IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 5916

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Emma Ashlee DUTTON
Delivered on:	26 November 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	At Mildura 28, 29, and 30 November, 1 and 2 December 2016 and at Melbourne 22 May 2017
Findings of:	Coroner Paresa Antoniadis SPANOS
Counsel assisting the Coroner:	Leading Senior Constable Remo ANTOLINI from the Police Coronial Support Unit
Representation:	Mr R. DONALDSON appeared on behalf of Ambulance Victoria Mr S. STAFFORD appeared on behalf of the State Emergency Service Ms K. POPOVA appeared on behalf of the Country Fire Authority.
Catchwords:	Two vehicle collision, deceased front seat passengers, vehicle drift or veer across centre dividing line, difficult extrication, SES, CFA, lane assist technology

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I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of EMMA ASHLEE DUTTON

and having held an inquest in relation to this death at Mildura on 28, 29, 30 November, and 1, 2 December 2016 and at Melbourne on 22 May 2017:

find that the identity of the deceased was EMMA ASHLEE DUTTON

born on 18 June 1991

and that the death occurred on 23 December 2013

at Calder Highway, Kiamal, Victoria 3490, between the 457 and 458 kilometre posts

from:

I (a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION (PASSENGER)

in the following circumstances:

INTRODUCTION[1]

1. Ms Dutton was a twenty-two year old single woman who worked as a retail assistant, was studying Public Relations at Deakin University and resided with her family in Mount Waverley. Ms Dutton is survived by her parents Shane Dutton [Mr Dutton] and Julie Dutton [Mrs Dutton], her sister Courtney, brother Jordan and boyfriend Stephen Castles. Emma's father remembers her as a beautiful girl who really added to society, gave freely of her time and was concerned about others.[2]

2. On Monday 23 December 2016, the Dutton family woke early to travel to Mildura to spend Christmas with Mrs Dutton's mother. In preparation for their holiday, the family 2012 black Volkswagen Passat sedan [the sedan] had been packed the night before. When they left Mount Waverley between 7.30am and 8.00am, it was cold and raining.[3] Mr Dutton was driving and Mrs Dutton sat immediately behind him in the driver's side rear passenger seat, with Courtney in the middle rear passenger seat and Jordan to her left.

[1] This section is a summary of background and personal circumstances and uncontentious circumstances that provide a context for those circumstances that were contentious and will be discussed in some detail below.
[2] Said during the police interview of Mr Dutton on 14 March 2014 at his home. Coronial brief page 332.
[3] City Link records show that the sedan (registration DUTTO8) was city bound on the Monash Freeway at Toorak Road at 7.59am, with the last toll registering for the journey on the Tullamarine Freeway at 8.12am. Coronial brief summary and statement of the coronial investigation DLSC Jamie Mitchel at page 278.

3. They drove to Glen Iris to collect Emma from her boyfriend's home and she sat in the front passenger seat. Mr Dutton drove out of Melbourne via City Link and the Calder Freeway and Highway towards Bendigo. It appears that they stopped at Marong and Sea Lake before driving continuing on their broadly north-westerly route through Ouyen.[4]

4. At about 1.00pm, on the Calder Highway at Kiamal, about seven kilometres [kms] north of Ouyen, there was a two vehicle collision involving the sedan and a 2005 white Mitsubishi Pajero Four Wheel Drive vehicle [the 4WD] being driven by Jeffrey Lyle Riordan [Mr Riordan] in the opposite direction. The collision and its aftermath were the focus of the coronial investigation and will be discussed in some detail below. Suffice for present purposes to say that both front seat passengers died at the scene, Emma on impact, and Pauline Riordan [Ms Riordan] after a lengthy and difficult extrication from the 4WD.[5]

INVESTIGATION AND SOURCES OF EVIDENCE

5. This finding is based on the totality of the material the product of the coronial investigation of the Emma and Ms Riordan's deaths. That is, the brief of evidence compiled by Detective Leading Senior Constable Jamie Mitchell from the Glen Waverley Major Collision Unit of Victoria Police [MCIU] and additional material obtained by my assistant Leading Senior Constable Remo Antolini from the Police Coronial Support Unit, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them.

