IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 0642

FINDING INTO DEATH WITH INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	**Traci O'Sullivan**
Date of birth:	1 February 1973
Date of death:	Between 5 February 2015 and 7 February 2015
Cause of death:	The combined effects of blunt force injuries to the head and penetrating injuries to the neck, check and abdomen
Place of death:	7 Timbertop Court, Frankston North Victoria 3200

HIS HONOUR:

INTRODUCTION

1. Traci Lee O'Sullivan was a 42-year-old woman who lived on her own, at 7 Timbertop Court, Frankston North Victoria 3200 at the time of her death.

2. Ms O'Sullivan has been described by family as a person who devoted herself to caring for her family. Her family have detailed that prior to her involvement with drugs, she was a well loved and happy woman.

3. Ms O'Sullivan was separated from her partner, Brett Robert Eastham, with whom she shared one young child (R). At the time of Ms O'Sullivan's death, R resided with Brett and Ms O'Sullivan's family at a separate residence. Brett would take R to visit Ms O'Sullivan every couple of days.[1]

4. Ms O'Sullivan was found deceased from the combined effects of blunt force injuries to the head and penetrating injuries to the neck, chest and abdomen at 7 Timbertop Court, Frankston North Victoria 3200 on 7 February 2015.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Ms O'Sullivan's death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] 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 the death occurred.[3]

7. 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,[5] or to determine disciplinary matters.

8. The expression 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

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[1] Statement of Brett Robert Eastham dated 7 February 2015, Coronial Brief.
[2] Section 89(4) *Coroners Act 2008*
[3] See Preamble and s 67, *Coroners Act 2008*
[4] *Keown v Khan* (1999) 1 VR 69
[5] Section 69 (1)

9. For coronial purposes, the phrase 'circumstances in which death occurred,'[6] 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.

10. 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.

11. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[7]

    (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;[8] 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.[9] These powers are the vehicles by which the prevention role may be advanced.

12. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[10] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[11] 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 level of confidence that the person caused or contributed to the death.

13. 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.

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[6] Section 67(1)(c)
[7] Section 72(1)
[8] Section 67(3)
[9] Section 72(2)
[10] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[11] (1938) 60 CLR 336

BACKGROUND

14. Ms O'Sullivan was the middle of three children born to Shirley and Barry O'Sullivan.[12] Shirley states that looking back, while her daughter appeared happy after leaving school, she did struggle with confidence issues and may have been a bit depressed.[13]

15. In June 2010, Ms O'Sullivan's father was moved into a nursing home. This was also the year that Ms O'Sullivan and Brett separated and Ms O'Sullivan 'started going downhill'.[14] Statements obtained from family detail that Ms O'Sullivan was using ice[15] as far back as August 2012 however, her use is said to have only been recreational at this point.[16]

16. In February 2013, Ms O'Sullivan's sister with whom she resided, Sharleen O'Sullivan, returned from a holiday. Sharleen details that upon her return, Ms O'Sullivan's behaviour had seemingly become worse and that she was using drugs more frequently. This frequent use soon turned into daily use.[17]

17. Not long after Ms O'Sullivan started using drugs daily, she also started using dating websites. Ms O'Sullivan is said to have become obsessed with online dating, taking Sharleen's car out in the evening and not returning until the following morning. Her family did not know what she was doing or who she was seeing.[18]

18. Ms O'Sullivan started bringing men back to the house. It was around this time that Sharleen became aware that Ms O'Sullivan was dealing ice and that her mental health was declining.[19]

19. On 24 January 2014 at approximately 10.00pm, Ms O'Sullivan abruptly told Sharleen that she had to leave the house. After leaving the house, she called Sharleen and told her that she too had to leave the premises because bikies were after her. Sharleen and Ms O'Sullivan met at a police station, before embarking on a delusional escapade over several hours that was driven by Ms O'Sullivan's drug induced paranoia and Sharleen's genuine concern for her sister's safety. Incidents like these would later become commonplace as Ms O'Sullivan's drug use worsened.[20]

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[12] Statement of Shirley O'Sullivan dated 18 June 2018, Coronial Brief.
[13] Ibid.
[14] Ibid.
[15] Crystal methamphetamine.
[16] Statement of Sharleen O'Sullivan dated 9 February 2015, Coronial Brief.
[17] Ibid.
[18] Ibid.
[19] Statement of Sharleen O'Sullivan dated 9 February 2015, Coronial Brief.
[20] Ibid.

