IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 4552

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:	**SNEZANA STOJANOVSKA**, born 16 January 1984
Delivered on:	30 July 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	16-20 July 2018
Counsel assisting the Coroner:	Ms Barbara Myers
Representation:	Paul D'Arcy, instructed by Robert Galbally of Galbally Rolfe, for Dragi Stojanovski Joshua Taaffe, instructed by Andrew George of Doogue and George Lawyers, for Vasko Stojanovski and Pisana Stojanovska Lisa Papadinas, instructed by Slater & Gordon, for the Kiklevski family
Catchwords:	Suspected homicide; death resulted directly from injury, was unexpected, violent and not from natural causes; notification to the Director of Public Prosecutions that the coroner believes an indictable offence was committed in relation to the death

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HER HONOUR:

BACKGROUND

1. Snezana Stojanovska (**Ms Stojanovska**) was 26 years old when she died at 14 William Street, Preston, in the home that she shared with her husband, Dragi Stojanovski (**Mr Stojanovski**), her mother-in-law, Pisana Stojanovska (**Pisana**), and her brother-in-law, Vasko Stojanovski (**Vasko**).

2. Ms Stojanovska left school at 16 years old to pursue a career in hairdressing. She had a good reputation with staff and customers at '*Cuts only*,' where she had worked for 18 months prior to her death. Ms Stojanovska was considered to be a very good hairdresser. Her colleagues described her as '*always smiling*' and an excellent, hard-working person.

3. Ms Stojanovska met Mr Stojanovski at a Macedonian nightclub when she was 18 years old. They were married in 2004 and she moved into his home on return from their honeymoon. Ms Stojanovska lived with her parents and siblings prior to marrying Mr Stojanovski. Ms Stojanovska was close to her family and enjoyed spending time with her two nephews, often expressing a desire to have her own children. In the weeks before she died, Ms Stojanovska told her manager at work that she hoped to start a family the next year.

4. Ms Stojanovska was in good health and did not suffer from any major medical problems. She had signs of mild, inactive asthma and suffered from the thyroid condition, Graves' disease.

5. Ms Stojanovska was pregnant at the time of her death. On Friday, 26 November 2010, she attended the Murray Road Medical Centre and had blood taken for a pregnancy test, to confirm the results of her positive, at-home pregnancy test. She booked an appointment for 11.30am on Sunday, 28 November 2010, to review the results of the blood test.[1]

THE PURPOSE OF A CORONIAL INVESTIGATION

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

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

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1 *ibid* at pages 1171 – 1172
2 Section 4 *Coroners Act 2008*

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,[6] or to determine disciplinary matters.

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

10. For coronial purposes, the phrase "*circumstances in which death occurred*,"[7] 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.

11. I note the observations of the Victorian Court of Appeal in *Priest v West*,[8] 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*."

12. 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.[9]

13. 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

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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
6 Section 69 (1)
7 Section 67(1)(c)
8 (2012) VSAC 327
9 *Perre v Chivell* (2000) SASR 282

the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

14. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[10]

    (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;[11] 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.[12] These powers are the vehicles by which the prevention role may be advanced.

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[13] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[14] 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.

16. 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.

REQUIREMENT TO HOLD AN INQUEST

17. Section 52(2) of the *Coroners Act 2008* provides the circumstances under which it is mandatory for a coroner to hold an inquest into a death. One of those circumstances is where a coroner suspects the death was a homicide and no person or persons have been charged with an indictable offence in respect of the death.

18. I suspected that Ms Stojanovska's death was the result of homicide. As no person or persons had been charged with an indictable offence in respect of the death, it was mandatory to hold an inquest.

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10 Section 72(1)
11 Section 67(3)
12 Section 72(2)
13 *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
14 (1938) 60 CLR 336

19. On 19 April 2018, I opened the inquest and made directions as to the future conduct of the matter.

20. At a further directions hearing on 17 May 2018, Mr Stojanovski made application pursuant to s.57 of the Act to be excused from giving evidence at the inquest. In summary, he objected to giving evidence on the grounds that his evidence may tend to prove that he has committed an indictable offence. I found that there were reasonable grounds for the objection. I informed Mr Stojanovski that he would be granted a certificate pursuant to s.57(5) of the Act if he gave evidence, and as to the effect of the certificate. Mr Stojanovski continued to decline to give evidence willingly. Having heard submissions from all relevant parties as to matters concerning the "*interests of justice*" as they related to the application, I granted Mr Stojanovski's application to be excused from giving evidence and provided written reasons for that ruling on 23 May 2018.

21. At a further directions hearing on 12 July 2018, Vasko and Pisana each made an application pursuant to s.57 of the Act, to be excused from giving evidence at the inquest on the grounds that their evidence may tend to prove that they had committed an indictable offence. After hearing submissions, I granted those applications and provided written reasons for those rulings on 17 July 2018.