6. All of this material, together with the inquest transcript, will remain on the coronial file.[6] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

7. The purpose of a coronial investigation of a *reportable death*[7] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death

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[4] Coronial brief page 194.
[5] All members of the Dutton family received injuries from serious to life threatening. The other driver, Mr Riordan received only minor injuries.
[6] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.
[7] The term is exhaustively defined in section 4. Apart from a jurisdictional nexus with the State of Victoria (see section 4(1)), reportable death includes *"a death that appears to have been unexpected, unnatural of violent or to have resulted, directly or indirectly, from an accident or injury"* (see section 4(2)(a) of the Act).

occurred.[8] It is self-evident that Emma's death was unnatural and resulted directly from an accident or injury and therefore falls within the definition of a reportable death.

8. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[9]

9. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[10]

10. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[11] These are effectively the vehicles by which the coroner's prevention role can be advanced.[12]

11. It is important to stress that coroners are <u>not empowered to determine the civil or criminal liability</u> arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[13]

FINDINGS AS TO UNCONTENTIOUS MATTERS

12. Despite the severity of her injuries, Emma was able to be visually identified and a Statement of Identification was signed by her uncle, a member of Victoria Police, on 24 December 2013. Her identity was uncontentious as were the date and place of her death.

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[8] Section 67(1).
[9] This is the effect of the authorities – see for example ***Harmsworth*** *v* ***The State Coroner*** [1989] VR 989; ***Clancy*** v ***West*** (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)
[10] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.
[11] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.
[12] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[13] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

13. I accordingly find, as a matter of formality, that Emma Ashlee Dutton, born on 18 June 1991, late of a Mount Waverley address, died between the 457 and 458 kilometre posts on the Calder Highway, Kiamal, Victoria 3490 on 23 December 2013.

MEDICAL CAUSE OF DEATH

14. Forensic pathologist Dr Noel Woodford (as he then was[14]) from the Victorian Institute of Forensic Medicine [VIFM] reviewed the circumstances of death as reported by police to the coroner, post-mortem CT scanning of the whole body undertaken at VIFM [PMCT] and performed an external examination of Emma's body at the Coronial Services Centre, Southbank.

15. Having done so, Dr Woodford provided an 18 page written report of his findings in support of his conclusion that Emma died as a result of *multiple injuries sustained in a motor vehicle collision as a passenger.*[15] He commented that the nature, distribution and severity of Emma's injuries is in keeping with the history of her having been involved in a motor vehicle collision and that the most severe injuries were to the head and neck with evidence of acute traumatic subarachnoid haemorrhage, atlanto-occipital disruption with haemorrhage into the brainstem and upper cervical cord.

16. Dr Woodford added that he found no evidence of natural disease of a type likely to have caused or contributed to death and noted that toxicological analysis of post-mortem samples taken from Emma showed no alcohol or other commonly encountered drugs or poisons, thus excluding substances as having played any role in her death.

17. Based on all the evidence available to me, I find that the medical cause of Emma's death is multiple injuries sustained in a motor vehicle collision as a passenger.

THE FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

18. The initial focus of the coronial investigation and inquest in relation to both Emma's and Ms Riordan's deaths was on how the collision occurred. Ultimately, there was an additional important issue that arose in relation to Ms Riordan's death that will not be addressed in this finding but only in the separate finding into her death. That is, the manner in which Ms Riordan was extricated from the 4WD and whether or not there was any avoidable delay which caused or contributed to her death.

[14] Dr Woodford is now Professor and Head of the Victorian Institute of Forensic Medicine.
[15] Coronial brief pages 27-44. The report includes Dr Woodford's formal qualifications and experience.

HOW THE COLLISION OCCURRED – THE LOCALE

19. As already mentioned, the collision occurred on the Calder Highway, Kiamal, about seven kilometres north of Ouyen between the 94 and 95 km posts from Mildura. Calder Highway is the main carriageway between Melbourne and Mildura and carries a very high volume of traffic both local and in transit.[16]

20. The collision occurred within a straight section of the highway with a posted speed limit of 100km/hr. At this location the highway runs generally north-south through a rural landscape and has provision for one lane of traffic in each direction. There are audible tactile strips along both fog lines and within the centre broken white line. The bitumen surface of the highway was dry and in very good condition at the time. The reservations on each side of the carriageway were sloped and raised above the level of the carriageway, sloping away to the level of adjacent farmland.[17]

21. At the time of the collision, the weather was fine and it was daylight with no apparent obstructions to driver visibility. As the highway ran north – south, it is unlikely that sun glare would have affected the visibility of either north or south bound vehicles.[18]

