IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005428

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Mr NA[1]
Date of birth:	1962
Date of death:	11 October 2021
Cause of death:	1(a) Compression of the neck 1(b) Hanging
Place of death:	Barkly Street, Portland, Victoria, 3305

[1] This finding has been published with a pseudonym in accordance with the family's wishes.

INTRODUCTION

1. On 11 October 2021, Mr NA was 59 years old when he was found deceased in a disused shed in Portland in circumstances suggestive of suicide. At the time, Mr NA lived in Portland with his wife of nearly 30 years.

2. Mr NA met his wife while walking along the Bridgewater beach in 1982. They began dating not long after and married in 1984 settling in the Portland area. The couple shared two children together.

3. Mr NA worked for a manufacturing plant since 1986. He remained with the same company for the remainder of his working career undertaking a number of roles, including shift supervisor across multiple departments.

4. In 2007, Mr NA injured his neck and back at work which resulted in time off and a WorkCover claim. On his return to work, his wife reported that Mr NA experienced bullying and harassment due to the time he took off work. Mr NA's mental health declined, he stopped socialising and started to spend all his spare time in the shed at home.

5. Mr NA had a subsequent WorkCover claim in around 2010, this time in relation to his mental health. He received a payout from WorkCover in 2012 and did not return to work afterwards. Mr NA's wife stated it appeared her husband was never able to really accept what happened to him at work.

6. In 2020, Mr NA tragically lost his twin brother to suicide. His wife commented that he coped with the loss of his brother better than she thought he would.

South West Healthcare Mental Health

7. In 2021, Mr NA's mental health deteriorated and he began to have severe panic attacks. On 24 January 2021, Mr NA presented to the Portland District Health Urgent Care where he was diagnosed with severe depression with acute high risk suicidal ideation. That day he was transferred to the South West Healthcare Acute Inpatient Unit (**AIU**) at Warrnambool Hospital.

8. He remained in the AIU until 29 January 2021 and was noted to have improved substantially when he was discharged to the Warrnambool Prevention and Recovery Centre (**PARC**).

9. Since his first admission in January 2021, Mr NA had three subsequent admission episodes to either the AIU or PARC (April, July and August 2021).

10. From Mr NA's third admission in July 2021 onwards he was managed by psychiatrist Dr Abidemi Bello who diagnosed him with treatment resistant major depressive illness associated with recurrent thoughts of self-harm and suicidal ideation and a co-morbid panic disorder on a background of a generalised anxiety disorder. Dr Bello noted Mr NA also had obsessive compulsive traits and that he experienced "*survivor shame, guilt, worthlessness and hopelessness that had become accentuated since his twin brother's death*".[2]

11. During his third admission on 4 August 2021, Mr NA commenced a course of electroconvulsive therapy (**ECT**). He had seven out of a planned 12 ECT treatments during his third admission but withdrew consent for further ECT as he felt it was not assisting his mental state.

THE CORONIAL INVESTIGATION

12. Mr NA's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

13. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

14. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

15. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr NA's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

[2] Statement of Dr Abidemi Bello dated 3 February 2022.

16. This finding draws on the totality of the coronial investigation into the death of Mr NA including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

17. On 11 October 2021, Mr NA, born 1962, was visually identified by his wife, who signed a formal Statement of Identification to this effect.

18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 13 October 2021 and provided a written report of his findings dated 14 October 2021.

20. The post-mortem examination showed a ligature injury to the neck consistent with the stated circumstances and no other significant trauma.

21. Routine toxicological analysis of post-mortem samples detected the antidepressants venlafaxine and its metabolite, and the antidepressant mirtazapine. No alcohol or any other common drugs or poisons were detected.

22. Dr Lynch provided an opinion that the medical cause of death was *1(a) compression of the neck* secondary to *1(b) hanging*.

23. I accept Dr Lynch's opinion.

Circumstances in which the death occurred

24. On 27 August 2021, Mr NA contacted PARC and Portland MHS due to experiencing suicidal ideation, thoughts of hanging, and increased anxiety symptoms. Accordingly, he was re-

[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

admitted to the Warrnambool Hospital AIU as a voluntary patient. This was his fourth psychiatric admission in 2021.

25. A Multidisciplinary Team Meeting (**MDT**) was held on 2 September 2021 and noted that Mr NA was displaying avoidant behaviour and expressed feeling unsafe when outside the psychiatric unit. It was decided that Mr NA would benefit from graded or intensive exposure[4] to best prepare him for his eventual transition to the community.

26. Mr NA was reviewed by his treating psychiatrist Dr Bello on 9 September 2021. Recommencement of ECT was discussed and agreed to by Mr NA and treatment was started the following day. He also consented to receive psychotherapy (**CBT**).

