



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2015 002134

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

**Amended pursuant to section 76 of the Coroners Act 2008¹*

INQUEST INTO THE DEATH OF TERRENCE MCCALLION

Findings of: State Coroner, Judge John Cain

Delivered on: 31 January 2024

Delivered at: Coroners Court of Victoria
65 Kavanagh Street, Southbank, Victoria, 3006

Counsel Assisting: Ms Abigail Smith, Senior Coroner's Solicitor, Coroners
Court of Victoria

Keywords: Uncharged homicide; drowning; Murray River; assault;
coronary artery atherosclerosis; mental health

¹ Amendments have been made to paragraphs 1 and 34 of the coronial finding concerning the location at which the incident occurred on 1 May 2015.

INTRODUCTION

1. On 1 May 2015, Mr Terrence McCallion (**Mr McCallion**) was pulled from the Murray River in Victoria in an unconscious and unresponsive state. Mr McCallion was conveyed by ambulance to the Mildura Base Hospital (**MBH**) where he later died.
2. At the time of his death, Mr McCallion was 55 years old and resided at unit 7/6-10 Sturt Highway Buronga, NSW. He is survived by his four children from a previous marriage and his partner, Ms Alison Siphthorne.
3. Mr McCallion had a criminal history with convictions for driving and sexual offences.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr McCallion's death constitutes a 'reportable death' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and the death appears to have been unnatural and unexpected.
5. Section 52(2) of the Act provides the circumstances under which it is mandatory for a coroner to hold an inquest into a death. One of those circumstances is where a coroner suspects the death was a homicide and no person or persons have been charged with an indictable offence in respect of the death.
6. The jurisdiction of the Coroners Court of Victoria is inquisitorial. The role of the coroner is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased, the cause of death and the circumstances in which death occurred.
7. It is not the role of the coroner to lay or apportion blame, but to establish the facts. It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.
8. The expression 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
9. For coronial purposes, the phrase 'circumstances in which the death occurred' refers to the context or background and surrounding circumstances of the death. Rather than being a

consideration of all circumstances which might form part of a narrative culminating the death, it is confined to those circumstances which are sufficiently proximate and casually relevant to the death.

10. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's 'prevention' role.
11. Coroners are also empowered to:
 - a) report to the Attorney-General on a death;
 - b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and
 - c) make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.
12. These powers are the vehicle by which the prevention role may be advanced.
13. All coronial finding must be based on proof or relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.² 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 that they caused or contributed to the death.
14. The proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.³ Facts should not be considered to have been proven on the balance of probabilities by inexact proofs,

² (1938) 60 CLR 336.

³ *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.⁴

15. Victoria Police assigned Detective Sergeant Adam Brymer to be the Coroner's Investigator for the investigation of Mr McCallion's death. Detective Acting Sergeant Brymer conducted inquiries on my behalf and submitted a coronial brief of evidence.
16. This finding draws on the totality of the coronial investigation into the death of Mr McCallion, 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.⁵
17. In this instance, I am unable to rule out the possibility that Mr McCallion's death may be due to homicide. I note the observations of the Victorian Court of Appeal in *Priest v West*⁶ where it was stated:

*"If, in the course of the investigation of a death it appears that a person may have caused the death, then the Coroner must undertake such investigations as may lead to the identification of that person. Otherwise, the required investigation into the cause of the death and the circumstances in which it occurred will be incomplete; and the obligation to find, if possible, that cause, and those circumstances will not have been discharged."*⁷

18. Consistent with the judgment in *Priest v West*⁸, and mindful that the Act mandates that I must conduct an inquest, one of the purposes of the inquest is to investigate any evidence that may lead to the identification of the person (or persons) who may have caused the death

⁴ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

⁵ 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.

⁶ [2012] VSCA 327.

⁷ *Ibid* [9].

⁸ As above at 5.

and the circumstances that led to the death. I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

19. On 1 May 2015, Terrence McCallion born 1 February 1960, was visually identified by his daughter, Ms Nikki Masierowski.
20. Identity is not in dispute and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

21. On 3 May 2015, Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an autopsy and provided a written report of her findings dated 16 October 2015.
22. The post-mortem CT showed rib and sternum body fractures. There was no evidence of cranial or facial fractures.
23. The post-mortem examination revealed evidence of medical intervention including an endotracheal tube, intravascular cannula and an indwelling urinary catheter as well as numerous injuries.
24. The following observations are taken from Dr Francis' report:
 - There were bruises over the right scalp, the right lateral eyelid, right axilla and posterior left axilla. These injuries were caused by blunt force injury. It was not possible for Dr Francis to determine precisely age bruises either macroscopically or histologically.
 - There were several irregular abraded injuries over the chest. Dr Francis commented that abrasions are blunt force injuries which are usually caused by friction. These injuries are nonspecific in appearance, and it is not possible to determine how exactly Mr McCallion sustained these injuries, particularly if he was wearing clothing at the time these injuries were sustained.