HOW THE COLLISION OCCURRED – THE DRIVERS

22. Jeffrey Riordan was a 64 year old married and recently retired man who had lived in Mildura all his life, most recently in Irymple. Mr Riordan had been driving since he was 18, had a full and current Victorian driver's licence. He told police that this was his first major accident and that he had owned the 4WD for 4-5 years and had never had any problems with it.[19]

23. The Riordans were planning to spend Christmas with their children in Melbourne. Mr Riordan had slept from about 10.30-11.00pm the previous night until he woke at 7.30am on 23 December 2013 and they left for Melbourne at 12.08pm 'on the dot'. At 12.52pm, Mr Riordan remembered looking at the time. He was enjoying the drive, the beautiful weather and the beautiful long straight stretch of road ahead. There were three or four cars behind him and they remarked on how quiet the traffic was.[20]

24. Mr Riordan then noticed an oncoming vehicle ahead of him, at first travelling on the correct side of the road for some 500-600 metres, before gradually veering across onto his side of the

[16] Or, between the 497 - 498 km posts, from Melbourne. See statement of Detective Leading Senior Constable Jenelle Mehegan, Collision Reconstructionist, Major Collision Investigation Group, coronial brief page 223.
[17] Statement of Rohan Earl Courtis, coronial brief page 194. Also DLSC Mehegan's statement, coronial brief page
[18] Ibid and statement of DLSC Mehegan, coronial brief page 224.
[19] Statement of Jeffrey Lyle Riordan dated 23 December 2013, coronial brief page 58. Also, pages 346-348 which are certificates under the Road Safety Act 1986 confirming that the 4WD was registered in Ms Riordan's name at the time and that Mr Riordan held a full Victorian driver's licence and had no recorded traffic offences.
[20] Ibid.

road. The vehicle 'got quicker and quicker and just kept coming across the road towards us and kept coming until it was completely on our side of the road.' Mr Riordan saw it was a black car and tried to get out of its way but it 'just kept coming and it all happened so fast'. He did not remember the impact other than hearing a loud crunch and the airbags deploying.[21]

25. Mr Riordan sustained minor injuries and was able to extricate himself from the 4WD, walk around and talk to emergency responders. He underwent a preliminary breath test at the scene, administered by local police, and no alcohol was detected.[22]

26. Mr Dutton was a 54 year old married man who resided in Mount Waverley with his family and retired about 14 months before the collision as a result of an eye injury. Medical reports obtained from Mr Dutton's treating doctors indicate that his overall health is good. However, in January 2012, Mr Dutton suffered a sudden onset of visual loss in his right eye and subsequently underwent a retinal detachment procedure and a vitrectomy, both in the right eye. His vision stabilised but his eyesight remained somewhat compromised following the procedures and underwent further investigations.

27. When last examined by Vitreoretinal Specialist Dr William Campbell, on 24 October 2013, Mr Dutton's vision remained compromised with visual acuities measured at 6/150 part in the right eye and 6/6 in the left. Nevertheless, Dr Campbell was of the opinion that 'Mr Dutton fulfils the minimum visual requirements to drive a car in Victoria and that it is very unlikely the poor vision in his right eye is sufficient explanation for his veering on to the incorrect side of a straight road.'[23]

28. Mr Dutton held a full and current Victorian driver's licence.[24] He underwent a preliminary breath test at the scene, administered by local police, and no alcohol was detected. Testing of a blood sample taken from Mr Dutton revealed no alcohol or other commonly encountered drugs or poisons apart from morphine and ketamine, both strong analgesics consistent with administration by medical or paramedic staff in an emergency setting, and the antidepressant citalopram at levels consistent with normal therapeutic use.[25]

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[21] Ibid.
[22] Coronial brief summary.
[23] Dr William G. Campbell's statement dated 6 March 2014, coronial brief page 337. Other medical reports from Associate Professor Justin O'Day are at coronial brief pages 338-340.
[24] At coronial brief pages 349-351 are certificates under the Road Safety Act 1986 confirming that the sedan was registered at the time and that Mr Dutton held a full Victorian driver's licence and had no recorded traffic offences.
[25] Coronial brief pages 341-343. Also, see footnote 30 below.

