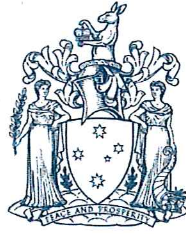

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 2013

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**SAVANNAH EVE PRICE-MIHAYO**
Date of birth:	30 October 2009
Date of death:	20 April 2014
Cause of death:	Undetermined
Place of death:	32 Longmuir Road, Watsonia, Victoria
Catchwords	Family violence homicide; death resulted directly from injury; was unexpected, violent, and not from natural causes

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HER HONOUR:

BACKGROUND

1. Savannah Eve Price-Mihayo (**Savannah**) was a 4-year-old girl, who lived with her mother, Amelia Price (**Ms Price**), and her 3-year-old sister, Indianna,[1] at the time of her death. Savannah and Indianna also regularly spent time with their father, Charles Mihayo (**Mr Mihayo**), at his home, including overnight periods.

2. Savannah and Indianna were described as "*two of the happiest girls*" who were best friends with "*unforgettably curly hair*" and "*infectious smiles*". They were described as affectionate, considerate and polite and as both having a great sense of humour. They dressed themselves identically and were often mistaken for twins.

3. Savannah was due to start school in the year after she died and was learning to write her name. She loved face painting and the colours pink and purple. Her favourite toy was a dinosaur wearing a tutu.

4. Savannah and Indianna's parents, Mr Mihayo and Ms Price, had separated in September of 2012 and had disputed the children's living arrangements since then. Mr Mihayo and Ms Price had attended dispute resolution and engaged in mediation to reach an agreement regarding the children's living and care arrangements. The relationship between Mr Mihayo and Ms Price was discordant and Mr Mihayo had expressed hostility and been threatening toward Ms Price regarding his ongoing dissatisfaction with their agreed parenting arrangements.

5. Savannah and Indianna both died on 20 April 2014, after Mr Mihayo suffocated them during a visit with him at his home.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Savannah's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and resulted directly from injury and was unexpected, violent and not from natural causes.[2]

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[1] Indianna Grace Price-Mihayo COR 2014 2014.

[2] Section 4 *Coroners Act 2008.*

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4]

8. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

9. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mechanism of death.

10. 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 of the circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate to be considered relevant to the death.

11. 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.

12. 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.

13. 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

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3 Section 89(4) *Coroners Act 2008.*
4 See Preamble and s 67, *Coroners Act 2008.*
5 *Keown v Khan* (1999) 1 VR 69.

Briginshaw v *Briginshaw*.[6] 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. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

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

15. On 22 April 2014, Savannah Eve Price-Mihayo's identity was confirmed through dental record comparison.

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

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

17. On 21 April 2014, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Savannah's body and provided a written report, dated 23 July 2014. In that report, Dr Baber concluded that a reasonable cause of death was '*Undetermined*'.

18. Dr Baber made a number of comments in relation to her anatomical findings, but concluded:

    "On the basis of the pathological examination alone, I am unable to arrive at a medical cause of death. The paucity of autopsy findings could support smothering, drowning or a combination of both (emphasis added)".

19. Toxicological analysis of the post mortem samples taken from Savannah were negative for common drugs or poisons.

20. I accept that it is not possible to determine to the standard of proof required in this jurisdiction, whether Savannah died by smothering or drowning, but that either or both are the mechanism by which the death occurred.

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[6] (1938) 60 CLR 336.

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

21. On 20 April 2014, Mr Mihayo sent Ms Price a text message, asking to see Savannah and Indianna and stating that he wanted to 'say goodbye' as he had decided he was not going to see the children anymore. Ms Price agreed that Mr Mihayo could see the children, but tried to arrange for him to spend time with them at her father's house. Mr Mihayo refused to attend Ms Price's father's home and Ms Price eventually agreed to take the children to Mr Mihayo's residence. Mr Mihayo lived in a small flat located at the back of the home of Ms Price's grandmother, Margaret Mills (**Ms Mills**).

22. When they arrived, Ms Price expressed concern about the children not understanding what he meant by saying goodbye. Mr Mihayo and the children went inside Mr Mihayo's home and he closed the door. Ms Price went into her grandmother's home to spend time with her while the children were with their father.

23. Approximately 20 minutes later, Savannah ran out to the back verandah. Savannah was dressed in a '*white princess dress*', which Mr Mihayo had purchased for her that day. Ms Price then heard Mr Mihayo call Savannah back into his home, saying "*you can show them in 10 minutes*".