27. Mr NA tolerated ECT well and was not observed to have any suggestion of memory impairment, a known side effect of the treatment.

28. At review on 17 September 2021 Mr NA's mood had improved and he was more positive about the future. The possibility of being transitioned home via PARC had previously been discussed with Mr NA however he indicated he did not wish to go and would return home when ready for discharge.

29. Accordingly, during an MDT on 23 September 2021 a plan was made to commence transitioning Mr NA to home using overnight/weekend leave. Mr NA was happy with the plan but wanted his wife included in planning.

30. Mr NA's mental state continued to improve, he denied suicidal ideation and when reviewed by Dr Bello on 5 October 2021, the plan was changed to discharge him home with weekly follow-up by his case manager from his psychologist Mr Owen and psychiatric review within a fortnight of discharge. Mr NA's wife attended the review by phone. The documentation of the review included a direction for Brynle Owen to phone Mr NA's wife to discuss her husband's discharge plan. There is no documentation of a call being made on 5 or 6 October 2021.

31. On 6 October 2021, Psychiatry Registrar Dr Alinie Guerriero reviewed Mr NA and noted he was hesitant about going home but had talked with his wife and she was pleased about his

[4] Exposure therapy is a form of cognitive behaviour therapy involving facing fears in either a gradual or intensive manner. People often avoid things they fear but over time this can make the fear and anxiety even worse. Graded exposure involves mild exposure to feared situations then gradually increasing to harder ones. Intensive exposure (or flooding) involves commencing exposure with the most difficult tasks.

pending discharge on Friday, 8 October 2021. During the review he denied suicidal ideation, presented as hopeful for the future, his mood appeared good and there were no other concerns.

Discharge Planning

32. On the morning of Friday 8 October 2021 Mr NA was administered his scheduled ECT and recovered well. He was reviewed by Dr Guerriero pre-discharge and reported reservations about going home as thoughts of self-harm had returned, including a fear that he may hang himself, and that he was anxious about whether or not to tell his wife about his suicidal thoughts. Dr Guerreiro explained he may always have such thoughts and that continued psychotherapy would help him find effective ways to manage such thoughts.

33. Dr Guerriero indicated she was not comfortable to discharge Mr NA at that time and wished to meet with Dr Bello and Mr Owen to further discuss.

34. Mr NA's wife stated she had a phone call with her husband at some point on 8 October 2021 during which he reported he did not need to be picked up as previously planned as he "*didn't feel comfortable coming home.*"[5]

35. At 12.30 pm, Mr Owen made a note in the medical record that he had twice tried to phone Mr NA's wife but there was no answer. He left a voicemail for her to contact the Portland MHS. Dr Guerriero also stated that to her best recollection she tried to phone Mr NA's wife without success.

36. Due to Mr NA's recently expressed suicidal ideation, an MDT meeting was held and attended by Dr Bello, Dr Guerriero, Mr Owen, a nursing manager, mental health care nurse, and a mental health team leader. The meeting was to discuss how to navigate Mr NA's discharge. Dr Bello stated Mr NA's wife was not available at the time.

37. Notes from a registered nurse who attended the MDT indicate delaying discharge until Monday was discussed to, among other things, hold a family meeting prior to discharge to discuss safety planning and encourage Mr NA to inform his wife of his suicidal ideation. However, both Dr Bello and Dr Guerriero stated at no time was there a formal plan to delay Mr NA's return home until the following Monday.

38. Following the MDT meeting Dr Bello reviewed Mr NA to discuss his planned discharge. Mr NA's wife was not present. Dr Bello explained to Mr NA that going home was part of the

[5] Statement of Mr NA's wife dated 20 November 2021.

agreed treatment plan and that he could decide between two options. The first option, going home as planned; or the second option, going on weekend leave with phone-call follow-up every day and review by Portland MHS on Monday with the option to return to the ward if required.

39. Mr NA preferred the second option of weekend leave. His bed was held in the event he required readmission after weekend leave. The plan for ongoing treatment inclusive of weekly ECT, psychotherapy and assertive case management remained unchanged.

40. The medical records indicate Dr Bello advised Mr NA that his wife would be contacted and informed of the safety plan.[6] The evidence suggests Mr NA's wife was not successfully contacted on or after 8 October 2021 by any South West Healthcare clinical staff.

41. A risk assessment was completed prior to discharge which recorded Mr NA as a moderate to high risk of suicide that was mitigated by his level of engagement, improved mood and support from his wife. Mr NA left the ward willingly and was driven home by a peer support worker.