29. As a result of injuries he sustained during the collision, and his lawyer's indication to police that he was unable to submit to an earlier interview, Mr Dutton was not interviewed by police until 14 March 2014.[26]

30. While he gave no account of how the collision occurred, as he did not remember and thought his last memory was of Wycheproof,[27] Mr Dutton gave some explanations and denied a number of potential issues or distractions put to him by the police during interview -

    a. He knew he wasn't drinking, had a rest and is not a silly driver.[28]

    b. He couldn't say definitely, but did not think he went to sleep as he had gone to bed early the night before, had rested and had taken one No-Doz tablet just before they left instead of having his usual morning coffee.[29]

    c. He took no medications apart from his usual antidepressant/anxiolytic.[30]

    d. The sedan was fitted with Lane Assist Technology which was operating at the time and no alarms sounded.[31]

    e. He thought that the family's two dogs were in the back, conceded one may have been sitting on Emma's lap, but in any event they did not distract him.[32]

    f. He was not eating food or drinking or being distracted by any mobile phones or other technology.[33]

    g. It was a beautiful day, a straight stretch of road and he was 'doing the trip easy.'[34]

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[26] Coronial brief pages 283 and following.
[27] Coronial brief pages 299, 303 and 317.
[28] Coronial brief page 294.
[29] Coronial brief pages 295, 308 and 310.
[30] Coronial brief page 296. Mr Dutton said he took an antidepressant at night. Dr Morris O'Dell a clinical forensic clinician from VIFM advised the DLSC Mitchell that escitalopram was an antidepressant and had no effect on drowsiness or the ability to do control a motor vehicle. Coronial brief page 277.
[31] Coronial brief pages 299-303, 329. This appears to be incorrect as a report obtained from the Volkswagen corporation states, *inter alia,* that "Lane Assist: An analysis of the control unit determined that the Lane Assist was switched on, but was not active (before or during the accident). That means that the Lane Assist could not intervene in the vehicle's steering…The data stored in the airbag control unit as a result of the crash was also analysed. This included data indicating the detection of a frontal collision, including the activation of the front airbags and belt tensioner." See coronial brief page 344. In addition, DLSC Mitchell obtained the following clarification from VW *verbatim* – "If the Lane Assist was switched on but not active it could be for a number of reasons, the system cannot clearly detect the marking on the lane the vehicle is in, for example, due to road works or snow, dirt, wet weather or oncoming lights, if the vehicles speed is less than 65 km/h, the radius of a bend is too small, if there are no lane markins, if the distance to the nearest lane marking is too great, if the Traction Control system is switched off, if the system does not detect any clear steering activity by the driver over an extended period, ie the system can be activated and warnging the driver for up to 30 seconds and then it switches off…The system also requires the windscreen in front of the camera to be cleaned regularly and that the camera is not covered…If the system is not working the indicator lamp lights up yellow on the dash…If it is working correctly it turns green."
[32] Coronial brief pages 303-305, 312.
[33] Coronial brief pages 305, 309, 313-314.
[34] Coronial brief page 308, 316.

HOW THE COLLISION OCCURRED – POLICE & EXPERT EVIDENCE

31. Although a number of people came upon the collision scene, rendered assistance and called emergency services, there were no independent eye witnesses to the collision between the two vehicles.

32. Responding police members, including the coronial investigator DLSC Mitchell, made observations of the vehicles post impact in their resting positions, noted physical evidence left by the vehicles in the vicinity, took photographs of the scene and took measurements. DLSC Mitchell concluded that the collision occurred when the sedan being driven north by Mr Dutton, veered at an angle across the centre dividing line and continued driving north in the south bound lane at an angle as it approached the 4WD. The approaching 4WD being driven by Mr Riordan slowed and he took evasive action, initially by steering as far left as possible, before swerving sharply to the right shortly before impact. The result was an offset head on collision occurring wholly within the southbound lane, both vehicles presenting their front passenger sides which took the brunt of the impact.

33. Neither driver raised any concerns with police about the performance of their respective vehicles. Nevertheless, Senior Constable Junny Hetherton from the Mechanical Inspection Unit of Victoria Police [MIU] undertook mechanical inspections of both vehicles on 14 January 2014 at a towing contractors premises in Mildura. SC Hetherton found the sedan to be in near new condition and the 4WD to be in good condition and found no mechanical faults with either vehicle which would have caused or contributed to the collision.[35]

34. Detective Leading Senior Constable Jenelle Mehegan (as she then was) from the MCIU attended the scene on the afternoon of 23 December 2013 and provided a Collision Reconstructionist Report of some pages 40 pages that is included in the coronial brief.[36] In her report, DLSC Mehegan set out the sources of evidence used in her reconstruction, indicated that she was present when another member measured the scene using a total survey station, included pertinent photographs and the formulas used to make her calculations and reach her conclusions about how the collision occurred.

