IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001320

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	JQ
Date of birth:	[redacted]
Date of death:	Between 8 and 9 March 2022
Cause of death:	1(a) Plastic bag asphyxia
Place of death:	Waurn Ponds Creek, Grovedale, Victoria, 3216

INTRODUCTION

1. On 9 March 2022, JQ was 16 years old when she was found deceased, having taken her own life. At the time of her death, JQ lived in [redacted] with her family.

2. JQ is remembered as a kind, thoughtful and gentle young woman. She adored her younger sister and was always protective of her. She enjoyed art, listening to music, watching horror movies and baking. She was a talented artist who often made things for her friends.

3. JQ attended primary school at [redacted] and at the time of her death was in year 11 at [redacted]. She performed well academically, winning academic awards.

4. In year 10 JQ failed a number of maths test, telling her parents she was tired and had difficulty concentrating, though she still achieved a B+ grade. Her parents believed that 2021 was a difficult year for her due to Covid-19 and the loss of her grandmother at the end of 2019.

5. JQ had previously attended Taekwondo but gave it up at the start of the 2021 school year to allow herself time to complete homework and rest. She kept fit by walking and enjoyed long walks alone and sometimes ran with friends.

6. JQ had a close group of friends, some of whom she had known since she was young. She was happy in their company and spent a lot of time speaking to them when not at school.

Mental health history

7. In early 2021, JQ disclosed that she was having suicidal thoughts to a friend, who encouraged her to speak to her parents. JQ told her parents she was unable to explain what was causing these feelings. She expressed being upset that the painless suicide methods she had researched online were not legal in Australia and disclosed self-harming. JQ told her parents that she did not feel depressed, and reassured her parents she would not take her own life as she knew how much her family and friends loved her.

8. JQ's parents provided personal support, and sought professional help from psychologist Sara Tatlow, who JQ saw every six weeks. JQ disclosed, in the company of her mother, that she had begun to experience suicidal ideation in 2020 during the Covid-19 lockdowns, and that her plan was to inhale nitrogen gas when she was "older", though she did not specify an age. Ms Tatlow and JQ completed a safety plan and discussed her access to nitrogen gas. JQ also

expressed feeling stress and pressure to achieve high grades at school, which led to her feeling overwhelmed, resulting in procrastination. This pattern of behaviour caused her anxiety and lowered her mood and sleep quality.

9. JQ's mental health appeared to improve during 2021 and during her last three sessions with Ms Tatlow she reported an improvement in her mood, sleep, appetite and engagement with friends. She stated that she had not experienced any self-harm or suicidal ideations, plans or behaviours during this time.

10. During her last session with Ms Tatlow on 26 November, JQ felt she no longer required support and suggested that she did not want to make further appointments unless "things went back to the way they were". Ms Tatlow encouraged her to book an appointment that could be cancelled at a later date if she and her parents decided it was not required. JQ and Ms Tatlow discussed her safety plan and ensured she had a copy in her bedroom should she need it. In January 2022, JQ declined to attend the previously booked appointment, and her mother cancelled it with the plan that they would find another psychologist.

11. When JQ returned to school for the 2022 year, she appeared to her parents to be genuinely happy. In around mid-February she told her parents she was feeling tired and overwhelmed. They planned to provide her extra support through tutoring, and advised her to focus on the subjects she was most interested in, such as art.

JQ's journal

12. JQ regularly kept a journal in which she wrote of her struggles with her mental health. She expressed having body image issues, including picking at her skin. She wore makeup and long sleeves to cover the sores and removed mirrors from her room in order to help her stop.

13. In late January 2021, JQ wrote in her journal of her disappointment that she would be unable to take her own life before receiving the Covid-19 booster vaccination as she did not like needles. In that entry she noted argon gas being the best option "for future reference". JQ received her booster vaccination on 3 March 2022.

THE CORONIAL INVESTIGATION

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

15. 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.

16. 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.

17. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of JQ'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.

18. This finding draws on the totality of the coronial investigation into the death of JQ 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.[1]

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

Circumstances in which the death occurred

19. At 4:31pm on 7 March 2022, JQ purchased a 2.2 litre cylinder of argon gas from Bunnings Warehouse in Werribee.

20. On the morning of 8 March 2022, JQ left for school with her sister. She appeared to be in good spirits. At 8:16am, she texted her mother letting her know she was going to study at the library after school.

21. At around 4pm, JQ was last seen by a friend at Laverton railway station, boarding a train to Hoppers Crossing. Her friend did not notice anything unusual about her demeanour and

[1] 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.

believed she was on her way home. At 4:58pm, JQ purchased a disposable gas bottle regulator at Bunnings Warehouse in Hoppers Crossing.

22. At 5:57pm, JQ's parents texted her to see when she would be home, to no response. At around 6:30pm, they reported her missing to Victoria Police. JQ's father attended at her school to see if she was there, and a staff member contacted the Deputy Principal who in turn contacted other staff members and families to ask if they had seen her.

23. At around 4:20pm on 9 March 2022, a bystander was walking his dog along the Waurn Ponds Creek in Grovedale when he located the body of a girl, later identified to be JQ, in the bushes beside the path. She had a plastic bag over her head, with an argon gas cylinder underneath the bag. He immediately called Triple Zero.

24. Two "suicide notes" were located near JQ, along with a note with what appeared to be a list of tasks to complete in order to affect her plan to take her own life. Further task lists were located on her mobile phone.

25. Data from JQ's phone indicated that she arrived at the location where she took her own life at 7:24pm on 8 March 2022.

Identity of the deceased

26. On 11 March 2022, JQ, born [redacted], was visually identified by her mother, who completed a Statement of Identification.

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

Medical cause of death

28. Senior Forensic Pathologist Dr Michael Phillip Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of JQ on 10 March 2022. Dr Burke considered the Victoria Police Report of Death (Form 83) and post mortem computed tomography (**CT**) scan and provided a written report of his findings dated 17 March 2022.

29. The post mortem examination showed findings in keeping with the known circumstances, including a plastic bag in situ around the head. The CT scan was unremarkable.

30. Toxicological analysis of post mortem samples did not identify the presence of any alcohol, common drugs or poisons, or volatile compounds[2].

31. Dr Burke provided an opinion that the medical cause of death was 1 (a) PLASTIC BAG ASPHYXIA.

FAMILY CONCERNS

32. In their signed statement, JQ's parents noted potential areas for process improvements that may prevent a similar situation from occurring in the future. These related to:

    i. The search for JQ, including "slow and repetitive" handovers between police members and delays in accessing CCTV footage.

    ii. The delays in approving a trace of JQ's mobile phone when she was reported missing.

    iii. The accessibility of argon gas.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Missing persons investigation

1. According to JQ's parents, when they reported her missing they were met with a "dismissive" attitude from police members who told them it was common for teenagers to go missing. They advised police that JQ had experienced suicidal thoughts and was seeing a psychologist, and that her disappearance was completely out of character, though believed this was dismissed as they had not witnessed or heard her express suicidal thoughts recently. JQ's investigation was then then transferred to Werribee police station, which her parents described as "exceptional" and noted the officers at that station provided a great deal of support.

2. Coroner's Investigator Detective Senior Constable (**DSC**) Nathan Johnstone advised that the missing persons investigation included the following:

    i. An extensive ground and aerial search in the Altona, Werribee and Geelong area.;

[2] The absence of volatile compounds does not exclude previous exposure to these compounds.

ii. Checks in relation to JQ's Myki card which showed it was last used at Westona railway station at 3:42pm on 8 March 2022;

iii. Protective Services Officers at railway stations and patrol vehicles in the North West Metro Melbourne and Geelong area were made aware JQ was missing;

iv. A media release was prepared for all outlets including social media;

v. Police liaising with JQ's school to liaise with other students and attempt to track her school laptop; and

vi. Police attendance at her grandparents' home in [redacted].