- There was evidence of compression of the neck with deep muscle haemorrhage and a fracture of the right thyroid cartilage horn with surrounding haemorrhage. These injuries may be seen in the setting of neck compression or blunt force injury to the throat. Dr Francis noted that sometimes during the process of endotracheal intubation manual pressure may be put over the cricoid cartilage. Dr Francis also noted that this was not recorded in the Ambulance Victoria report within the MBH records which states that there were two attempts made for successful intubation by paramedics. However, Dr Francis stated that if this pressure was applied, it may have contributed to at least some of the haemorrhage noted in this region.
- There was posterior left second and third rib fractures with associated intercostal muscle haemorrhage.
- There were anterior rib fractures and a sternal body fracture with associated intercostal muscle haemorrhage, alveolar haemorrhage and fat emboli in the small pulmonary vessels. Dr Francis noted that these injuries are often seen in the setting of cardiopulmonary resuscitation.

25. Further, on 6 August 2015, Dr Francis was provided with additional information by Victoria Police which indicated that Mr McCallion was also assaulted approximately two weeks prior to his death. Dr Francis was asked to consider whether any of injuries observed during the autopsy process may have been sustained during the prior incident. Dr Francis noted that the ageing of bruises was imprecise with the medical literature suggesting that the presence of yellow discolouration in a bruise indicates a bruise has been present for at least 18 hours. On review of Mr McCallion's injuries, Dr Francis stated that it was not possible to ascribe any of his injuries with any certainty to this prior event.

26. Dr Francis further noted that there were several potential causes for Mr McCallion's injuries – the alleged assault two weeks previous to this event, the alleged assault prior to entering the water, whilst he was being extricated from the water, resuscitation injuries and medical intervention. It was not possible for Dr Francis to be specific about the mechanism of many of his injuries in the setting of multiple potential causes.

27. In addition, Dr Francis observed that there was significant single vessel coronary artery atherosclerosis. This occurs when the narrowing of the coronary arteries causes the supplied area of heart muscle to die (myocardial infarction) or it may cause arrhythmias (disturbance in the nervous system regulating the heart beat). Both of these can result in sudden death. If there was a short time interval between the onset of the arrhythmia and death, then ischaemic changes may not be identifiable at autopsy.
28. Dr Francis noted that there are many risk factors for coronary atherosclerosis including increasing age, smoking, hypertension, family history, diabetes mellitus, obesity, male sex and other factors such as hyperlipidaemia (high cholesterol).
29. Toxicological analysis of post-mortem blood showed lignocaine in the specimen which was likely to have been administered during resuscitative measures. There was also evidence of prior cannabis use. Acetone was also detected in an antemortem specimen which did not indicate any significant pathology.
30. Dr Francis provided an opinion that the medical cause of death was *drowning following assault*. A contributing factor was identified as *coronary artery atherosclerosis*.
31. I accept Dr Francis's opinion as to the cause of death.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

32. On 1 May 2015, Mr McCallion was alone at his residence in Buronga, NSW when he was visited by an associate, Mr Matthew Knight (**Mr Knight**). Mr Knight and Mr McCallion were known to each other. The evidence suggests that Mr Knight had walked across the George Chaffey Bridge from his residence in Mildura, Victoria to Mr McCallion's house. When Mr Knight arrived at the premises, he was invited inside by Mr McCallion.
33. Mr Knight informed Mr McCallion that had just completed a drug deal/run. Mr Knight also told Mr McCallion that he wanted to go back to the Victorian side of the Murray River and offered to pay Mr McCallion \$500 to drive him back across the border into Victoria.⁹

⁹ Transcript of interview with Mr Matthew Knight on 26 April 2022 at CB 371.