22. The inquest commenced on 17 July 2018. Six witnesses were called and cross-examined over two days. On 19 July 2018, I heard closing submissions from Counsel.

23. This finding does not purport to recite all of the evidence heard at the inquest, only that which is relevant to the findings which I am required to make under the Act, namely identity, cause of death and the circumstances in which the death occurred.[15]

SCOPE OF THE INQUEST

24. Ms Stojanovska's identity was not in dispute and required no further investigation. The medical cause of death was not disputed and was stated to be asphyxia secondary to neck compression. The primary issue relating to the cause of death is whether the neck compression was caused by entrapment by the barbell and weights or some other means.

25. In the circumstances where Mr Stojanovski's explanation for the injuries did not accord with the medical evidence relating to the injuries, it was necessary to inquire as to the mode or

[15] Section 67

manner of neck compression. It was submitted by counsel assisting me and I accepted, that this was a matter to be determined as part of the circumstances in which the death occurred.

26. The agreed scope of the inquest was as follows:

    (a) the cause of death – what injuries caused the death and what explanation is there for the injuries;

    (b) the time of death;

    (c) the chronology of events leading to the death (the circumstances in which the death occurred); and

    (d) the identity of any persons involved in the death.

27. The following witnesses gave evidence at the inquest:

    (a) Dr Malcolm Dodd (**Dr Dodd**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, who performed the autopsy upon Ms Stojanovska's body;

    (b) Dr Harry Brennan (**Dr Brennan**), a Sports Science and Physical Preparation Co-ordinator at the Victorian Institute of Sport, who provided an expert opinion to the Court;

    (c) Cullen Hamilton (**Mr Hamilton**), Ambulance Victoria paramedic, who attended the emergency call to Ms Stojanovska at 11.14am on 28 November 2010;

    (d) Harry Higney (**Mr Higney**), a resident of William Street, Preston;

    (e) Sergeant Justin Stanton (**Sgt. Stanton**), a police officer who was then stationed at the Darebin Crime Investigation Unit and who attended the scene on 28 November 2010; and

    (f) Detective Acting Sergeant Scott Riley (**D/A/Sgt. Riley**), a detective at the Homicide Squad and the Coroner's Investigator since 2015.

28. This finding is based on the totality of the material which was the product of the coronial investigation into Ms Stojanovska's death. This includes the Coronial Brief, the oral evidence

of all the witnesses who testified at inquest, each of the documents tendered during the inquest and the matters contained in the final submissions of Counsel.

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

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

29. On 28 November 2010, Vasko Stojanovski identified Ms Stojanovska's body to be that of his sister-in-law, Snezana Stojanovska, born 16 January 1984.

30. As set out above, 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 Act

31. On 2 December 2010, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Stojanovska's body. Dr Dodd provided a written report, dated 8 February 2011, which contained the following observations:

    (a) Ms Stojanovska had an abrasion to her neck area, which extended from the middle towards the left side of the neck and a superficial abrasion to the centre of her upper chest. There was no bruising under the skin associated with these abrasions;

    (b) Ms Stojanovska had scattered areas of bruising beneath the right and left areas of the jaw and beneath the left ear, which was visible externally and had associated haemorrhaging under the skin;

    (c) during the internal examination of the neck area, deep haemorrhaging was located to the left and right side of the neck;

    (d) Ms Stojanovska had petechial haemorrhaging to her face, which is consistent with asphyxiation;

    (e) Ms Stojanovska's hyoid bone and larynx were intact;

    (f) Ms Stojanovska was approximately 12 weeks pregnant;

    (g) there was no apparent evidence of significant, naturally-occurring disease which would lead to a sudden collapse and subsequent asphyxia due to compression of the barbell and weights; and

(h) the multiplicity and distribution of the bruises on the skin of the neck and chin and superficial and deep strap muscles is not in accord with an uncomplicated entrapment by the barbell and weights.

32. Dr Dodd concluded that Ms Stojanovska died from asphyxia and compression of the neck. He provided an opinion as to the mechanism of the death, which I will discuss in detail in relation to the circumstances in which the death occurred.

33. Toxicological analysis of post mortem specimens taken from Ms Stojanovska was negative for common drugs and poisons.

34. I accept the cause of death proposed by Dr Dodd.

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

35. On Saturday, 27 November 2010, Ms Stojanvska worked from approximately 9.00am to 5.00pm. She then had a meeting at work, which finished at about 5.30pm. After the meeting, Ms Stojanovska returned home to 14 William Street, Preston, and changed into her pyjamas and dressing gown.

36. Mr Stojanovski, Vasko and Pisana were also home that Saturday evening and overnight into Sunday morning, 28 November 2010.