3. DSC Johnstone further advised that appropriate handovers were made with all members at the start of each shift change to ensure appropriate enquiries were continuing to be made to locate JQ.

4. At the time of JQ's death, Victoria Police had in place the Victoria Police Manual – Procedures and Guidelines (**VPMG**) relating to missing persons investigations which included mandatory and non-mandatory actions to be taken. The more comprehensive Victoria Police Manual (**VPM**) on missing persons investigations was introduced in September 2023, which sets out the responsibilities of police in relation to missing persons searches. Compliance with the VPM is mandatory.

5. Further, Coroner Ingrid Giles in her recent inquest into the deaths of five transgender women heard evidence from Deputy Commissioner Patterson that a new Practice Guide 'Missing Persons – Initial Actions to locate' will soon be published to provide further guidance for members and the steps to be undertaken following a missing person's report, and the VPMG on missing persons investigations and Investigative Guidelines will also be updated to reflect current practice and expectations.[3]

CCTV

6. JQ's parents reported that police were constrained in their search as obtaining CCTV footage required around a 24-hour turnaround time. Further, CCTV footage was not available at Geelong and Marshall railway stations.

[3] See Coroner Ingrid Giles, Form 37 Finding into death with inquest, COR 2020 6727 Bridget Flack delivered on 29 August 2024 at page 48.

7. Though in JQ's case it appears nothing would have turned on having that footage available at the time, in line with my prevention role I intend to make a recommendation regarding CCTV footage at train stations.

Triangulation of phones

8. Requests for triangulation of phones are governed by federal legislation, namely the *Telecommunications Act 1997* (Cth) (**Telecommunications Act**). At the time of JQ's death, section 287 of the Telecommunications Act required that authorising officers needed to form a belief that triangulation was reasonably necessary to prevent or lessen a serious and imminent threat to the life or health of a person in order to approve the request.

9. The fact that an 'imminent' threat to life or health was required for triangulation may have caused delays in approving triangulation in JQ's case, and likely many others, including the matter investigated by Coroner Giles as referenced above. Investigators ultimately obtained one result from JQ's phone from triangulation run for a two-hour period from 2:43am on 9 March 2022. The result was "locate failed", indicating her phone had been turned off.

10. I am pleased to note that on 12 April 2023, in response to coronial recommendations in a New South Wales matter, the Telecommunications Act was amended to remove the requirement for the threat to be 'imminent'.[4]

Adequacy of missing persons investigation

11. Based on the evidence before me I consider that the Victoria Police response to JQ's disappearance was timely and appropriate, considering the constraints they were faced with. I am unable to comment on the attitudes of police members towards JQ's parents other than to say it is extremely disappointing that they felt dismissed and let down during such a difficult and undoubtedly nerve-wracking period.

12. I hope that the updates to Victoria Police policy and procedure with regarding to missing persons investigations, and the amendment of the Telecommunications Act help to reduce any avoidable delays in future investigations. The updates to Victoria Police procedures, in providing guidance to investigating members in conducting their investigation, may in turn

[4] See in this regard 'Findings into the death of Thomas James Hunt', 4 September 2020, State Coroner Magistrate Teresa O'Sullivan; Explanatory Memorandum, Telecommunications Legislation Amendment (Information Disclosure, National Interest and other Measures) Bill 2022 (Cth) 3(a).

assist in providing support and reassurance to reporting family members that a thorough investigation is on foot.

13. Ultimately, the evidence indicates that JQ arrived at the location where she took her own life at 7:24pm on 8 March 2022, around the time she was reported missing, and she likely took her own life shortly thereafter. Therefore, any factors causing delays in locating JQ could not be considered contributory to the tragic outcome.