24. At 2.35pm, Mr Mihayo telephoned emergency services, stating that he wanted to "*report a double murder*". He said that there were "*two people dead*" and gave the address, requesting that emergency services get there as quickly as possible.

25. Ms Price and Ms Mills overheard the children laughing and singing until, shortly prior to 2.40pm, they noticed that it had become quiet. Ms Price stated that she immediately became concerned because Savannah and Indianna were never quiet.

26. At this time, Ms Price went out and knocked on Mr Mihayo's door. She noticed that the security screen door was locked. Mr Mihayo called out "*just a minute*". Ms Price knocked again and Mr Mihayo responded "*let me know when they get here*". Ms Price replied "*who?*" to which Mr Mihayo said "*you'll know when they get here*".

27. Ms Price, who was concerned that Mr Mihayo had harmed the children, ran straight into Ms Mills' house and immediately telephoned the police to report her concerns. The time was 2.44pm. The police arrived shortly thereafter, while Ms Price was on the telephone to the emergency services operator.

28. Police officers called Mr Mihayo's name and asked him to come out of his house. As he did so, Mr Mihayo stated "*I've killed my two children*".

29. After securing Mr Mihayo, police officers entered the unit and found Savannah and Indianna, deceased, inside the unit.

30. Ambulance officers were also in attendance and attempted CPR on both children for approximately 45 minutes, along with drug therapy. A defibrillator was applied, which showed asystole (pulseless, with no electrical activity). At approximately 3.36pm, resuscitation was ceased on both children and Savannah and Indianna were each declared deceased.

31. Mr Mihayo later told police officers that he had smothered the children with a pillow and then bathed them before telephoning the police.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Criminal proceedings

32. Mr Mihayo was arrested at the scene and later charged with murder in relation to Savannah and Indianna's deaths.

33. At his committal hearing on 22 August 2014, Mr Mihayo pleaded guilty to two counts of murder and, on 5 November 2014, was convicted of murder in relation to both deaths.

34. On 18 December 2014, he was sentenced to life imprisonment with a minimum term of 31 years' imprisonment.

35. Justice Lasry remarked that:

"*Killings like this are subject to regular public discussion, and so they should be, because they are hideous crimes devoid of any form of justification or proper explanation. To the extent that, by enquiry and analysis, there can be identified an understandable pattern of reasons why parents, usually men, murder their children in circumstances of marital conflict, that pattern needs to be understood so that such events can be stopped or substantially reduced in number*;" and

"*Our community continues to be shocked by the actions of fathers like you killing their children in an atmosphere of marital discord ... It is difficult to think of more serious murders. Vulnerable and trusting children being killed by someone who professes to love*

them. It is a terrible breach of trust."

Family violence

36. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by a person within an intimate personal relationship is particularly shocking, given that it is expected to be a place of trust, safety and protection. The death of a child at the hands of a parent, whose role it is to ensure that child's safety and protection, is simply unspeakable.

37. For the purposes of the *Family Violence Protection Act 2008* (Vic), the intimate personal relationship between Mr Mihayo and his daughters, Savannah and Indianna, was one that fell within the definition of '*family member*'. Savannah and Indianna's deaths occurred in the context of a hostile child custody dispute between their parents, following Mr Mihayo and Ms Price's separation in September 2011. Mr Mihayo had previously threatened to kill Ms Price and had been controlling, verbally abusive and threatening toward her in the period since they separated. Mr Mihayo's actions, in killing Savannah and Indianna, were acts of filicide.[7] On this basis, both Savannah and Indianna's deaths were considered to have occurred in the context of family violence.

38. As a result, I requested that the Coroners Prevention Unit (**CPU**)[8] examine the circumstances of Savannah and Indianna's deaths as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[9]

39. The CPU identified the presence of known risk factors for family violence, including an acrimonious separation and conflict in parenting and child custody and care negotiations.

<u>Child custody and care negotiations</u>

40. The CPU identified that, prior to February 2014, Mr Mihayo and Ms Price engaged in mediation with a Family Dispute Resolution (**FDR**) practitioner on three occasions in person and by telephone on one occasion, through the Relationships Australia Family Relationships Centre at Greensborough (**Greensborough FRC**).

[7] Filicide is the act of a parent killing their own child.

[8] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[9] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian community.

41. On 14 September 2011, Mr Mihayo contacted the Greensborough FRC for support in relation to reaching a child custody agreement with Ms Price, but later advised that he and Ms Price had reached agreement on their own. As such, the Greensborough FRC closed the case.