34. According to Mr Knight, Mr McCallion agreed to drive him back to Victoria. They left Mr McCallion's address in Mr McCallion's white Nissan Pulsar. Mr McCallion drove the vehicle and Mr Knight sat in the front passenger seat. Mr Knight provided directions as to where he wanted to go and directed Mr McCallion to the section of the riverbank in Victoria next to a large tree which is directly opposite 6365 Sturt Highway, Trentham Cliffs in NSW. This is approximately 11 kilometres from Mr McCallion's home address in Buronga, NSW.
35. When they arrived at the location, Mr McCallion stopped the car. The evidence suggests that Mr Knight reached across the front console of the vehicle and removed the keys from the ignition, before putting the keys in his pocket. He then struck Mr McCallion with his forearm across the throat. Mr McCallion responded asking '*what have I done*'.¹⁰ Mr Knight did not reply but reached across and grabbed Mr McCallion by the throat and pulled him towards him in a 'headlock'. He held him in this position for a short time before releasing him. He then got out of the car and walked around the front of the car to the driver's side of the car. Mr McCallion moved across to the passenger seat to avoid Mr Knight. Mr Knight walked to the front of the car slammed the bonnet of the car with both hands and said, '*You're going to die today cunt*'.¹¹
36. Mr McCallion got out of the passenger side door of the car and ran to the riverbank and jumped into the river.¹² Once in the river, he moved quickly to a position in the water behind the branches of a tree that was overhanging the river which he held onto.¹³ Mr Knight then took a spanner from the car and moved towards the riverbank throwing the spanner at Mr McCallion intending to strike him. The spanner did not make contact with Mr McCallion, and it sunk into the river.¹⁴ Mr McCallion then moved away from his position behind the tree swimming towards the middle of the river.
37. In an interview with Victoria Police on 27 April 2022, Mr Knight stated that he went back to the boot of the car and found a fishing tackle box, removed a fishing knife, walked to the

¹⁰ Transcript of interview with Mr Matthew Knight on 26 April 2022 at CB 371 and 376.

¹¹ Transcript of interview with Mr Matthew Knight on 26 April 2022 at CB 371.

¹² Transcript of interview with Mr Matthew Knight on 3 May 2015 at CB 351.

¹³ Transcript of interview with Mr Matthew Knight on 26 April 2022 at CB 371 and 377.

¹⁴ As above at 9.

riverbank took off his shoes and swam out in the direction of Mr McCallion with the knife in his right hand stating that, '*I was gunna cut his head off*'.¹⁵

38. As Mr McCallion swam towards the middle of the river, he appeared to be in some difficulty. Mr Knight described it as Mr McCallion bobbing in and out of the water screaming for help. Mr Knight developed a stitch below his right shoulder blade but continued to swim a little further.¹⁶
39. At that time, it was around 2.40pm and a houseboat was travelling upstream and noticed Mr McCallion in the water waving his arms. The houseboat manoeuvred in an attempt to render assistance to Mr McCallion. One of the passengers of the houseboat recalled Mr McCallion yelling '*help me*', '*oh god, help me*'.¹⁷ After seeing the houseboat, Mr Knight returned to the shore and attempted to direct the houseboat in the direction of Mr McCallion.¹⁸
40. The houseboat was unable to retrieve Mr McCallion from the water as they passed him. They then launched their motorised dingy to retrieve Mr McCallion from the water. By the time the dingy reached Mr McCallion, he had sunk below the surface. He was pulled unconscious from the water into the dingy and transferred onto the houseboat where CPR was commenced.¹⁹ While Mr McCallion was being retrieved from the river Mr Knight swam back to the bank and drove away from the river in Mr McCallion's car.
41. The passengers of the houseboat contacted emergency services, and ambulance paramedics attended at the scene shortly thereafter. CPR was continued and Mr McCallion was transferred to MBH for treatment. Ms Siphthorne was contacted by Victoria Police and subsequently attended MBH.
42. That afternoon at around 5.30pm, Mr Knight returned to the home of his twin brother, Mr Bradley Knight and sister-in-law, Ms Katerina Knight where he had been residing for approximately 4 weeks. Ms Knight was home at the time, and he provided her with an

¹⁵ Transcript of interview with Mr Matthew Knight on 27 April 2022 at CB 392.

¹⁶ Transcript of interview with Mr Matthew Knight on 26 April 2022 at CB 372.

¹⁷ Statement of Mr Denis Byrne dated 2 May 2015 at CB 137.

¹⁸ Transcript of interview with Mr Matthew Knight on 3 May 2015 at CB 352.

¹⁹ Statement of Mr Denis Byrne dated 2 May 2015 at CB 138.

account of what had occurred between himself and Mr McCallion. He stated that he could 'get 6 to 10 years for this'.²⁰

43. Mr Bradley Knight returned home at around 8.40pm that evening. Mr Bradley Knight recalled that when pulled into his driveway, that Mr Knight pulled in behind him in a vehicle and told his brother that it was Mr McCallion's car. He advised Mr Bradley Knight that he had tried to confront Mr McCallion about being a paedophilia and that Mr McCallion had jumped in the river and drowned.²¹
44. Mr McCallion sadly passed away at MBH in the evening on 1 May 2015.