Suicides by inert gas inhalation

14. Victorian Suicide Register[5] data shows that there were 342 inert gas inhalation suicides for the period of 2000 to 2024. An inert gas is a gas that, in given conditions, does not readily undergo chemical reactions with its environment. The main inert gases used in suicides in Victoria are helium, nitrogen, argon and hydrocarbons.

15. The mechanism of death inert gas inhalation suicide is asphyxia. When the gas is inhaled (usually with the aid of a plastic bag or similar to ensure sufficient concentration of the gas is inhaled), it displaces oxygen from the lungs and prevents blood from being oxygenated, which in turn leads to unconsciousness and death.

16. Inert gas has been promoted by "right to die" groups such as Exit International as a peaceful and effective suicide method since at least the 1990s. Researchers have linked the spread of inert gas inhalation suicide in Australia and internationally with the dissemination of material, particularly on the internet, produced by the "right to death" movement.[6] Exit International have also suggested that another reason for the method rising in popularity may be due to the increasing availability and convenience of access to inert gases, which were previously for predominantly industrial use.[7]

17. Victorian Coroners have engaged at length with Commonwealth and state government entities regarding measures to reduce inert gas inhalation suicide, with mixed degrees of success. The most success has been in curbing the ease of access to helium, which is the most frequently

[5] The Victorian Suicide Register (VSR) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

[6] See for example Ogden R and Hassan S, "Suicide by Oxygen Deprivation with Helium: A Preliminary Study of British Columbia Coroner Investigations", *Death Studies*, 35(4), 2001, pp.338-364; Grassberger M and Krauskopf A, "Suicidal asphyxiation with helium: Report of three cases", *Middle European Journal of Medicine*, 119(9-10), 2007, p.323; Austin A, Winskog C, van den Heuvel C and Byard R, "Recent trends in suicides utilising helium", *Journal of Forensic Sciences*, 65(3), 2011, pp.649-651.

[7] Nitschke P and Stewart F, *The Peaceful Pill Handbook*, revised edition, Bellingham: Exit International US, October 2009, p.67.

used gas in inert gas inhalation suicides in Victoria. Between 2000 and 2024, 45.9% of inert gas inhalation suicides involved the use of helium.

18. On 16 April 2023, following several coronial investigations culminating in findings referencing the ease of access to helium and including relevant recommendations to stymie its use in suicide, Consumer Goods (Non-refillable Helium Cylinders) Safety Standard 2022 came into effect. The ACCC advised the Court of the following with regard to the standard:

On 16 April 2023 the mandatory safety standard (Consumer Goods (Non-refillable Helium Cylinders) Safety Standard 2022) for all non-refillable helium cylinders supplied in Australia came into effect. This means that from 16 April 2023, suppliers must (by law) comply with the requirements of the mandatory safety standard. Significant penalties apply to those suppliers who do not. The mandatory safety standard applies to the sale of non-refillable helium cylinders to intermediaries and consumers.

The mandatory safety standard makes it much more difficult to misuse non-refillable helium cylinders for suicide by requiring a mixture of 21% +/- 1.0% oxygen and 79% helium. This means that attempted use will result in unpleasant side effects associated with cumulative levels of carbon dioxide and delayed loss of consciousness, providing opportunities for reconsideration by the user and intervention by others, compared to a 100% helium mixture.

The mandatory safety standard also includes a requirement to add labelling to the cylinder and/or secondary packaging to advise that the cylinder contains an oxygen and helium blend. It also requires warnings about inhalation of the gas such as 'do not inhale' and 'may cause suffocation'.

The mandatory safety standard does not apply to refillable helium cylinders. The ACCC's research indicates that the purchasing or renting of these products generally requires the customer to either establish an account with the supplier and/or provide identification. They are generally supplied to commercial operators and smaller businesses. It would appear that the heightened barriers to access these cylinders provides a deterrent at this time. However, following the introduction of the mandatory safety standard the ACCC will monitor the market to assess whether regulatory intervention results in any behavioural change.