35. DLSC Mehegan's expert assessment is that for an unknown reason, the sedan has crossed onto the incorrect side of the highway and collided with the 4WD in an offset head on collision causing severe damage to the front passenger side of both vehicles. The damage

[35] Coronial brief pages257 and following. I note that SC Hetherton was unable to locate the passenger side front suspension and wheel assembly of the sedan and commented that "If there had been a run flat failure this would leave corresponding marks on the road, and tend to cause the vehicle to pull towards the passenger side. If the suspension had collapsed, this would have similar tendencies." The movement of the sedan shortly before the collision was a drift or veer to the right or the driver's side, not towards the left or passenger side. Coronial brief page 263.
[36] Her statement is at coronial brief pages 215-216 and her report proper commences at page 217.

profiles of the vehicles indicate that at impact the front passenger side of the sedan was partially in the south bound lane and partially on the bitumen shoulder east of the south bound lane. The angle of the sedan at impact is "slight" and is more consistent with a drift or veer than a deliberate steering action.[37]

36. Significantly, DLSC Mehegan noted that the speedometer needle of the sedan was stuck at 100kph and the RPM at 1600, in her view, consistent with the vehicle having been set on cruise control at impact (and the overall drift or veer hypothesis) and also consistent with her calculations.[38] The 4WD was travelling at a lower speed that the sedan at impact, about 83.5kph.

37. Furthermore, DLSC Mehegan's expert assessment is that at impact the 4WD was wholly in the south bound lane but being steered to the right. The position of the 4WD at impact in addition to the pre-impact "yaw" is consistent with the 4WD having first been steered to the left and then to the right as evasive actions.[39]

38. Based on the damage to the front of both vehicles, DLSC Mehegan inferred that at impact the vehicles commenced to rate in an anticlockwise direction with the sedan continuing off the road to the east and commencing to travel up the embankment, while the 4WD has travelled onto the northbound lane towards the western shoulder.[40]

FINDINGS/CONCLUSIONS

39. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [41]

40. Adverse findings or comments against individuals in their professional capacity, or institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession, and in so doing caused or contributed to the death under investigation. By

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[37] Coronial brief page 248. The sedan's encroachment onto the south bound carriageway was significant, the passenger side being a *minimum of 1.8 metres* and up to 2.8 metres onto the incorrect side. Coronial brief page 254.
[38] Coronial brief page 235. See also SC Hetherton's observations at coronial brief page 257 – "The tacho needle was [sic] in found at approximately 140 rpm and the speedo needle was at approximately 99kmp which would be consistent with the vehicle travelling in top gear at the time of impact.
[39] Ibid.
[40] Coronial brief page 249. I note that DLSC found no evidence (neither physical evidence at the scene nor witness accounts) which suggested that either driver braked before impact, although she could not entirely exclude this possibility. If they braked they left no skid marks or no discernible skid marks.
[41] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336* especially at *362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"

analogy, a driver's contribution to the death of a passenger, is measured against the standards reasonably expected of a driver.

41. Having applied the applicable standard of proof to the available evidence, I find that:

    a. At all material times, Mr Dutton was driving the sedan and Emma was the front seat passenger.

    b. The sedan drifted or veered across the centre dividing line into the south bound carriageway and into the path of the oncoming 4WD.

    c. Despite steering the 4WD as far left as possible and then steering sharply to the right to avoid imminent impact, Mr Riordan was unable to avoid a collision with the sedan.

    d. The available evidence does not enable me to make a positive finding as to the reasons why the sedan veered or drifted across the centre dividing line into the path of the 4WD.

    e. That said, such evidence as there is, *is consistent with, as opposed to indicative of,* Mr Dutton being asleep, distracted or otherwise oblivious to the position of his sedan on the highway and the emergent situation evolving for a short period of time immediately preceding the collision, and this was the primary cause of the collision.

    f. Emma was wearing a seatbelt and the sedan's front airbags deployed on impact providing her with some protection.

    g. Nevertheless, Emma sustained severe injuries, including severe head and neck injuries, and died on impact or immediately thereafter.

DISTRIBUTION LIST

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

The family of Emma Dutton

Ambulance Victoria

State Emergency Services

Country Fire Authority

Detective Leading Senior Constable Jamie Mitchell (#30704) c/o O.I.C. Glen Waverley Major Collision Unit, Victoria Police

Traffic Accident Commission

Signature:

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PARESA ANTONIADIS SPANOS
Coroner
Date: 23 November 2018

Cc: LSC Remo ANTOLINI c/o O.I.C. Police Coronial Support Unit