IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2001 0819

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**GEORGE GERMANOS**
Delivered on:	17 June 2016
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	16 June 2016
Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Counsel assisting the Coroner:	Ms Jodie Burns, Senior Legal Counsel.
Catchwords	Homicide, no person charged with indictable offence in respect of a reportable death, mandatory inquest.

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HER HONOUR:

BACKGROUND

1 Mr Germanos was born on 10 December 1959. Up until his death on 22 March 2001, he lived with his parents in Oakleigh.

2 Mr Germanos' work history included crowd control, the fruit and vegetable industry and debt collecting. He also had a number of unsuccessful businesses in the automotive and beverage industries. Two years before his death, Mr Germanos, in partnership with Vince Benvenuto (**Mr Benvenuto**), managed a coffee shop in Were Street Brighton. Despite Mr Germanos contributing $30,000 into the business, it lasted five months before being sold at a loss. Mr Germanos lost all of his investment.

3 Mr Germanos was an accomplished power lifter. He also had an interest in firearms and had been a member of the Oakleigh Gun Club.

THE PURPOSE OF A CORONIAL INVESTIGATION

4 At the time of Mr Germanos' death the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the *Coroners Act 2008* (**the Act**) has applied to the finalisation of investigations into deaths that occurred prior to the commencement of the Act.[1] Mr Germanos' death constituted a '*reportable death*' under the *Coroners Act 1985* (Vic), as his death occurred in Victoria, and was both unnatural and violent.[2]

5 The jurisdiction of the Coroners Court of Victoria is inquisitorial[3]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

[1] Coroners Act 2008, section 119 and Schedule 1. All references which follow are to the provisions of this Act, unless otherwise stipulated.
[2] Section 3, definition of 'Reportable death', *Coroners Act 1985.*
[3] Section 89(4) *Coroners Act 2008.*

6 It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7 The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8 For coronial purposes, the circumstances in which 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 in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9 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 'prevention' role.

10 Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) 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

(c) 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. These powers are the vehicles by which the prevention role may be advanced.

11 All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[5] 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.

[4] *Keown v Khan* (1999) 1 VR 69.
[5] (1938) 60 CLR 336.

12 Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

13 While Mr Germanos' identity was not in dispute and he was not a person placed in "*custody or care*" as defined by section 3 of the Act, his death is considered to be a homicide. Therefore, it is mandatory to conduct an inquest into the circumstances of his death.

VICTORIA POLICE HOMICIDE INVESTIGATION

14 Immediately after Mr Germanos' death, Victoria Police commenced a criminal investigation because the death was considered to be a homicide.

15 Despite an extensive homicide investigation, no person or persons have been charged with indictable offences in connection with Mr Germanos' death.

16 The purpose of a coronial investigation (including an inquest) is not to investigate possible criminal conduct and/or compile a brief of evidence in preparation for a future criminal trial. Further, the Act expressly prohibits a coroner from making any statement in a finding or comment that a person is or may be guilty of an offence.[6] However, I note the observations of the Victorian Court of Appeal in *Priest v West*,[7] 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*."

17 Consistent with this judgment, 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, bearing in mind that I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.[8]

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[6] Section 69(1) of the Act.
[7] (2012) VSCA 327.
[8] *Perre v Chivell* (2000) 77 SASR 282.

18 Section 7 of the Act specifically states that a coroner should avoid unnecessary duplication of inquiries and investigations, by liaising with other investigative authorities, official bodies or statutory officers. The rationale behind this provision is to allow for consideration of public interest principles that weigh against the potential benefits of any further investigation, such as further cost to the community. It also acknowledges that although a number of authorities or organisations may have the mandate to investigate, some are more appropriately placed than others to do so in any given circumstance.

19 In this case, I acknowledge that the Victoria Police Homicide Squad has conducted an extremely thorough investigation in this matter.