INVESTIGATION BY POLICE

45. Following Mr McCallion's death, Victoria Police commenced an investigation with the assistance of the NSW Police Force (NSWPF) which included the taking of witness statements, obtaining CCTV, recorded interviews and crime scene examinations.
46. CCTV obtained during the police investigation depicts Mr Knight at 12.40am on 2 May 2015, at the Mildura Gateway Tavern. He arrived at the location in Mr McCallion's vehicle. He stayed at the premises for a short time to play the poker machines. He left the premises at around 12.52am.²²
47. At around 1.00am, CCTV depicts Mr Knight walking into the United Petrol Station on the corner of Benetook Ave and Fifteenth Street in Mildura with plastic fuel cans which he filled with petrol and then left on foot.
48. At around 2.00am that morning, Ms Siphorne attended McCallion's home address. Upon entering the house, she located Mr McCallion's mobile phone, e-cigarette and glasses. She advised police that Mr McCallion did not usually leave the house without these items. Ms Siphorne also noticed that both taps in the bathtub were turned on and the cushions in the lounge room were spread across the floor. Ms Siphorne reported this information, and a

²⁰ See statement of Katrina Knight dated 2 May 2015 at CB 155.

²¹ See statement of Mr Bradley Knight dated 2 May 2015 at CB 160.

²² Appendix Q to CB.

crime scene was established at Mr McCallion's home unit.²³ The NSWPF Forensic Services Group subsequently conducted a forensic examination at the location.

49. Ms Siphthorne also reported to police that on 18 February 2015, Mr Knight had attended Mr McCallion's house. While Mr Knight was still at the residence, Mr McCallion called Ms Siphthorne and stated '*I need you to call the police. Matt Knight is here. I fear for my life he is talking crazy, and he is off his head...I need you to ring the police as soon as you get off the phone*'.²⁴ Ms Siphthorne told police that she immediately contacted triple zero²⁵ and Mr McCallion called her later than evening to explain that he drove Mr Knight home to get him out of the house and that he said '*I think that he is going to do something to me*'.²⁶
50. At around 3.00am on 2 May 2015, Mr Bradley Knight attended Mildura Police Station (MPS) to report the information that Mr Knight had shared with him and his wife. Namely, that Mr Knight had assaulted Mr McCallion somewhere on the Murray River and that Mr McCallion had run into the river and drowned. Mr Bradley Knight also confirmed that Mr Knight had spoken to him and his wife about disposing of Mr McCallion's vehicle.
51. Later that day, Mr Knight was apprehended by Victoria Police in Colignan, Victoria. He initially attempted to flee but was taken into custody and interviewed at the MPS. Prior to being taken to the MPS, Mr Knight showed Victoria Police where he had concealed Mr McCallion's white Nissan Pulsar in Watt Bend Forrest in Kulkyne Way, Colignan. Mr Knight provided a no comment interview after obtaining legal advice.²⁷
52. A crime scene was established and processed by the Victoria Police Forensic Services Centre. A crime scene was also established at location at the Murray River where the incident had occurred, and a number of exhibits were seized by Victoria Police.
53. On 3 May 2015, Mr Knight was interviewed by members of the Victoria Police Homicide Squad and provided a partial account of the incident and acknowledged being with Mr

²³ Statement of Detective Senior Constable, Mark Tanzini dated 12 May 2015 at CB 258; See also statement of Alison Siphthorne dated 3 May 2015 at CB 46 – 48.

²⁴ Statement Alison Siphthorne dated 3 May 2015 at CB 43

²⁵ See transcript of Triple Zero call from Alison Siphthorne dated 18 February 2015 at CB 327.

²⁶ Ibid.

²⁷ Appendix I to CB.

McCallion at the riverbank and that he placed him in a headlock and grabbed him around the throat. Mr Knight also stated that Mr McCallion entered the water voluntary and had made comments about wanting to die due to being a paedophile.²⁸ Mr Knight was reviewed by Forensic Medical Officer, Dr Gerald Murphy who assessed his mental fitness to continue the interview. Dr Murphy assessed Mr Knight as mentally capable to be interviewed noting that he was calculating his behaviour. The interview was not taken any further and he was released from custody without charge.