42. Later that year, Ms Price and Mr Mihayo accessed the Greensborough FRC's mediation services. Mr Mihayo and Ms Price both attended and they were able to reach a parenting agreement. Mr Mihayo and Ms Price agreed that the children would live with Ms Price and Mr Mihayo would have the children in his care every weekend, from Friday evening through to Monday morning. Subsequently, on 10 April 2012, the Greensborough FRC closed their file.

43. In January 2013, Ms Price contacted the Greensborough FRC and advised that Mr Mihayo had threatened her. The Greensborough FRC encouraged Ms Price to seek a Family Violence Intervention Order (**FVIO**). The Greensborough FRC did not engage with the couple further at this time, due to the safety concerns raised by Ms Price and because there was no FVIO in place.

44. In February 2014, Ms Price and Mr Mihayo again engaged the Greensborough FRC to resolve their ongoing dispute over the children's custody and access. Mr Mihayo did not attend his scheduled appointment on 7 April 2014 and it was rescheduled for 28 April 2014.

45. On 10 April 2014, Ms Price attended the Greensborough FRC for an individual appointment. At this appointment, Ms Price stated to the workers that she was concerned that Mr Mihayo had been "*triggered*" by a recent child homicide, which was an act of filicide by the father. The CPU believes the child homicide to be the death of Luke Batty, some two months prior. The staff responded to Ms Price's concerns by encouraging her to '*rely on her gut instinct*'.

46. Child custody agreements reached in informal mediation, such as those agreed through a FDR service, are not legally binding. As such, each party can informally and unilaterally vary the agreement. The evidence indicates that Mr Mihayo's killing of Savannah and Indianna was motivated by his strong hostility toward Ms Price over the children's custody and care arrangements; which intensified in an atmosphere of long-standing marital and ex-marital discord.

47. The evidence shows that Mr Mihayo had become increasingly frustrated by the terms of the children's custody and care arrangements that had been agreed at mediation in 2012.

Mr Mihayo viewed his weekend care of the children as a 'babysitting' role, one which he asserted allowed Ms Price to have personal freedom on weekends. Mr Mihayo expressed that he believed the children's custody and care arrangements to be for Ms Price's convenience, rather than being made in the children's best interest.

48. Ms Price stated that Mr Mihayo's unstable, erratic and threatening behaviour had caused her to change the care arrangements that they had agreed in 2012. Mr Mihayo reportedly believed, however, that he was being unfairly excluded from parental decision-making.

49. Having identified service contact with a FDR service in the period proximate to the deaths, the CPU assessed the adequacy of the services' response to the identified risks.

50. The website for Greensborough FRC states they are able to:

    (a) provide information, advice, group sessions and dispute resolution to help people reach agreements; and

    (b) make referrals to services in their area.

51. It is unclear in the Greensborough FRC's statement that the services and support provided by the Greensborough FRC included a comprehensive risk assessment for either party, provision of information on identifying safety concerns and referrals to support services for intervention.

52. The CPU reviewed the information provided by the Greensborough FRC and identified gaps in their practice when they implemented the Common Risk Assessment Framework (**CRAF**). By telling Ms Price to rely on her gut instinct, in relation to her concerns regarding the recent child homicide, the Greensborough FRC transferred decision-making and safety planning back to Ms Price, with limited information about how to manage her concerns.

53. The CPU identified that service provision to Ms Price by the Relationships Australia run Greensborough FRC could have been improved at the time by a comprehensive implementation of the CRAF, in particular the use of the Aide Memoir within its policies and procedures. Using the Aide Memoir could have assisted staff to highlight the risk that Mr Mihayo posed to Ms Price and the children and enabled them to assist Ms Price to create a safety plan to manage the risk.

54. The CPU considers that Greensborough FRC staff member's response could have been strengthened through a conversation that identified strategies, such as ensuring that

Mr Mihayo's contact with the children was fully supervised by another adult at all times. There was no evidence of these or any other strategies being discussed with Ms Price.

55. Although Savannah and Indianna were not victims of family violence before the fatal incident, if Ms Price's concerns about Mr Mihayo's recent trigger of Luke Batty's death had been given more weight in the Greensborough FRC's risk assessment, then Ms Price may have taken steps to ensure the children's safety on 20 April 2014.