37. According to the information given in their police interviews, Ms Stojanovska, Mr Stojanovski and Vasko watched television during Saturday evening. Ms Stojanovska and Mr Stojanovski did so in the dining/lounge area, near the stairs. Vasko watched television in the family room at the rear of the house before going to bed at approximately 10.00pm. Pisana appears to have been tidying.

38. Mr Stojanovski told police that he and Ms Stojanovska went to bed at approximately 10.00pm, having watched '*Hey! Hey! It's Saturday*.'

39. Pisana went to bed at about midnight and thought that Ms Stojanovska and Mr Stojanovski had gone to bed a short while before her.

40. At 11.14am on 28 November 2010, Vasko used the landline at the house to telephone emergency services and report Ms Stojanovska's death.[16] The call terminated prior to paramedics attending and the operator telephoned back to obtain further details. Pisana

[16] Coronial Brief pages 931 – 935

answered the telephone and spoke to the operator for a short time. Pisana then became distressed and Vasko then resumed speaking to the operator. At this time, the operator asked that someone remove the item from Ms Stojanovska's throat (the barbell). Vasko told Pisana to remove the weight from Ms Stojanovska's throat[17] and in the phone call, it is indicated that she did as she was directed, lifting the barbell and placing it on the seat directly above Ms Stojanovska's head.

41. At 11.20am, Ambulance Victoria paramedics, Joshua Grose and Cullen Hamilton (**the paramedics**), arrived at the scene.[18] Vasko directed them to the garage.

42. When they entered the garage, the paramedics saw Ms Stojanovska lying on her back, on an ironing board which was propped up on telephone books. Ms Stojanovska was wearing a T-shirt, pyjama pants, a dressing gown and had gloves on her hands. She was not wearing shoes, socks or a bra. Her pyjama pants were pulled down at the back, appearing to be caught on the ironing board.

43. A barbell with one five kilogram weight on each end was propped against a chair, which was positioned at the head of the ironing board. There were no collars on the barbell to hold the weightplates in place. A fruit box was on Ms Stojanovska's left side, with the barbell resting just behind it.

44. The paramedics found no signs of life. Ms Stojanovska's body was cold to the touch and rigor mortis had set in.

45. Mr Stojanovski was at Ms Stojanovska's feet and Pisana was at her left side. They were inconsolable and the paramedics had difficulty moving them away from Ms Stojanovska.

46. Despite the fact that the paramedics knew that Ms Stojanovska had been deceased for some time, as a means of appeasing the family members, the paramedics placed defibrillation pads on Ms Stojanovska's chest. To do this, Ms Stojanovska's shirt was raised. The paramedics did not move any other items of her clothing.

47. The paramedics did not make any resuscitative efforts and radioed to request police attendance.

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[17] Coronial Brief, p935
[18] *ibid* at pages 1135 - 1139 and 1155 - 1157

48. Victoria Police officers, Constables Erin Clark and Kellee Jordan, arrived shortly thereafter, at 11.31am.[19] Acting Sergeant Christopher Yates[20] arrived at the scene at 11.35am. At 11.42am, Detective Senior Constables Justin Stanton[21] and Timothy Lee arrived at the scene.

49. During the time that the paramedics were at the home, Vasko told paramedic Joshua Grose that he had tried to telephone a General Practitioner but could not get through.[22] I note that a telephone call was made to the High Street Medical and Dental Centre at Preston at 10.37am.[23] This was the only record of a telephone call being made to a GP by any member of the household prior to the emergency services call at 11.14am on Sunday, 28 November 2010. The next telephone call to a medical clinic was made at 11.28am, from the landline at 14 William Street, Preston, after the arrival of the paramedics.[24]

50. There were three possible means of entry/exit from the garage at 14 William Street, Preston:

    (a) a large panel lift/roller garage door leading to the driveway (**the garage door**);

    (b) an internal door from the entrance hall (**the internal door**); and

    (c) a doorway leading into the back yard which had both a wooden door (**the wooden door**) and external security screen door (**the security door**).

51. The paramedics, who were first to attend the scene at 11.20am, noted that the wooden door was open. They told Sergeant Yates that they had closed the wooden door and put defibrillation pads onto Ms Stojanovska but otherwise had not moved anything.

52. On arrival, Constables Clark and Jordan both noted that the garage door was closed. The police officers noted that all external doors to the house were locked and they found no signs of forced entry into the house. Detective Senior Constable Timothy Lee opened the wooden door and noted that the security door to the backyard was locked and there was no key present.

