. The delay between Ms Ioannidis's death in October 2011, the delivery of the finding in January 2014, and this application is unfortunate. There is the potential here to undermine the fair and efficient operation of the coronial system. Coronial investigations should be conducted efficiently and fairly and finalised as expeditiously as possible. When concluded, it is desirable that there be finality and certainty for family members and other parties alike.

58. Having considered the application and for the reasons set out above, I am satisfied that there are new facts and circumstances in those parts of Prof Duflou's report and the water levels data that make it appropriate to order that -

    (a) the finding as to the cause of Ms Ioannidis' death is set aside and the investigation is re-opened to further investigate the cause of death, specifically to obtain a further report from Dr Burke addressing the issues raised in Prof Duflou's report and/or to elucidate the differences between them whether by engaging a third forensic pathologist or otherwise.

    (b) the finding as to the circumstances of Ms Ioannidis' death, in so far as the depth of water in Darebin Creek at the relevant place and time is an issue and touches on the possibility of drowning, is set aside, and the investigation re-opened to further elucidate the water levels data by obtaining evidence from an appropriately qualified expert or otherwise.

59. Ultimately, the forensic value of Prof Carrington's report, is that it identifies Mr Asaad as a perpetrator of violence against Ms Ioannidis and therefore a person of interest in relation to

[22] [2018] VSCA 188 [77-78]

her death. That much was known at the time the finding was written; was an obvious focus of the coronial investigation; and was explicitly addressed in the finding. It follows that I do not consider it appropriate to set aside any aspect of the finding or to re-open the investigation into Ms Ioannidis' death on the strength of Prof Carrington's report and/or the associated submissions of Counsel.

DISTRIBUTION OF DETERMINATION

60. I direct that a copy of these reasons and order is to be provided to:

The Applicant, Mr Anastasios (Tass) Stouraitis c/o MJR Criminal Lawyers and Robinson Gill Lawyers

Senior Sergeant Brumby, Police Coronial Support Unit for provision to the Coronial Investigator

PUBLICATION OF DETERMINATION

61. As indicated above, the finding was not published at the time it was delivered to the parties in January 2014. However, as this case is now in the public domain and has achieved a degree of notoriety, it is appropriate that the court's findings are open to public scrutiny and its processes explained as far as possible. I therefore order publication of this determination and the finding (Attachment 1) on the court's website.

Signature:

Paresa Antoniadis Spanos
Deputy State Coroner
Date: 6 November 2025

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 003854

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of LOUISA IOANNIDIS
without holding an inquest:
find that the identity of the deceased was LOUISA IOANNIDIS
born on 15 February 1987, aged 24
and that the death occurred on or about 2 October 2011
at Darebin Creek, Reservoir, Victoria 3073
from:

1 (a) CONSISTENT WITH DROWNING.

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Ioannidis' death was reported to the Coroner on 11 October 2011. This was the date on which the body of an unidentified female, broadly fitting her description, was found by a person walking near Darebin Creek, Reservoir. Visual identification was not possible owing to the degree of decomposition, and Ms Ioannidis' identity was established by fingerprint analysis on 19 October 2011. Ms Ioannidis was found fully clothed and wearing a pink terry towelling robe over her clothes.

2. A full post-mortem examination was performed by Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (VIFM), who also reviewed the circumstances as reported by the police to the Coroner and post-mortem CT scanning of the whole body (PMCT). Dr Burke advised that it would be reasonable to formulate the cause of Ms Ioannidis' death as *consistent with downing*. He advised that the post-mortem examination showed no evidence of significant natural disease or injury and that, in particular, there was no

evidence of neck or head injury to suggest that she had been held down in the water, or otherwise subjected to trauma, immediately preceding death.

3. Routine post-mortem toxicological analysis revealed ethanol (alcohol) at a concentration of 0.01g/100mL and Delta-9-tetrahydrocannabinol (one of the main psychoactive ingredients of cannabis) at a concentration of ~129ng/mL. The toxicologist advised that the specimen received showed signs of decomposition, which can change the concentration of any drugs and poisons if they were present at death, and even prevent the detection of drugs and poisons by the presence of decomposition substances. Dr Burke noted the toxicologist's report, and also commented that ethanol might be formed by the process of decomposition.

4. In investigating the circumstances surrounding Ms Ioannidis' death on behalf of the Coroner, investigating police ascertained that she was last seen alive by her partner, Mr Youseff Asaad, on 2 October 2011 in the late evening, running towards the Darebin Creek. According to his account, they had argued that day and he had told Ms Ioannidis he was going to leave her. Mr Asaad said that at about 6.00pm he was at the house packing his belonging. He loaded them into Ms Ioannidis' car and they both drove to his parents' home in Reservoir. Ms Ioannidis became very emotional and begged Mr Asaad to come back. Ms Ioannidis left Mr Assad at his parents' home and, as far as can be ascertained, returned home.