42. At the time he commenced weekend leave, Mr NA was prescribed:

    i. Venlafaxine 375mg nightly.
    ii. Quetiapine 50mg morning, 75mg nightly.
    iii. Mirtazapine 15mg nightly.

Weekend Leave

43. That evening Mr NA's wife returned home to the family home in Portland. She noticed one of the cars was gone from the driveway and that some of Mr NA's personal items were on the kitchen bench and she realised her husband had returned home. She stated that at this time she realised she had two missed calls, one from her husband and one from the hospital. Mr NA returned a short time later and informed his wife he was not given the option to stay at the ward and that he had been driven home.[7]

44. The following morning, being 9 October 2021 and Mr NA's first day of weekend leave, Mr NA's wife noted he woke in a good mood. He mowed the lawns in the morning and later visited some friends at the golf club.

[6] South West Healthcare medical records pg 727.
[7] Statement of Mr NA's wife dated 20 November 2021.

45. Mr NA received a call from the Access Team in the morning and he stated he was ok. The plan for twice daily phone calls was discussed and Mr NA indicated this was a "*bit much*" and it was agreed to reduce the calls to once daily.[8]

46. Also that morning, Dr Bello documented additional information about the clinical decision-making surrounding Mr NA's discharge. Dr Bello recorded that Mr NA's risk of harm to self was moderately elevated and he had a number of risk factors for suicide but few were modifiable. Moreover, his risk was chronically elevated and unlikely to be addressed by hospitalisation. Dr Bello recorded the disadvantages of hospitalisation were that Mr NA would be further disconnected from his supports including family and community, and his coping and problem-solving skills would likely decline.

47. On 10 October 2021, Mr NA's mood had deteriorated. Mr NA's wife noted he spent the whole day on the couch and would not talk to her. Further, she stated he looked physically ok but it was evident that he was struggling.

48. The scheduled follow-up call from the Access Team occurred at around 11.54 am. Mr NA reported his mood was "*so so*" and that his mental state had declined since commencing leave.[9] He did not raise any further concerns and declined an afternoon follow up call.

49. At 11.30am on Monday 11 October 2021, Fred Nittsjo, Team Leader and psychologist at Portland MHS, phoned Mr NA to undertake the planned review. This was Mr Nittsjo's first contact with Mr NA in a clinical setting although he had attended the MDT meeting on 8 October 2021 when Mr NA's discharge was discussed.

50. During the review Mr NA reported that he felt depressed over the weekend but was aware that would happen. He denied suicidal ideation, plan or intent. He did not request a return to the ward and was happy to stay at home and attend the ward as planned on Thursday for his next ECT that was scheduled for Friday. Mr NA indicated he did not want any further contact that day.

51. Mr NA's wife spoke to her husband that morning and he reported that he was ok. She left for work and returned at about 2.00 pm that afternoon. Mr NA greeted his wife and appeared to be in a good mood as if nothing were wrong. Mr NA's wife continued work on her home computer and a short time later Mr NA left the house in his car without saying anything.

[8] South West Healthcare medical records pg 737.
[9] Ibid pg 740.

52. At around 5.15 pm, two members of the community were walking on 'Bills Walk' in Portland. They took a shortcut and walked past the large open sheds situated at the end of Barkly Street, Portland. The sheds are a short distance from Mr NA's home and owned by his former employer.

53. Inside one of the sheds they noticed a man, now known to be Mr NA, hanging from an electrical cord tied to the rafters of the shed. They immediately contacted emergency services.

54. Victoria Police were the first to respond and arrived at the scene at around 5.24 pm. Attending police made multiple attempts to untie the electrical cord ligature without success. Whilst these attempts occurred, attending police supported Mr NA's weight to remove the pressure from the ligature and noted he was warm to the touch.

55. The electrical cord remained tied around Mr NA's neck until one of the attending members reached up the electrical cord, pulled down hard and snapped it in the process. Police were now able to remove the ligature, lowered Mr NA to the floor and immediately commenced cardiopulmonary resuscitation (**CPR**).

56. Police continued CPR until Fire Rescue Victoria and Ambulance Victoria paramedics arrived a short time later. Paramedics did not detect any signs of life and Mr NA was verified deceased at the scene at 5.35 pm on 11 October 2021.

CPU REVIEW

57. In Mr NA's wife's statement provided for the coronial brief, she expressed concerns in relation to the care her husband received prior to his death. In particular, she expressed frustration at the fact she was not contacted prior to her husband's return home and that in her view, Mr NA felt as though he had no support.

58. In light of these concerns and as part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**) about the clinical management and care provided to Mr NA during his last episode of care.

59. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any particular concerns which have been raised.

Discharge Planning

60. The CPU noted that the medical records indicate Mr Owen made at least two calls to Mr NA's wife on 8 October 2021 that went unanswered and left a voicemail message to call Portland MHS about her husband's discharge. As no one from the hospital or Portland MHS were able to speak with Mr NA's wife that day, her concern that no one checked that she was home appears to be valid.

61. Upon the CPU's advice, I directed a statement be obtained from South West Healthcare addressing the expectation of mental health discharge planning and communication with family. A statement was subsequently provided by Mr Richard Campion, Executive Director Mental Health and Wellbeing Services, South West Healthcare.

62. Mr Campion stated that when a family member cannot be contacted before a patient goes home on weekend leave, the decision as to whether to proceed with the leave rests with the treating team led by the authorised psychiatrist.

63. Mr Campion indicated that inability to contact a family member is not a barrier to the patient leaving as planned as long as factors such are the following are adequately considered:

> *Factors such as risk profile, opportunities for intervention and contact from mental health services during the period of leave, previous discussions that may have been held with family and carers, and the potential impacts upon care and the consumer should the leave not proceed.*[10]

64. The CPU noted Mr NA had been positive about going home until the morning of discharge when he reported suicidal thoughts to Dr Guerriero. The CPU clinician considered Dr Guerriero appropriately made the decision to postpone Mr NA's discharge to allow him to be reviewed by Dr Bello.

65. Dr Bello offered Mr NA the opportunity to trial weekend leave or discharge as originally planned. The CPU advised this was an appropriate, patient-centred approach. It was documented that he left the ward willingly. There was nothing to suggest he left the Warrnambool Hospital against his wishes.

[10] Statement of Mr Richard Campion, Executive Director Mental Health and Wellbeing Services, South West Healthcare, 8 November 2023.

66. In a subsequent statement[11] provided to the Court, Dr Bello reported that she considered Mr NA suffered a panic attack on the morning of 8 October 2021, consistent with previous patterns, and that he had settled by the time she reviewed him later that afternoon. Dr Bello advised that if discharge planning were cancelled whenever Mr NA became anxious about how he would manage at home, it would "*be counterproductive for his therapy and risked creating a dependency state and an artificial feeling of safety on the ward that could make Mr NA hospital-bound*."[12]

67. The CPU advised the clinical reasoning around Dr Bello's decision not to cancel any form of going home, and instead offer a home-based alternative in weekend leave, appeared to reflect adequate consideration of the risks and benefits to Mr NA. Further, the CPU considered without the benefit of hindsight and based on information available to Dr Bello at the time, her weighing up of the benefits and risks of Mr NA going home was carefully undertaken and the decision reasonable.

Contact with Mr NA's wife

68. Throughout her statements, Dr Bello emphasised the importance of the supportive efforts of Mr NA's wife in mitigating the risk of suicide. However, due to difficulty contacting her on 8 October 2021, it appears Mr NA's wife had limited information to perform this role unless Mr NA informed her of the recent developments with his suicidal ideation, something he had previously struggled to do.

69. The CPU suggested after Mr Owen's inability to contact Mr NA's wife, communication could have been enhanced by requesting the Access Team during their weekend calls with Mr NA to share the events of 8 October 2021 with her. The CPU considered that while communication with Mr NA's wife was not optimal, this was unlikely to have changed his clinical course. Nor was it likely that better communication would have provided an opportunity for prevention of Mr NA's death.

70. Further, the CPU noted that neither the Access Team nor Mr Nittsjo contacted Mr NA's wife to obtain collateral information about her husband's condition over the weekend which may have provided them with a more holistic picture of Mr NA's mental state and how he was coping at home.

[11] Subsequent Statement of Dr Abidemi Bello dated 6 November 2023.
[12] Ibid.

South West Healthcare Internal Review

71. Following Mr NA's death, South West Healthcare on their own accord engaged an independent external expert, Conjoint Professor Matthew Large, to provide an opinion regarding the appropriateness of the care Mr NA received and identify any deficiencies and potential system improvements. A copy of Professor Large's report was made available to the Court.

72. Professor Large concluded that the care and treatment provided to Mr NA was of a high standard and there were no deficiencies in the risk assessments that were undertaken, including that conducted by Fred Nittsjo on 11 October 2021. He indicated that the decision to allow Mr NA home on 8 October 2021 "*was reasonable and was well within peer acceptable practice*" and the plan for community follow-up was appropriate.[13]

73. Professor Large's report made no reference to the lack of contact with Mr NA's wife. The CPU noted that Professor Large did not have access to Mr NA's wife's statement in the coronial brief and therefore was likely unaware that the treating team had not been able to contact her on 8 October 2021.