53. Photographs were taken at the scene whilst Ms Stojanovska's body was still in situ.

54. During the two-and-a-half hours that Victoria Police officers were at 14 William Street, Preston that day, Mr Stojanovski was in the lounge/dining room on all fours, sobbing and

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19 *ibid* at pages 26 – 28, 29 – 34 and 35 – 40
20 Now Sergeant Yates
21 Now Sergeant Stanton
22 Coronial Brief, p1138 - Statement of Joshua Grose dated 10 February 2011, paragraph 22
23 Coronial Brief, p1184
24 Coronial brief, p1178

wailing and at times vomiting. Victoria Police officers tried to speak to Mr Stojanovski to obtain an account of events, but they were unable to elicit a coherent response from him. Pisana was also in the lounge/dining room and it was not possible to obtain any information from her, due to her distress and language barriers. Vasko was in the kitchen area. He told police that he had last seen Ms Stojanovska between 9.00pm and 10.00pm the previous night, when she and Mr Stojanovski were watching television together, and that she often worked out in the garage. He stated that he was upstairs when he heard his mother scream and went down to enquire. It was then that he found out that Ms Stojanovska was dead.

55. Ms Stojanovska's death was reported to be a tragic weightlifting accident.

56. The homicide investigation into Ms Stojanovska's death did not start until 2 December 2010, when Dr Dodd advised Victoria Police that his autopsy findings were not consistent with the death being the result of an uncomplicated entrapment by the bar and weights.

57. On 3 December 2010, Victoria Police officers attended 14 William Street, Preston, and seized various items including the barbell, ironing board, six assorted books, a pair of five kilogram metal weight plates, a pair of gloves, two mobile telephones and a personal diary and laptop belonging to Ms Stojanovska.[25]

58. Mr Stojanovski, Vasko and Pisana were also interviewed that day.[26]

59. During his interview on 3 December 2010, Mr Stojanovski recounted his version of events of the night of 27 November and morning of 28 November and said that he had no concerns that someone else might be responsible for Ms Stojanovska's death. Mr Stojanovski reported to police officers:

    (a) that Ms Stojanovska had gone to bed at approximately 10.00pm the night before and when he awoke that morning, he found that she was not in bed;

    (b) he then remembered that Ms Stojanovska had said that she was going to get up early to exercise;

    (c) he went to the garage and saw Ms Stojanovska, apparently deceased, lying on a makeshift bench press with the barbell across her neck;

[25] *ibid* at pages 49 – 55
[26] *ibid* at pages 56 – 425

(d) he went into the garage and tried to remove the barbell from Ms Stojanovska's neck, but was unable to and started to feel faint;

(e) he crawled out of the garage and saw Pisana, who entered the garage and removed the barbell from Ms Stojanovska's neck, placing it against the chair behind the makeshift bench press; and

(f) his brother then telephoned triple zero.

60. During his interview, Vasko reported that he went to bed at approximately 10.00pm on the Saturday night. He said that Mr Stojanovski and Ms Stojanovska were watching television in the lounge area, near the stairs. He was awoken the next morning by Pisana's screams and, when he got downstairs, his mother told him that Ms Stojanovska was dead. Vasko said that he telephoned emergency services and that Pisana moved the barbell and weights whilst he was on the telephone to emergency services. He was on the telephone to emergency services when the paramedics arrived.

61. During her interview, Pisana said that:

(a) she last saw Ms Stojanovska alive when Mr Stojanovski and Ms Stojanovska went to bed shortly before midnight on the Saturday;

(b) the next morning, she was awoken by a frightening noise. She came downstairs slowly and found Mr Stojanovski lying face down on the floor;

(c) she immediately went to check whether the doors in the house were locked;

(d) whilst she did this, Mr Stojanovski remained on the floor, shaking;

(e) she was yelling "*what's wrong? What's wrong?*;"

(f) she opened the internal door to the garage and screamed when she saw Ms Stojanovska;

(g) she went to Ms Stojanovska and started shaking her, trying to move her and get her to respond;

(h) she was at the door of the garage when Vasko came downstairs;

(i) she moved the bar from Ms Stojanovska's neck when the emergency services operator asked her to but did not take any of the weights off the bar;

(j) the wooden door was open, but the security door was closed and locked; and

(k) it was her practice to check that all the doors and windows were locked each morning and night.

62. Pisana suffers from multiple medical conditions, including chronic pain syndrome affecting her arms, neck, back and legs, osteoarthritis and osteoporosis. Given her frail state, investigators doubted Pisana's physical ability to have moved the barbell and weights. However, I note that this is not a matter of great significance in that there are many reasons why people can and cannot do things in certain circumstances, such as in the event of a surge of adrenaline in situations of high emotion or stress.