20 In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Germanos' death is an unsolved homicide case which Victoria Police continues to investigate. The confidential nature of the ongoing investigation prevents me from reciting each and every matter which has been established by the Homicide Squad. However, the following important matters have been established and are able to be disclosed:

(a) that forensic examination of four fired rounds recovered from the crime scene and extracted from Mr Germanos' body during autopsy, identified all four rounds to be either .38 special or .357 magnum in calibre;

(b) that forensic testing determined that the projectiles fired into Mr Germanos' body were all fired from the same weapon and that the weapon was either a .38 or .357 calibre magnum;

(c) that Mr Germanos' hands were tested for the presence of gunshot residue. A pair of black leather gloves that accompanied Mr Germanos was also tested for the presence of gunshot residue. Two gunshot residue particles were detected on the palm of the left glove. Gunshot residue was not detected on any other part of the gloves or on Mr Germanos' hands;

(d) that on 17 April 2014, Victoria Police, offered a $1,000,000 reward to any person who provided information which leads to the conviction of any persons responsible for Mr Germanos' death. To date, no person has provided Victoria Police with any information that has led to any person being charged with criminal offences relating to Mr Germanos' death;

(e) that the homicide investigation into Mr Germanos' death is ongoing and the Homicide Squad file remains open; and

(f) that despite the extensive homicide investigation which has already taken place, and despite a very large reward having been offered, the person or persons responsible for Mr Germanos' death have, to date, been unable to be identified.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

21 The Deceased was visually identified by Penny Ziakas on 24 March 2001 to be George Germanos. Ms Ziakas declared herself to be Mr Germanos' sister.

22 Mr Germanos' identity was also confirmed by fingerprint matching.

23 Identity was not disputed and therefore required no investigation beyond what is set out above.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

24 On 23 March 2001, Dr Malcolm Dodd, Forensic Pathologist with the Victorian Institute of Forensic Medicine, conducted an autopsy on Mr Germanos' body, which revealed that Mr Germanos died as a result of injuries inflicted by four or possibly five projectiles to his face, torso and right side of the body.

25 Dr Dodd provided a written report, dated 30 May 2001, which concluded that a reasonable cause of death was multiple gunshot injury.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

26 On Wednesday 21 March 2001, the day before his death, Mr Germanos was observed arguing in the street with another male. The precise nature of the argument is not known.

27 On the evening of Thursday 22 March 2001, Mr Germanos left his home between 9.30 and 10.00 pm, telling his father, Alex, that he was going to work. Mr Germanos was seen at Café La Via, situated at 252 Glenferrie Road, Malvern. He arrived at that location between 10.15 and 10.30 pm. He stayed for about 15 minutes, having a coffee and cigarette before leaving. Mr Germanos' movements after leaving the café are not known.

28 At about 11.10 pm, on the same evening, several residents adjacent to Inverness Park Armadale heard sounds similar to gun shots. A witness close to the park was awoken by three noises. Believing the noises to be gun shots emanating from the park, the witness observed through a window a male person, approximately 20 years old, slim build, average height, wearing a light coloured top and dark trousers, running in a north westerly direction from the park.

29 At 11.15pm, Mr Germanos was located in the park, lying on his back with his head pointing in a northerly direction. There were two wounds to his forehead, a wound above his upper lip and a wound to his upper right chest. He was deceased at that time. A black glove was found in Mr Germanos' right hand and a second glove was located on the footpath 580mm from his left foot. A bullet was located on the footpath, 260mm from Mr Germanos' left shoulder. A second bullet was located in the soil under Mr Germanos' head. On the ground, around a park bench about nine metres north of Mr Germanos, were seven cigarette butts. Mr Germnos' motor vehicle, a Valiant sedan registered number JLB727, was located parked outside 31 Inverness Avenue Armadale, approximately 100 metres from where his body was found.

FINDINGS

30 Having investigated the death of George Germanos and having held an Inquest in relation to his death on 16 June 2016, at Melbourne, make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was George Germanos, born 10 December 1959; and

(b) that Mr Germanos died on 22 March 2001, at Inverness Park, Armadale from multiple gunshot injuries, in the circumstances described above at paragraphs 26-29.

(c) that despite an extensive criminal investigation conducted by Victoria Police, no person has been identified to date as being responsible for causing Mr Germanos' death. On that

basis, I am satisfied that no investigation which I am empowered to undertake, would be likely to result in the identification of the person or persons who caused Mr Germanos' death.

31 I note that in the future, if new facts and circumstances become available, section 77 of the *Coroners Act 2008* 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 that time.

32 I convey my sincerest sympathy to Mr Germanos' family and friends.

33 Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

(a) Mr Germanos' family, senior next of kin.

(b) Detective Leading Senior Constable Ben Kelly, Victoria Police, Coroner's Investigator.

(c) Detective Inspector Michael Hughes, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 17 June 2016