LIGATURE CUTTERS

74. Police who attended to Mr NA on 11 October 2021 noted he was still warm to the touch on their arrival, and that they experienced difficulty removing the electrical cord ligature.

75. As part of their review, the CPU advised that specially designed ligature cutters are available and are standard equipment issued to clinician in mental health wards throughout Victoria. Commonly available ligature cutters are designed similar to a hook with the sharpened edge on the inner-side of the hook and a dull, rounded outer edge in such a way that prevents the cutter from being used as a sharp implement weapon.

76. To understand how ligature cutters are used in Victoria and whether they could have been of assistance in Mr NA's resuscitation, I directed a series of statements be obtained from:

    i. The Office of the Chief Psychiatrist.

    ii. Ambulance Victoria; and

[13] Report of Conjoint Professor Matthew Large dated 4 March 2022.

iii. Chief Commissioner of Police

77. Dr Neil Coventry, Chief Psychiatrist advised that his office had not provided any guidance to Victorian mental health services on the requirement to provide ligature cutters on mental health wards, and that individual mental health services are responsible for decisions about the provision of ligature cutters in their own units.

78. Ambulance Victoria advised that ligature cutters are not part of the basic equipment provided to paramedics due to concerns they could be used as a weapon in the back of an ambulance or scene of an incident.

79. Further, Ambulance Victoria advised that paramedics have other materials available to them and would usually use trauma shears to cut through ligatures when required.

80. The Victorian Government Solicitor's Office (**VGSO**) provided a response on behalf of the Chief Commissioner of Police.

81. The VGSO advised that for Victoria Police to meaningfully assess the viability of the proposal for ligature cutters to be issued for all police vehicles, a detailed feasibility study would need to occur considering anticipated benefits, occupational health and safety risks, costs and implications of implementing the proposal.

82. The VGSO advised that such a process would be resource intensive and costly, and that due to financial constraints and other priorities, Victoria Police was not currently in a position to assess the viability of ligature cutters to be rolled out across Victoria Police.

FINDINGS AND CONCLUSION

83. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was Mr NA, born 1962;

b) the death occurred on 11 October 2021 at Barkly Street, Portland, Victoria, 3305;

c) the cause of Mr NA's death was compression of the neck secondary to hanging; and

d) the death occurred in the circumstances described above.

84. The available evidence, including the lethality of the means chosen and a significant history of mental ill health, supports a finding that Mr NA intentionally took his own life.

85. Without the benefit of hindsight of the tragic outcome, Dr Bello's decision to allow Mr NA to leave the Warrnambool Hospital AIU despite his disclosure of suicidal ideation on 8 October 2021 was reasonable and appropriate when viewed in its proper context.

86. It was unfortunate that clinical staff could not contact Mr NA's wife prior to her husband commencing leave from the ward to enable her to plan for his return as she was a key support and protective factor for him.

87. Similarly, the lack of collateral information from Mr NA's wife about her husband's mood/behaviour whilst on leave was a missed opportunity for a more holistic assessment of his mental state and coping away from the ward.

88. That said, the evidence before me does not support a finding that the communication shortcomings resulted in Mr NA's death, nor that better communication with Mr NA's wife would have likely resulted in different outcome.

89. I commend the efforts of the first responders who attended to Mr NA's care on 11 October 2021 and provided resuscitation efforts. Given the time that elapsed between the call to emergency services and the arrival of police, and uncertainty about how long Mr NA had been hanging before discovery, the evidence does not support a finding that access to a ligature cutter would have saved Mr NA's life. However, the ready availability of ligature cutters would likely have assisted police to commence CPR sooner.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments on a matter connected with the death, including matters relating to public health and safety or the administration of justice:

1. I note the indication from the Chief Commissioner of Police that Victoria Police is not currently in a position to assess the viability of a ligature cutter rollout to police members.

2. However, this appears to be a relatively inexpensive, safe and effective tool which could be included in the equipment issued with each police vehicle or unit, rather than to individual police members with the potential to improve the timeliness of resuscitative efforts in similar cases in the future.

3. Whilst I make no formal recommendation in the circumstances of this case, I would encourage the Chief Commissioner to consider the provision of ligature cutters to Victoria Police members in the field.

I convey my sincere condolences to Mr NA's wife, children and family for their loss.

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

Mr NA's wife, senior next of kin

South West Healthcare

Office of the Chief Psychiatrist

Ambulance Victoria

Chief Commissioner of Police c/o Victorian Government Solicitor's Office

Senior Constable Mick Ford, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 13 November 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.