63. Counsel for Vasko and Pisana made additional, written submissions on 20 July 2018, in which they stated that Pisana and Vasko's statements were entirely consistent with each other's. They referred to the relevant transcripts of interview in the Coronial Brief and reconstruction that Vasko participated in,[27] noting that Pisana and Vasko had never said that the barbell was balanced horizontally on Ms Stojanovska's neck and Vasko had stated that one end of the barbell was on the ground when he saw Pisana move the barbell off Ms Stojanovska's neck and onto the chair above her head.

64. I accept these submissions. I find that there is insufficient evidence before me to be satisfied to the Coronial standard as to the precise position of the barbell in relation to Ms Stojanovska's body, when she was found.

65. Analysis of the seized items revealed the following:

(a) the barbell loaded with two 5kg plates weighed 29.5kg;

(b) the Nokia 1661 mobile telephone belonged to Ms Stojanovska;

(c) the Nokia 1680 mobile telephone belonged to Mr Stojanovski. This mobile telephone contained details of a call made at 10.37am on 28 November 2010, to Dr Mario Marazita's Medical Clinic. Dr Marazita is Mr Stojanovski, Vasko and Pisana's General Practitioner. The telephone call did not connect. Records obtained from Optus confirm the details of this telephone call;[28] and

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[27] Coronial Brief, 172 at Q428, 562 – 6:37 into the video, 562 – 7:10 into the video, 563 – 7:32 into the video, 564 - 8:36 into the video

[28] *ibid* at pages 1182 – 1184

(d) Ms Stojanovska's diary contained notes of day-to-day activities, including work, exercise and training, music, movies and meals. The diary entries on 16 and 18 November 2010 appeared to have different characteristics to other entries in the diary. The entry on 18 November 2010 had the words "*interval training*" which are not used elsewhere in the diary. There were no exercise entries in the diary between 25 July 2010 and 16 November 2010.

66. The telephone call made on Mr Stojanovski's mobile phone to Dr Marazita's clinic at 10.37am on 28 November 2010 is significant. The telephone call to the clinic was made 35 minutes before the telephone call to emergency services. Vasko told paramedic Joshua Grose that he had tried to telephone a GP prior to deciding to call for an ambulance, but could not get through.[29] The only telephone call from Mr Stojanovski's mobile telephone on the morning of 28 November 2010 is the call placed at 10.37am, to the Stojanovski family's GP; a call which did not connect. If this is the same call that Vasko was referring to, it took place a significant period of time prior to the emergency services call he placed at 11.14am. Ambulance Victoria paramedics arrived at the scene within six minutes of the emergency services call and found no signs of life and the onset of rigor mortis. Ms Stojanovska's body was cold to the touch. These signs are evidence of the fact that Ms Stojanovska would not have been alive at the time that the call was made from Mr Stojanovski's mobile phone to the High Street Medical and Dental Clinic.

67. In February 2011, DNA testing determined that Mr Stojanovski was the father of Ms Stojanovska's baby.[30]

68. On 2 April 2011, Mr Stojanovski and Vasko were shown a reconstruction of the scene in the garage at 14 William Street, Preston, at St Kilda Road Police Complex. They were questioned further about the circumstances surrounding Ms Stojanovska's death. Pisana did not participate in the reconstruction.

69. On 11 April 2011, Mr Stojanovski and Vasko were arrested and interviewed by the investigators.

70. On 12 April 2011, Pisana was arrested and interviewed by the investigators.

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[29] See paragraph 49, herein
[30] *ibid* at pages 1132 – 1133

71. During his interview on 11 April 2011, Mr Stojanovski raised the possibility that Ms Stojanovska may have been killed by an intruder. He said that he thought someone had keys to their house.

72. On 25 September 2015, Victoria Police investigators obtained a statement from Dr Harry Brennan (**Dr Brennan**), a Sports Science and Physical Preparation Coordinator at the Victorian Institute of Sport.[31] He viewed the crime scene photographs and stated:

    (a) that the equipment set-up depicted in the photographs was the strangest he had ever seen;

    (b) the use of an ironing board would be very uncomfortable and the manner in which the ironing board was propped on the books was very precarious;

    (c) the positioning of the chair behind the head of the ironing board was also extremely strange as trying to lift the bar out from a position above head height is difficult; and

    (d) that he would have expected a person training to be wearing a sports bra, t-shirt, leggings and training shoes, not pyjamas and a dressing gown, with bare feet.

73. Of most significance in Dr Brennan's opinion was that there were no collars on the bar, so the metal discs would slide around. Dr Brennan stated:

    (a) that when a person is going to 'fail' during a lift, one side fatigues first and, with no collars on the bar, the discs would slide off of the bar. This happens very quickly – the disc on one side slips which forces the bar to move off-balance to the other side, which then forces the disc on that side to slip;

    (b) in most cases, the discs would come completely off the bar and it is difficult to imagine why this did not happen;

    (c) the bar would have had to have landed on the deceased in a balanced position for this not to have occurred;

    (d) he had never seen or heard of an incident where a bar has come to rest across a person's neck; and

[31] *ibid* at pages 1159 – 1167

(e) even for an inexperienced person, the natural reaction when reaching failure point is to direct the bar to the chest.