54. Almost four years later, on 21 January 2019, Mr Knight attended MPS to speak to police about his involvement in the incident with Mr McCallion on 1 May 2015. Mr Knight made admissions to police about assaulting Mr McCallion and having armed himself with a knife. He also subsequently participated in a recorded interview with police which was suspended after Mr Knight requested to speak to a lawyer.²⁹
55. Victoria Police had concerns about Mr Knight's mental health status, as he presented with what appeared to be symptoms of psychosis including auditory hallucinations and he had a recent history of substance misuse. Forensic Medical Officer, Dr Gerald Murphy conducted a medical assessment of Mr Knight. Dr Murphy indicated that Mr Knight was not fit for interview and required further assessment and treatment by specialist mental health experts. Mr Knight was conveyed and admitted to the MBH Psychiatric Unit for treatment.³⁰ He was discharged from MBH on 6 March 2019.³¹
56. Following further investigation by Victoria Police, on 19 April 2021, investigators attended Mr Knight's home address and arrested him in relation to the death of Mr McCallion. Mr Knight guided investigators to the scene of the incident and provided a recorded account and re-enactment of the events of 1 May 2015. Mr Knight participated in a recorded interview with police and made admissions to assaulting Mr McCallion before he ran into the river and drowned.³²

²⁸ Appendix J to CB.

²⁹ Statement of Acting Superintendent Scott Anderson at CB 295; Appendix K to CB.

³⁰ Mildura Base Hospital medical records at CB 306 – 307.

³¹ Mildura Base Hospital medical records at CB 312.

³² Appendix L to CB.

57. On 25 April 2022, Mr Knight presented to Robinvale Police Station wishing to inform police about his involvement in Mr McCallion's death.
58. The following day on 26 April 2022, Mr Knight was located by police in the Robinvale central business district and agreed to attend the Robinvale Police Station to provide a further record of interview based on the account he had provided the previous day. Mr Knight provided a detailed account of the events from 1 May 2015 and informed investigators that he intended to kill Mr McCallion.³³
59. On 27 April 2022, Mr Knight presented for a third time to the Robinvale Police Station and participated in another recorded interview during which he made similar admissions to the previous two days.³⁴
60. On 23 February 2023, Victoria Police wrote to the Office of Public Prosecution (**OPP**) seeking advice in relation to possible jurisdictional issues relating to any charges brought against Mr Knight and the viability of possible charges against Mr Knight arising from the assault and drowning of Mr McCallion on 1 May 2015. Due to concerns about the admissibility of Mr Knight's statements and records of interview due to Mr Knight's mental health issues, charges were not recommended by the OPP. The OPP having reviewed all the evidence considered that there was no reasonable prospect of conviction. Mr Knight has not to date been charged with any criminal offences connected with the death of Mr McCallion.³⁵
61. Despite a thorough and comprehensive criminal investigation by Victoria Police, no person or persons have been charged with an indictable offence in relation to Mr McCallion's death.
62. It is important to note that it is not the purpose of a coronial investigation to investigate possible criminal conduct and compile a brief of evidence in preparation for a future criminal trial. Section 69 of the Act expressly prohibits a coroner from including in a finding or a comment, any statement that a person is or may be guilty of an offence. I further note that the OPP has advised against pursuing any charges relating to the death of Mr McCallion.

³³ Transcript of interview of Mr Matthew Knight on 3 May 2015 at CB 366 – 385; Appendix M to CB.

³⁴ Transcript of Interview of Matthew Knight at CB 387 – 392; Appendix N to CB.

³⁵ Letter from OPP to Victoria Police dated 3 July 2023.

63. In light of the extensive investigation by Victoria Police and after carefully reviewing all of the available evidence, I am satisfied that no further investigation is required by me and there is sufficient evidence for findings to be made in this matter.
64. I note that if new facts and circumstances become available in the future, section 77 of the Act allows any person to apply to the Court for an order that some or all of these findings be set aside. Any such application would be assessed on its merits at the time.

FINDINGS AND CONCLUSION

65. Having investigated the death of Terrence McCallion and having held an inquest on 31 January 2024, I make the following findings, pursuant to section 67(1) of the Act:
- a) the identity of the deceased was Terrence McCallion, born 1 February 1960;
 - b) the death occurred on 1 May 2015 at Mildura Base Hospital Mildura, Victoria;
 - c) the cause of death was drowning following assault with a contributing factor being coronary artery atherosclerosis;
 - d) the death occurred in the circumstances described above; and
 - e) I am satisfied to the coronial standard of proof that the weight of the evidence supports the conclusion that the actions of Mr Knight caused or contributed to the death of Mr McCallion
66. I convey my sincere condolences to Mr McCallion's family for their loss.
67. 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.
68. I direct that a copy of this finding be provided to the following:

Ms Alison Siphthorne, Senior Next of Kin

Detective Acting Sergeant Adam Brymer, Coroner's Investigator

Signature:



JUDGE JOHN CAIN
STATE CORONER

Date: 4 April 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 inquest. 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.