5. At some stage later in the evening of 2 October 2011, Mr Asaad stated that he returned to the couple's home in Seston Street, Reservoir, to find his car keys. He looked for Ms Ioannidis but could not find her in the house. He walked out to Seston Street, turned right into Tyler Street and saw Ms Ioannidis running very fast towards Darebin Creek. She was wearing a pink dressing gown, and Mr Asaad stated that he saw her robe under the streetlight as she ran away. He told police that he did not chase Ms Ioannidis, but instead returned to the house to wait for her there.

6. According to his account, Mr Asaad attempted to contact Ms Ioannidis by telephone the next morning, and then walked to the creek later in the day, where he noticed a pink robe snagged on a branch in the creek. Mr Asaad told police that that he thought Ms Ioannidis might have taken off her robe and thrown it into the creek as she was running. Ms Ioannidis was not seen again by Mr Asaad or her family over the next few days, and a missing persons report was eventually made to police.

7. As part of their investigation of her death, police investigated the relationship between Ms Ioannidis and Mr Asaad. They established that the couple met when she was about 15 years of age, and they began a relationship in the following years. Ms Ioannidis began to use cannabis, ice and other drugs of dependence in her late teenage years, and continued to do so until her death. On several occasions, Ms Ioannidis reported to police that she was a victim of domestic violence. On two occasions, intervention orders were made against Mr Asaad, by way of protection of Ms Ioannidis. During the course of their relationship, Ms Ioannidis alleged many instances of physical violence including one where Mr Asaad allegedly threw boiling water over her. Neighbours who provided statements to the police also reported hearing the couple fighting and observing Ms Ioannidis with injuries.

8. Of relevance to Ms Ioannidis' state of mind is a journal that she kept, generally containing lists of things to do and thoughts about how she was feeling. Entries were made periodically, and were mostly positive. All diary calendar entries ceased around the time in September 2011, when she was advised that her criminal history prevented her from obtaining employment as a personal care attendant. From her diary, it is apparent that Ms Ioannidis was arranging to sell her mother's rainbow lorikeets to pet shops. There are also several references to missing her mother greatly (Ms Ioannidis' mother died shortly after suffering a severe asthma attack on New Year's Eve in 2009). Her diary entries became increasingly negative from about September 2011.

9. The purpose of a coronial investigation is to ascertain, if possible, the identity of the deceased, the medical cause of death and the circumstances in which death occurred, and where possible to contribute to a reduction in the number of preventable deaths.[1] It is not the Coroner's role to determine civil or criminal liability and Coroners are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[2]

10. The police investigation of Ms Ioannidis' death was particularly comprehensive, as is amply reflected in the brief of evidence provided to the court, and to the deceased's family. Whilst I acknowledge that there is considerable evidence to support the conclusion that the relationship between Ms Ioannidis and Mr Asaad was volatile and, at least episodically, characterised by

[1] See section 67 of the Act.

[2] See section 69 of the Act but note section 49(1) which obliges the Principal Registrar to notify the Director of Public Prosecutions if the coroner ... believes an indictable offence may have been committed in connection with the death.

violence, and that she likely suffered from undiagnosed mental illness, the evidence does not support a finding that Mr Asaad caused or contributed to her death.

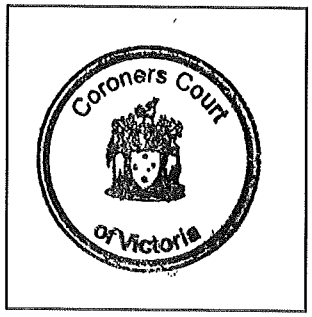
11. Nor did I consider it likely that an inquest at which the witnesses who had already provided statements would be tested, would have materially elucidated the circumstances of her death. It was on this basis that I declined the request made by Ms Ioannidis' brother, Mr Anastasios Stouraitis, to hold an inquest into her death.

12. I find that Louisa Ioannidis' cause of death is *consistent with drowning.* The evidence does not enable me to be satisfied to the appropriate standard of proof whether she intentionally took her own life, or whether she died from accident or misadventure. As it stands, the evidence does not support a finding that any other person caused or contributed to her death. As with any coronial investigation, an application can be made in the future to re-open the investigation into Ms Ioannidis' death if new facts or circumstances come to light.

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

The family of Ms Ioannidis
Mr Youseff Asaad
Detective Senior Constable Carla McIntyre, Darebin Crime Investigation Unit.

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: **30 January 2014**