74. During Dr Brennan's evidence, when questioned on the amount which the bar, with no collars on the bar to secure the plates, would need to tilt for the plate/s to fall off, he responded that it would only need to tilt "*a couple of millimetres*."[32]

75. Dr Brennan was asked whether he had seen a bar come to rest horizontally across somebody's neck or was aware of any cases in which a person had died after a barbell came to rest on their neck. Dr Brennan stated that he had not and was unaware of any cases.[33] However, when Counsel for Vasko and Pisana produced a media article which outlined an incident in which a 15 year old male had died after being found with a barbell, loaded to 98 kilograms, on his neck, Dr Brennan accepted that it appeared in that case that a barbell had come to rest across the young man's neck. He was unaware of the specific circumstances of the case and there was no detail in the article as to the position in which the young man was discovered.[34]

76. I note that the article referred to specifically advises that to avoid such an incident when lifting alone, collars should not be put on the barbell because then the weights can easily be tipped off in the case of difficulty. I note also the significantly heavier weights in that case, being more than three times the amount of the barbell and weights in this case.

77. Counsel assisting submitted,[35] and it was supported by Counsel for the Kiklevski family, that not only is it very unlikely that the bar would come to rest horizontally on Ms Stojanovska's throat, but that any slight movement would have caused the end of the barbell to tip and rest on the floor. Additionally, any slight movement would have caused the weight plates to come off, first one side and then the other. I accept these submissions.

78. Dr Dodd gave evidence at the inquest and commented more fully on his findings. He told the Court:

(a) that Ms Stojanovska was not suffering from any significant, naturally occurring disease which would lead to a sudden collapse and subsequently asphyxia due to compression of the barbell and weights;[36]

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32 T p40, 2-4
33 T p24, lines 24-26 and T p46, lines 3-8
34 T p46, lines 3-8
35 T p106, lines 6-11
36 T p14, lines 12-24

(b) Ms Stojanovska had a tendency to asthma, but it was not active, florid asthma,[37] and had a benign thyroid condition, Graves' disease;[38]

(c) that he had found several, separate bruises to Ms Stojanovska's cheek and neck,[39] and bruising to approximately one third of the sternocleidomastoid muscle to the left side.[40] Beneath the left ear, there was a dense area of fresh haemorrhage and further area of dense haemorrhage up underneath the left side of the jaw;[41]

(d) there was an area of bruising beneath the right jaw,[42] and bruising beneath the right ear lobe,[43] the bruising being more or less symmetrical on both sides;[44]

(e) that the haemorrhage to the deep layer only of the right sternocleidomastoid muscle was in a more or less symmetrical pattern to that on the left;[45]

(f) that, in his internal examination, he found patchy bruising to the shoulder and up posteriorly[46] and there was also bruising visible both externally and internally to the right antecubital fossa hook with the elbow[47] and bruising to the back of the scalp;[48]

(g) that the bruising to the deep layer of the right sternocleidomastoid muscle was brought about by a considerable degree of compression.[49] He did not think it caused by the use of muscle struggling against the weight of the barbell, nor by Mr Stojanovska attempting to lift the barbell off Ms Stojanovska's neck and dropping it multiple times,[50] as was later put to him by counsel for Vasko and Pisana,[51] stating:

> "*bruising and abrasion across here* (pointing to the front of the neck) *could readily be explained by a bar, the bruising around the neck could be explained by the bar if the bar was being pressed down and the woman was moving her neck from side to side. It would not explain at all the areas of bruising which are under - under the*

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37 T p14, lines 6 - 9
38 T p14, lines 8-11
39 T p9, lines 28-31
40 T p11, lines 5-12
41 T p11, lines 13-16
42 T p11, lines 25-27
43 T p4, line 26 - T p5, line 3
44 T p12, lines 14-27
45 T p12, lines 2-3
46 T p13, lines 14-16
47 T p13, lines 17-20
48 T p13, lines 21-26
49 T p23, line 31 - T p24, line 4
50 T p24, lines 15-17
51 T p20, lines 3-5; T p25, lines 15-21

ears and much higher under the jaw. They're just so far away from that area that it's - it doesn't gel."[52]

(h) he considered that the bruising to the deep layer of the right sternocleidomastoid muscle was "*directly related to the compression of the neck*."[53] He went on:

"*it's more likely to be caused by a deep, compressive type of injury, possibly by manual compression and possibly by a thumb or fingers in that area where the – it's more of like a pincer-like mechanism which has caused bruising deep only, but not superficially*."[54]

