



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000004

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Therese McCarthy
Deceased:	Con Panagiotou
Date of birth:	7 February 1948
Date of death:	1 January 2025
Cause of death:	1a: Traumatic head, ribs, pelvic and spinal injuries sustained in a motor vehicle incident (pedestrian)
Place of death:	The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria
Keywords:	Motor vehicle collision – Single vehicle – Pedestrian

INTRODUCTION

1. Con Panagiotou was 76 years old when he died from traumatic injuries sustained in a motor vehicle incident on 1 January 2025. At the time of his death, Con resided alone in Blackburn South.
2. Con migrated from Greece to Australia and worked for a range of manufacturing factories. He was married to Helen Panagiotou, and they had one daughter together, [REDACTED]
3. According to [REDACTED] Con experienced a mental breakdown shortly after she was born. This caused Con to stop working and he began receiving disability support. His inability to work affected his mental health and financial independence.
4. Con suffered from numerous chronic medical conditions, including Klinefelter syndrome, schizophrenia, depression and poorly controlled Type 2 Diabetes Mellitus. According to his treating General Practitioner ('GP'), it was difficult to engage Con in a treatment plan because he was non-compliant with his medication and consistently expressed a lack of concern for his health and wellbeing.

THE CORONIAL INVESTIGATION

5. Con'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.
6. 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.
7. 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.
8. Coroner John Olle had carriage of this investigation until it came under my purview in August 2025 for the purposes of finalising the investigation and making findings.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Con's death. The Coronial 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.
10. This finding draws on the totality of the coronial investigation into the death of Con Panagiotou 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

11. On 19 December 2024 at about 10.02pm, Con was crossing Middleborough Road in Box Hill South from the east side to the west side. Other drivers witnessed Con walking quickly between two cars before he stepped out in front of an oncoming car driven by Mona Abed ('Mona').
12. Mona was unable to avoid a collision with Con. He traversed over the bonnet over her vehicle and struck his head on the left-hand side of the windscreen. As a result of the impact, Con was thrown a short distance and came to a rest near the stop line on Middleborough Road, adjacent to Ailsa Street.
13. Mona stopped her vehicle and observed Con to be unconscious. She contacted Triple Zero and emergency services arrived shortly after. Paramedics stabilised Con at the scene and conveyed him to the Royal Melbourne Hospital ('RMH') in a critical condition.
14. Upon arrival to RMH, Con was triaged and admitted to the Intensive Care Unit. On 20 December 2024, an intracranial pressure (ICP) monitor was inserted by the neurosurgery team for assessment and treatment of an intracranial haemorrhage. Con also underwent bilateral

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.

pelvic surgery on 24 December 2024, however after a period of monitoring, he had poor neurological recovery.

15. Following discussions with his family, Con was extubated and transitioned to comfort care on 30 December 2024. He subsequently passed away on 1 January 2025.

Further Investigation

16. Police attended and processed the scene of the collision. Mona was given a preliminary breath test which returned a negative result. She was later conveyed to the Box Hill Police Station where she provided a blood sample which also returned a negative result to alcohol and illicit substances.

Mechanical Inspection

17. Victoria Police conducted a mechanical inspection of Mona's car involved in the collision. The examination did not reveal any mechanical fault or failures with the car, a 2004 Suzuki Ignis sedan, which would have caused or contributed to the collision.

Collision Scene

18. Middleborough Road, Box Hill South is a divided roadway which runs north to south. There is a painted traffic island that separates the north and south bound lanes at the intersection where the collision occurred. Notably, Victoria Police observed there was a pedestrian crossing located north of Ailsa Street which was approximately 26 meters from where the collision occurred.
19. Victoria Police also noted that on the night of the collision, the conditions were dry and clear, and the road was in good condition. Middleborough Road displays a speed limit of 60km/h however Victoria Police did not consider speed as a contributing factor to the collision.
20. Having investigated all aspects of the accident, I am satisfied that there are no prevention opportunities that have been identified.

Identity of the deceased

21. On 1 January 2025, Con Panagiotou, born 7 February 1948, was visually identified by his daughter, [REDACTED]

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

Medical cause of death

23. Forensic Pathologist Dr Joanne Chi Yik Ho from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy on the body of Con Panagiotou on 8 January 2025 and provided a written report of her findings dated 21 May 2025.

24. The findings of post-mortem imaging showed multiple injuries consistent with being struck by a vehicle. The post-mortem imaging further identified a left basal ganglia haemorrhage,² which was initially thought to be atypical for a traumatic bleed.

25. Neuropathological examination of the brain performed by Associate Professor Linda Iles from VIFM determined that the haemorrhage observed was of traumatic aetiology, although less common than in other locations.

26. Toxicological analysis could not be performed as there were no suitable antemortem specimens.

27. Dr Ho provided an opinion that the medical cause of death is appropriately formulated as '*1(a) Traumatic head, ribs, ribs, pelvic and spinal injuries sustained in a motor vehicle incident (pedestrian)*'.

28. I accept Dr Ho's opinion.

FINDINGS AND CONCLUSION

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

- a) the identity of the deceased was Con Panagiotou, born 7 February 1948;
- b) the death occurred on 1 January 2025 at The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria from traumatic head, ribs, ribs, pelvic and spinal injuries sustained in a motor vehicle incident (pedestrian).
- c) the death occurred in the circumstances described above.

² A common form of intracerebral haemorrhage which usually results from poorly controlled long-standing hypertension.

30. That Mona, the driver of the vehicle which struck Con was in no way responsible for his death and could not have foreseen Con's pathway in front of her vehicle. Further, I acknowledge this is likely to have been a traumatic event for her and note that she cooperated fully with the investigation which has assisted the court to make these findings.
31. Having considered all of the circumstances, and on the balance of probabilities, I find that the death of Con Panagiotou was the unintended consequence of his deliberate action to cross the road, rather than by any intentional act or omission on his behalf.

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

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

██████████, Senior Next of Kin

The Royal Melbourne Hospital

Leading Senior Constable Bill Droutsas, Coronial Investigator

Signature:



Coroner Therese McCarthy

Date: 03 July 2026

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.