Victorian Royal Commission into Family Violence (**Royal Commission**)

56. Due to the specific risks associated with child custody or care disputes, it is particularly important that persons working in FDR and FRC centres, particularly in relation to parenting disputes and arrangements, have appropriate knowledge and expertise in family violence. This issue was considered in the Royal Commission into Family Violence, where there were three relevant recommendations:

(c) Recommendation 1: The Victorian Government review and begin implementing the revised Family Violence Risk Assessment and Risk Management Framework (known as the 'CRAF') [by 31 December 2017], in order to deliver a comprehensive framework that sets minimum standards and roles and responsibilities for screening, risk assessment, risk management, information sharing and referral throughout Victorian agencies. The revised framework should incorporate:

(i) a rating and/or weighting of risk factors to identify the risk of family violence as 'low, medium or high';

(ii) evidence-based risk indicators that are specific to children; and

(iii) comprehensive practice guidance.

The framework should also reflect the needs of the diverse range of family violence victims and perpetrators, among them older people, people with disabilities, and people from Aboriginal and Torres Strait Islander, culturally and linguistically diverse and lesbian, gay, bisexual, transgender and intersex communities.

(d) Recommendation 22: The Victorian Government amend the *Family Violence Protection Act 2008* (Vic) to establish a rebuttable presumption that, if an applicant for a family violence intervention order has a child who has experienced family violence, that child should be included in the applicant's family violence intervention order or

protected by their own order [within 12 months].

(e) Recommendation 182: The Victorian Government and other relevant parties, in designing the recommended Statewide Family Violence Action Plan and implementing the Commission's other recommendations:

   (i) give priority to reducing family violence in rural, regional and remote communities;

   (ii) improve access to services by victims and perpetrators of family violence in such communities;

   (iii) investigate and fund the use of technological solutions to provide access to service providers—among them those with experience in safety planning and counselling;

   (iv) when contracting for and funding services in these communities, recognise:

      1. the importance of building the capacity of universal services to deliver family violence services in order to facilitate an effective, locally based response; and

      2. the need for flexibility in contracting and funding arrangements in order to facilitate collaboration between different services and providers.

57. I support the relevant Royal Commission recommendations.

Filicide

58. The CPU searched the Victorian Homicide Register and identified that 88 Victorian children have been killed by their parent/step-parent.[10] Amongst these, seven deaths occurred in the context of a child custody dispute, arising from four separate incidents. A further three people have died in the context of a child custody or care dispute, including intimate partner and other intimate or familial relationships.

59. Professor Ogloff presented expert evidence at the inquest into the death of Luke Batty[11] regarding filicide.[12] It was concluded that there is no validated actuarial tool available to

[10] In the period that the Homicide Register has been operational.
[11] COR 2014 0855.
[12] The deliberate act of a parent killing their own child.

predict filicide. In that context, it was not possible for anybody to predict the deaths of Savannah and Indianna.

60. Some literature[13] highlights that 'Spousal revenge' killers (sometimes called "*retaliation killers*" or "*Medea Complex 1 killers*") appear to kill their child/ren out of a desire to cause harm to the child's other parent. While it is widely acknowledged that the killing seems to arise from misdirecting rage from the spouse to the child and the dehumanization of the child, there are no adequate explanations of why this occurs.[14] Ms Price's friend described it as "*incomprehensible*" that Mr Mihayo would hurt Savannah and Indianna. Indeed, to all persons other than the perpetrator, filicide is a completely senseless and incomprehensible act.

61. Investigations identified that Mr Mihayo had researched the term "*ways to kill your wife*" in the weeks leading the fatal incident. He had also previously threatened Ms Price that he would "*slit (her) throat*". I note that only four days prior to Savannah and Indianna's deaths, on 16 April 2014, Ms Fiona Warzywoda had been killed by her former partner in the setting of an ongoing child custody dispute. There are, of course, many other examples of deaths of persons (usually female) at the hands of an intimate (or previously intimate) partner. With this background, and considering that filicide is unpredictable, it would have been more reasonable for those close to Ms Price to expect that she, rather than the children, may be the victim of a violent act by Mr Mihayo.

'*Say Something*' campaign

62. The VSRFVD also noted that Savannah and Indianna's deaths occurred in circumstances whereby friends and family identified having witnessed family violence between Mr Mihayo and Ms Price, in the form of emotional abuse, and of holding real concerns about Mr Mihayo's contact with Savannah and Indianna on 20 April 2014.

63. Ms Price's father, Brian Price, stated that when Ms Price advised him that Mr Mihayo wanted to 'say goodbye' to the children, he was so concerned that he and his wife drove to shops near to Mr Mihayo's residence, "*in case Amelia needed me for anything*".