(i) in relation to the assertion that it may have been caused by Mr Stojanovska attempting to lift the barbell off Ms Stojanovska's neck and dropping it multiple times:

"*the inference there would be, at the time that he discovered her body, she would be expired at that point and so any force applied to the body at that point wouldn't result in bruising because at that point she has no circulation*."[55]

(j) his opinion as to the mode of the injuries which caused Ms Stojanovska's death was that:

"*(t)he pattern of bruises, the many, quite separate bruises and in particular the ones up underneath the ear and around the jaw, did not fit at all with the story presented that this may have been an entrapment by a barbell. If there was entrapment by a barbell I would expect a, more or less, discrete area of bruising here* (motioning to the front of the neck) *and nothing above or nothing below. I would accept a certain amount of bruising on the upper chest perhaps, certainly across the front of the neck, but* (the bruising) *extended well across to the left and we have bruising under the jaw, both sides and also bruising up under the left ear, which is well away from the area of compression – potentially - from the barbell. I think this fits the pattern of manual neck compression, strangulation*;"[56]

(k) this case, being his autopsy findings, had been reviewed within the VIFM through a case conference and that "*from the top, down - from the Director, Assistant Director*

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52 T p20, lines 7-14
53 T p24, lines 15-17
54 T p25, lines 1-6
55 T p25, lines 21-25
56 T 14, line 27 to T p15, line 16

and all my pathology colleagues, all are in one mind about the representation of these injuries;"[57] and

(l) Dr Dodd was questioned by Counsel for Vasko and Pisana as to other possible causes for some of the injuries to Ms Stojanovska's neck.[58] In particular, it was suggested that if Ms Stojanovska had been alive when she was found and if resuscitation attempts had been made by paramedics, that could have explained some of the injuries, particularly the bruising under the chin and possibly some of the bruises around the neck. He stated, "*the bar by its nature is a rigid, cylindrical structure and we have two independent small areas of bruising* (under the chin) *which are quite separate from each other and geometrically don't match the bar at all … they're about here and here, but they are separated by a certain distance of normal skin and* (are) *quite oval in configuration*."[59]

79. I note that Ms Stojanovska was deceased, cold to the touch and with the onset of rigor mortis, when paramedics arrived and that they did not make any resuscitation attempts. Prior to the paramedics' arrival, Vasko, Pisana and Mr Stojanovski did not attempt CPR when the emergency services telephone operator attempted (multiple times) to direct them to check Ms Stojanovska for a pulse, in order to commence CPR prior to arrival of the ambulance.[60]

80. It was submitted by Counsel Assisting and supported by Counsel for the Kiklevski family, that Dr Dodd's evidence strongly supports a finding that Ms Stojanovska died from neck compression caused by manual strangulation and that the evidence of Dr Dodd and the paramedics supported a finding that the probable time of death was around midnight on Saturday, 27 November 2010. I accept this submission.

81. Counsel for Vasko and Pisana and for Mr Stojanovska made no submissions in relation to the time of death. In relation to the mode of neck compression, Counsel for Mr Stojanovski made no submissions and Counsel for Vasko and Pisana submitted that, although accepting that multiplicity and distribution of the injuries were not in accord with an uncomplicated barbell entrapment[61] and putting aside the under the ear and jaw injuries,[62] it was not the same as a dynamic incident or a complicated weightlifting accident.[63] Mr Taaffe submitted that there was insufficient evidence for me to make a finding to the requisite standard of proof, that the

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57 T p19, lines 5-10
58 T p19, lines 19-21
59 T p21, line 29 to T p22, line 5
60 Coronial brief, Transcript of '000' telephone call, pp 931-935
61 T p119, lines 7-8
62 T p120, line 31 to T p121, line 3
63 T p119, lines 10-20

mode of the neck compression was manual strangulation. Mr Taaffe directed me to pages 361-362 of *Briginshaw*[64] and noted that the general principle was confirmed in the 1992 High Court case of *Neat Holdings v Karajan Holdings*,[65] submitting that:

> "*to find in the circumstances of this case that it was … strangulation would be a most serious finding and the evidence doesn't lend sufficient support to that, for Your Honour to be satisfied to the high standard required.*"

82. I do not accept this submission, noting that Mr Taaffe confined his submissions to the neck injuries, setting aside the ovoid bruises.[66] I cannot set aside the evidence regarding the ovoid bruises under Ms Stojanovska's ears and chin. Dr Dodd's evidence in relation to the ovoid bruising is compelling and wholly relevant to findings which I *must* make, if possible, pursuant to s.67(1)(c) of the Act.

