IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 1998 2331

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**GIANNI (JOHN) FURLAN**
Delivered on:	31 August 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	31 August 2017
Counsel assisting the Coroner:	Leading Senior Constable King Taylor, Police Coronial Support Unit
Representation:	Nil
Catchwords:	Homicide, no person charged with an indictable offence in respect of a reportable death, mandatory inquest

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HER HONOUR:

BACKGROUND

1. Gianni (John) Furlan (**Mr Furlan**) was born in Italy on 17 May 1950. In 1957, Mr Furlan immigrated to Australia with his mother, Amabile Furlan and step-father, Zarko Filipec.

2. Mr Furlan had two children from a de facto relationship. At the time of his death, Mr Furlan was not in a relationship and he lived alone in a single-fronted weatherboard home in Sydney Road, Coburg North.

3. Mr Furlan was self-employed and operated a car wrecking yard located at 47 Sages Road, Glenroy. He also was the owner of two commercial properties that he leased.

4. Mr Furlan is reported to have been a hard and aggressive business man, which resulted in a number of disgruntled customers making claims against him through the Small Claims Tribunal.

5. On 20 November 1996, Mr Furlan was convicted and fined $1,000.00 after the Office of Fair Trading (now known as Consumer Affairs Victoria) prosecuted him in relation to illegal motor car trading.

6. Mr Furlan is also reported to have made allegations to Consumer Affairs Victoria regarding other persons he believed to have engaged in illegal motor car trading. As a result of the information supplied by Mr Furlan, a person was charged by Consumer Affairs Victoria for tampering with odometer readings.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. At the time of Mr Furlan's 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 Furlan's death constituted a '*reportable death*' under the *Coroners Act 1985* (Vic), as his death occurred in Victoria, was violent, unexpected and not from natural causes.[2]

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[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.*

8. 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.

9. 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.

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

11. For coronial purposes, the phrase "*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.

12. 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.

13. 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.

14. 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

[3] Section 89(4) *Coroners Act 2008*
[4] *Keown v Khan* (1999) 1 VR 69

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.

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

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

15. On 4 August 1998, Dr A. J. Hill, Honorary Senior Forensic Odontologist to the Victorian Institute of Forensic Medicine compared ante-mortem dental records of John Furlan and confirmed that the Deceased person was Gianni (John) Furlan.

16. Identity is not in dispute in this matter and requires no further investigation.

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

17. On 3 August 1998, Dr David Ranson (**Dr Ranson**), a Deputy Director, Head, Division of Forensic Pathology (as he then was), practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Furlan's body. Dr Ranson subsequently provided a written report which concluded that Mr Furlan died from a percussive injury (blast damage).

18. I accept the cause of death proposed by Dr Ranson.

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

19. On Monday 3 of August 1998, at approximately 8.35am, Mr Furlan was driving his white Subaru Liberty sedan motor vehicle with Victorian registration OLV-130 in a northerly direction along Lorensen Avenue, Coburg North, when it exploded, killing him.

20. At the time of the explosion, Mr Furlan was the only occupant of the vehicle and he was taking his usual route from his home address in Sydney Road, Coburg North via the Merlynston Newsagency, to his auto wrecking business premises situated in Sages Road, Glenroy.

[5] (1938) 60 CLR 336

VICTORIA POLICE HOMICIDE INVESTIGATION

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

22. Mr Furlan's death was initially investigated by the Homicide Squad and then transferred to the Arson and Explosives Squad. Despite this investigation, no person or persons have been charged with indictable offences in connection with Mr Furlan's death.

23. 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.*"

24. 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.[7]

25. 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.

26. In this case, I acknowledge that the Victoria Police, through the Arson and Explosives Squad, has conducted an extremely thorough investigation in this matter.

27. In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Furlan's death is an unsolved and open homicide case.

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[6] (2012) VSCA 327
[7] *Perre v Chivell* (2000) 77 SASR 282

28. The Coroner's Investigator, Detective Sergeant Paul Tierney, has provided a statement to the Court in relation to this matter.

29. The confidential nature of the Victoria Police's ongoing investigation prevents me from reciting each and every matter which has been established by the Arson and Explosives Squad. However, Detective Sergeant Paul Tierney's statement indicates that the following important matters have been established and are able to be disclosed:

    (a) that despite an extensive criminal investigation by Victoria Police, no person or persons have been charged with an indictable offence in relation to Mr Furlan's death; and

    (b) that in 2000, Victoria Police announced a reward of up to $100,000 for information that may lead to a conviction in relation to Mr Furlan's death. To date, the reward offered has not been paid to any person;

    (c) that the homicide investigation into Mr Furlan's death is ongoing and the Arson and Explosives file remains open.

FINDINGS AND CONCLUSION

30. Having investigated the death of Gianni (John) Furlan and having held an Inquest in relation to his death on 31 August 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Gianni (John) Furlan;

    (b) that Gianni (John) Furlan died on 3 of August 1998, on Lorensen Avenue, Coburg North, from a percussive injury (blast damage); and

    (c) that the death occurred in the circumstances set out above;

    (d) that despite an extensive criminal investigation conducted by Victoria Police, no person or persons have been identified, to date, as being responsible for causing Mr Furlan's 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 Furlan's death.

31. I note that in the future, if new facts and circumstances become available, 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 that time.

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

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

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

(a) Mr Furlan's family;

(b) Detective Sergeant Paul Tierney, Coroner's Investigator;

(c) Detective Inspector Michael Roberts, Officer in Charge of the Arson and Explosives Squad, Victoria Police; and

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

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 31 August 2017