<u>The availability of argon gas</u>

19. Of the 342 inert gas inhalation suicides between 2000 and 2024, 21 (6.1%) of these deaths, including JQ's, involved argon gas. Unfortunately, and perhaps as its use in suicide is less common, the Court's efforts to restrict the availability of argon gas have not been successful.

20. Argon gas is primarily used in electric arc welding and accordingly, the evidence in most cases is that the deceased obtained welding argon from a specialist industrial supplier. However, there were four recent deaths, including JQ's, where the deceased used disposable bottles of argon gas from Bunnings.

21. On 13 June 2019, Coroner Rosemary Carlin (as she then was) delivered her finding in the death of Diane Bell[8], who took her own life by argon gas inhalation. Coroner Carlin explored the possibility of regulating argon (and other inert gas) sales through Victorian legislation.

22. The *Drug, Poisons and Controlled Substances Act 1981* (Vic) (**DPCSA**) prohibits the sale of deleterious substances[9] to those seeking to misuse them, for example by ingestion or inhalation. Coroner Carlin considered that an amendment to the DPCSA to include inert gases in the definition of "deleterious substances" *would create a legal requirement for retailers of these gases to refuse sale if they believe the gas will be misused. It would also create an imperative for the DHHS (Department of Health and Human Services) to educate retailers about the risks of misusing these gases and how to refuse sales.*

23. Coroner Carlin made the following recommendations:

    i. *That the Department of Health and Human Services explore whether the deleterious substances provisions of the Drugs, Poisons and Controlled Substances Act 1981 (Vic) might be amended to include the major gases used in inert gas inhalation suicide in Victoria; and whether such an amendment would have any practical impact on Victorians' ability to access these gases for the purposes of suicide.*[10]

    ii. *That the Australian Competition and Consumer Commission expand the scope of its engagement with Australian gas manufacturers, importers and suppliers, to include not only helium but all common gases used in inert gas inhalation suicide, when*

[8] Coroner Rosemary Carlin, COR 2017 002906, *Form 38 Finding into Death without Inquest of Diane Bell (a pseudonym),* delivered 13 June 2019.
[9] "Deleterious substances" is defined by section 57 of the DPCSA and means methylated spirits and volatile substances, the latter including plastic solvent, cleaning agent, glue, gasoline etc.
[10] Coroner Carlin repeated this recommendation in the matter of Jae Manning, who died by helium inhalation suicide. COR 2018 001315 refers.

considering what design modifications could be made to reduce people's ability to use gas cylinders and associated equipment in suicide.

24. The Department of Health and Human Service (**DHHS**) rejected the recommendation. Secretary Kym Peake noted that while the suggest amendment to the DPSCA was possible, *it would be very difficult to establish the substance intended use was for the purpose of suicide … it is likely that many retailers would not have the skills to detect the intended use was for suicide.* By contrast, the main indication for inappropriate use of the listed "deleterious substances" is repeated purchases, which would not be the case where inert gas was purchased for the purpose of suicide.[11]

25. The ACCC advised that in consultation with international regulators, they had not identified any feasible design modifications for gas cylinders that would reduce the ability to use them in suicide.

26. On 15 June 2020, I delivered my finding in the death of Malcolm Wallace, who died by plastic bag asphyxia and argon gas inhalation. In my finding I acknowledged the responses to Coroner Carlin's recommendations, in particular the difficulty in establishing that someone was purchasing argon gas for legitimate welding needs, but I maintained then, and still do, that *the benefits of restricting access specifically to argon gas outweigh the impost on redefining the grounds for distribution.*[12] Accordingly, I made the following recommendation:

    i. *With the aim of promoting public health and safety and preventing like deaths, I recommend that the Department of Health and Human Services consider amending the deleterious substances provisions of the Drugs, Poisons and Controlled Substances Act 1981 (Vic) to specifically include argon gas.*