83. Counsel for Mr Stojanovski confined his submissions to the question involving the identity of anyone who may have been involved in the death. Mr D'Arcy submitted that the Victoria Police's investigation into Ms Stojanovska's death did not commence well, pointing to the fact that no officer tried to open the garage door from the outside and that the homicide investigation did not commence until Dr Dodd's notification that his autopsy findings did not accord with the story presented as to Ms Stojanovska's manner of death.

84. Sergeant Stanton gave evidence about his observations of the garage door on 28 November 2010. He stated that he tested the garage door from the inside and found it to be locked. On questioning by Mr D'Arcy as to how he had been able to determine that the garage door was locked, Sergeant Stanton told the Court that he had been a building supervisor for many years prior to becoming a police officer and he knew a locked door from an unlocked one.[67] Sergeant Stanton was very clear that he tested the garage door from the inside and found it to be locked.

85. Sergeant Stanton's evidence supports Pisana's evidence, contained in the Coronial Brief, that she checked the doors and windows on the morning of Ms Stojanovska's death and found them to be locked.[68] I note Pisana's evidence at page 159 of the Coronial Brief that she could not check the garage door at the time Mr Stojanovski located Ms Stojanovska, so she "*had to*

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64 (1938) 60 CLR 336
65 110 ALR 449, at 450
66 T p121, line 18 to T p122, line 23
67 T p70, lines 16-19
68 CB p1011 - Record of police interview with Pisana on 12 April 2011

go and check them from the front later." Pisana's evidence that the house was locked and secure was consistent throughout her various police interviews. As Pisana refused to give evidence willingly and was excused from giving evidence pursuant to s.57 of the Act, I was unable to elicit further evidence as to her checking of the home's security on the morning of 28 November 2010.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

86. Despite a comprehensive investigation into Ms Stojanovska's death, no person or persons have been charged with an indictable offence in respect of the death.

87. It is important to note that it is not the purpose of a coronial investigation to investigate possible criminal conduct to compile a brief of evidence in preparation for a future criminal trial. Section 69 of the Act expressly prohibits a coroner from including in a finding or a comment, any statement that a person is or may be guilty of an offence.

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

89. Homicide is the killing of one person by another person. In forming the belief, on the balance of probabilities, that Ms Stojanovska's death was the result of a homicide, I make no finding as to criminality on the part of Mr Stojanovski, Vasko or Pisana. I note that the evidence indicates that Mr Stojanovski, Vasko and Pisana were the only persons present in the house at the time of Ms Stojanovska's death and that there was no evidence of forced entry to the house.

90. Mr D'Arcy submitted that there is insufficient evidence in this case to find that any particular person was involved in Ms Stojanovska's death.

91. Mr Taaffe submitted that there is no basis to conclude that either Pisana or Vasko had any involvement in the death or any involvement in changing the scene or covering up the death.[69] He submitted:

"*the most that could be said of them is they are simply present in the household when the death occurs. Any finding as to a potential involvement in the death itself or dealing with it afterwards, in my submission, would be entirely speculative and also would be a most*

[69] T p125, lines 1-4

serious finding against them that would require a high degree of satisfaction for Your Honour to make that finding."[70]

92. I accept both Mr Taaffe and Mr D'Arcy's submissions. I accept that there is insufficient evidence before me find to the Coronial standard which of Mr Stojanovski, Vasko and/or Pisana caused Ms Stojanovska's death.

93. The Act provides that the Principal Registrar must notify the Director of Public Prosecutions (**DPP**) if the coroner investigating the death forms the belief that an indictable offence may have been committed in connection with a death.[71]

94. I am satisfied on the available evidence that Ms Stojanovska's death meets the definition of a homicide. I believe that an indictable offence has been committed in connection with her death.

95. Accordingly, pursuant to s.49 of the Act, I direct the Court's Principal Registrar to notify the DPP that I believe an indictable offence may have been committed in connection with the death.

FINDINGS AND CONCLUSION

96. Having investigated the death of Snezana Stojanovska and having held an inquest in relation to her death on 17-19 July 2018, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Snezana Stojanovska, born 16 January 1984;

    (b) that Ms Stojanovska died on or about 27 November 2010, at 14 William Street, Preston, Victoria, from asphyxia and compression of the neck; and

    (c) that the death occurred in the circumstances set out above, in which Ms Stojanovska was manually strangled and her death was due to homicide.

97. I convey my sincerest sympathy to Ms Stojanovska's family and friends.

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

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[70] T p125, lines 4-12
[71] Section 49

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

(a) Dragi Stojanovski, senior next of kin;

(b) Naum and Gina Kiklevski;

(c) Vasko Stojanovski and Pisana Stojanovska;

(d) Detective Acting Sergeant Scott Riley, Coroner's Investigator, Victoria Police; and

(e) Detective Inspector Tim Day, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 30 July 2018