64. Ms Mills stated that when Ms Price told her that Mr Mihayo wanted to 'say goodbye' to the children, she felt so worried that she mentioned it to her neighbour. The neighbour advised Ms Mills that she would be around "*in case anything goes wrong*". Ms Mills also expressed

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[13] G. Carruthers, 2013, 'Making sense of spousal revenge filicide', *Aggression and Violent Behavior* 29 (2016) 30–35.
[14] Ibid.

her concerns to her daughter on 20 April 2014, when she telephoned from Queensland.

65. Ms Price's close friend, Keryn Arrowsmith, stated that Mr Mihayo had been threatening and abusive toward Ms Price, but never toward the children. Her statement supported the apparently generally held position that Mr Mihayo was a potential threat to Ms Price's safety, but nobody close to Ms Price or the children believed Mr Mihayo would have ever harmed Savannah or Indianna.

66. Previously, Coroners have made comments and recommendations in relation to the under-reporting of family violence out of concern for possible repercussions for the victim and a perception that outside involvement may exacerbate a situation (which the victim appears to be managing).

67. In the Finding into the death of Nicole Joy Millar,[15] the then State Coroner, Judge Ian Gray,[16] recommended that Victoria Police, together with Crime Stoppers, conduct a trial extending the '*Say Something*' campaign to family violence. Crime Stoppers is a not-for-profit that relies substantially on government crime prevention grants for project and campaign delivery costs. I have noted in recent findings into deaths that occurred as a result of family violence,[17] that in its response to Judge Gray's recommendation, Crime Stoppers highlighted budgetary constraints as a barrier to implementing this action. Crime Stoppers recently advised the Court that it has been unsuccessful in securing the required funding.

68. A public awareness campaign promoting the definition of family violence in the broader community may assist family and friends of victims of family violence to better understand what constitutes family violence. Such a campaign may also assist them to identify when people are at risk and encourage them to seek assistance.

Relevant coronial recommendations

69. The findings into the deaths of Darcey Iris Freeman[18] and Luke Batty[19], which are both cases of filicide following separation and child custody and care disputes, are relevant to the deaths of Savannah and Indianna Price-Mihayo. A number of the recommendations in the finding into the death of Luke Batty are relevant to this investigation.

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[15] COR 2010 2064.
[16] Judge Ian Gray retired as the State Coroner in December 2015.
[17] Investigations into the deaths of Stuart Rattle (COR 2013 5647) and Drew Dax (COR 2015 0188).
[18] COR 2009 0447.
[19] COR 2014 0855.

70. In His Honour's finding into the death of Luke Batty, then State Coroner, Judge Ian Gray, recommended that:

> *"following a validation of the CRAF, all agencies operating in the area of family dispute resolution should integrate use of the CRAF to accurately identify risks to a person and to any relevant children and give greater weight to the victim/s' level of fear."*

71. This approach is considered to assist in understanding the level of risk of further or escalating family violence.

72. As mentioned above, the Greensborough FRC's service provision to Ms Price, prior to the children's deaths, could have been enhanced by a comprehensive implementation of the CRAF, in particular by the use of the Aide Memoir. I note that, since the deaths, Relationships Australia has updated their FRC policies and procedures to include the Aide Memoir.

73. I understand that Relationships Australia is currently reviewing their FRC policies and I consider that the community would be well served by the continued inclusion of the CRAF in Relationships Australia's FRC policies. As with all good policy implementation, this would be best reinforced, practically, through continuing professional development of staff members.

74. In the course of my investigation, I have not identified any other missed opportunities to prevent the fatal event.

75. I am satisfied, having considered all of the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION

76. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Savannah Eve Price-Mihayo, born 30 October 2009;

    (b) the death occurred on 20 April 2014, at 32 Longmuir Drive, Watsonia, Victoria;

    (c) the medical cause of death is undetermined but is consistent with either suffocation or drowning; and

(d) the death occurred in the circumstances set out above.

77. I convey my heartfelt condolences to Savannah and Indianna's family and friends at their tragic and untimely deaths in 2014.

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

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

(a) Amelia Price, senior next of kin.

(b) Detective Sergeant Steve Martin, Victoria Police, Coroner's Investigator.

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

(d) Greensborough Family Relationship Centre.

(e) Relationships Australia.

Signature:

JUDGE SARA HINCHEY
STATE CORONER

DATE: 14 FEBRUARY 2017