27. DHHS again rejected the recommendation providing the same reasons as in the case of Diane Bell, though expanded on these by noting that placing an expectation on retailers to assess whether a single purchase of an inert gas is for legitimate purposes would not be feasible, and that amending the DPCSA would require consultation and communication which in turn

[11] Letter from Department of Health and Human Services to Coroners Court of Victoria, dated 20 September 2019. https://www.coronerscourt.vic.gov.au/sites/default/files/2019-11/2018%201315%20and%202017%202906%20Response%20to%20recommendations%20from%20DHHS_MANNING%20and%20BELL_Redacted_0.pdf

[12] Coroner Audrey Jamieson, COR 2018 005646, *Form 38 Finding into Death without Inquest of Malcolm Wallace,* delivered 15 June 2020.

would raise public awareness of argon gas misuse, which may *have the unintended effect of increasing the attractiveness of inert gases as a means of suicide.*

Recent developments

28. On 28 May 2024, Dr Jeremy Dwyer of the Coroners Prevention Unit wrote to the ACCC on my behalf, enquiring as to whether the ACCC had identified any new countermeasures to reduce the risk of inert gas inhalation suicide in Victoria or Australia and specifically, had they explored any new interventions that might reduce the public's access to argon and nitrogen. Dr Dwyer also enclosed updated Victorian coronial data.

29. Nick O'Kane, Acting General Manager, Risk Management and Policy, Consumer Product Safety Division provided a response on 19 June 2024. Mr O'Kane's response spoke to the changes that have been made regarding helium gas. He noted that *the ACCC directs its resources to matters that provide the greatest overall benefit to the Australian community and is unable to pursue all product safety matters that come to its attention.* Further, while the ACCC is aware that gases such as argon (and nitrogen) can be used in suicides, it *does not propose recommending mandatory standards for argon or nitrogen at this time.* He advised that *the ACCC will continue to work closely with other government departments and agencies that have roles in suicide prevention, identification of unsafe consumer goods and administration of schemes regulating goods that present safety risks to Australian consumers.*

30. I see no merit in making a recommendation in this matter given the Department of Health has twice declined to amend the deleterious substances provisions of the *DPCSA* following coronial recommendations, and the ACCC's advice that they have been unable to identify any feasible design modifications for gas cylinders which would reduce the ability to use them in inert gas inhalation suicide, and do not propose recommending mandatory standards for argon.

31. It is certainly frustrating and disappointing to be in a position where making a recommendation would be fruitless, particularly as the data held by the Court indicates that these suicides will continue. However, I and my colleagues at the Court will continue to monitor these deaths and conduct comprehensive investigations with the view to identifying and making appropriate recommendations as soon as they may arise.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) With the aim of promoting public health and safety and preventing like deaths, I recommend that the Department of Transport conduct an audit of CCTV coverage at both Melbourne metro and regional railway stations to ensure all stations have appropriate coverage, and that the footage is easily accessible to emergency services.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was JQ, born [redacted];

   b) the death occurred on 9 March 2022 at Waurn Ponds Creek, Grovedale, Victoria, 3216;

   c) I accept and adopt the medical cause of death ascribed by Dr Michael Phillip Burke and I find that JQ died from plastic bag asphyxia in circumstances where I find she intended to take her own life;

2. AND, while the evidence does not enable me to make a finding as to the precipitating factor(s) that influenced JQ to adopt the course of action she ultimately chose, I find that she did so on a background of perceived academic pressure and anxiety and suicidal ideation.

3. AND FURTHER, I find that the conduct of Victoria Police in their missing persons investigation following JQ's disappearance was appropriate in the circumstances.

I convey my sincere condolences to JQ's family for their loss.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

JQ's parents, Senior Next of Kin

Australian Competition and Consumer Commission

Department of Transport

Victoria Police

Sergeant Nathan Johnstone, Coroner's Investigator

Signature:

AUDREY JAMIESON

CORONER

Date: 28 February 2025

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.