20. Sharleen tried to get help for Ms O'Sullivan on several occasions. She called Victoria Police, 'psychiatric wards, hospitals, rehabs, counselling services and drug rehab clinics… Every single one of them said because she is an adult- she had to do it herself'.[21]

21. Ms O'Sullivan started to 'turn' on those closest to her, directing her paranoia towards her sister. In addition to becoming hyper-suspicious, Mr O'Sullivan's memory started to falter. This in turn, got her into trouble with drug-related business transactions.[22]

22. Sharleen eventually got Ms O'Sullivan into 2 WEST[23] for mental health assistance. Despite her family's best efforts, Ms O'Sullivan is alleged to have continued to deal drugs while an inpatient. Statements indicate that from this point, Ms O'Sullivan's mental health continued to decline and the relationship she had with Sharleen became increasingly strained.[24]

23. Ms O'Sullivan was experiencing delusions in relation to people doing things to negatively affect and control her. She would often get herself into a rage, becoming aggressive and violent.[25]

24. In 2014, Ms O'Sullivan was diagnosed with drug induced schizophrenia.[26]

25. Around mid-2014, R and Sharleen moved out of the residence they shared with Ms O'Sullivan and into Shirley's home.[27]

26. Ms O'Sullivan's mental health deteriorated further and she started drinking a considerable amount of alcohol. She also stated that she was angry that people would not believe that she was hearing voices and that people were coming to get her. When questioned about who was after her, Ms O'Sullivan would not provide details.[28]

27. Throughout the decline of her mental health and increasing drug use, Ms O'Sullivan continued to deal drugs from her home. Sharleen states that while Ms O'Sullivan did not owe her dealers any money, Ms O'Sullivan's customers owed her money.[29]

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[21] Ibid.
[22] Ibid.
[23] Peninsula Health, Inpatient Mental Health Unit, Adult Acute Mental Health Unit (2 West), Frankston Hospital.
[24] Statement of Sharleen O'Sullivan dated 9 February 2015, Coronial Brief.
[25] Ibid.
[26] Ibid.
[27] Statement of Shirley O'Sullivan dated 18 June 2018 and statement of Sharleen O'Sullivan dated 9 February 2015, Coronial Brief.
[28] Statement of Shirley O'Sullivan dated 18 June 2018, Coronial Brief.
[29] Statement of Sharleen O'Sullivan dated 9 February 2015, Coronial Brief.

VICTORIA POLICE HOMICIDE INVESTIGATION

28. Immediately after Ms O'Sullivan's death, Victoria Police commenced a criminal investigation because the death was considered to be a homicide.

29. Ms O'Sullivan's death was investigated by the Homicide Squad. Investigations determined that Ms O'Sullivan had been involved in low-level drug trafficking for several years and this became the focus of their investigations. Initial inquiries focussed around persons connected to Ms O'Sullivan immediately prior to her death.

30. Through analysis of telephone records, the telephone handset located at the crime scene and various other lines of inquiry, several persons of interest were identified.

31. Despite this investigation, no person or persons could be implicated and charged with indictable offences in connection with Ms O'Sullivan's death.

32. I note the observations of the Victorian Court of Appeal in *Priest v West*,[30] 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.*

33. 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.[31]

34. 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

[30] (2012) VSCA 327
[31] *Perre v Chivell* (2000) 77 SASR 282

or organisations may have the mandate to investigate, some are more appropriately placed than others to do so in any given circumstance.

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

36. In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Ms O'Sullivan's death is an unsolved homicide case.

37. The Coroner's Investigator, Detective Leading Senior Constable Kyle Simpson, has provided a statement and briefing material to the Court in relation to this matter.

38. The confidential nature of the Victoria Police's investigation prevents me from reciting each and every matter which has been established. However, Detective Leading Senior Constable Kyle Simpson's statement and supplementary briefing material indicates that the following important matters have been established and are able to be disclosed:

39. Transfer blood was sighted on Ms O'Sullivan's right ankle that had the general appearance of finger marks.[32] Initial Deoxyribonucleic acid (DNA) results indicated a DNA mixture with two contributors suitable for comparison to persons of interest. The major profile matched Ms O'Sullivan's, with a partial male profile detected in the minor.[33] The partial male DNA profile was entered into the *National Criminal Investigation DNA Database*. Results excluded several persons of interest.

40. In mid-2017, a low stringency DNA database search was conducted, which prompted further investigation of the mixed DNA profile taken from Ms O'Sullivan's right ankle. The results showed that a known associate of Ms O'Sullivan, Adam Slomczewski could not be excluded. This triggered further examination of exhibits from the scene, including YFP[34] analysis. YFP[35] DNA profiles were obtained from the reference samples of Mr Slomczewski and his brother Peter Slomczewski.

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[32] Photo exhibit #59-60, Coronial Brief.
[33] Statement of Forensic Officer, Tara Jayne Seddon dated 1 June 2018 and Forensic Officer, Lisa Federle dated 4 June 2018 and Lisa Federle dated 12 June 2018, Coronial Brief.
[34] As the Y chromosome is inherited from father to son, male relatives of the same paternal lineage will have identical or very similar YFP profiles.
[35] Specific sequences of information in DNA that are known to be variable between people are analysed and are used for comparison purposes in forensic investigations. Forensic scientists use the information obtained from a number of those variable sequences (loci) to compare biological material obtained from evidentiary samples to DNA from reference samples from unknown individuals.

41. DNA results found that Mr Slomczewski's DNA could not be excluded on several evidentiary items, including a section of the rear fence, Ms O'Sullivan's right ankle, right hand palm, inner left upper arm, clothing pocket and two bedroom door handles.[36]

42. On 4 April 2018, Victoria Police sought additional statements in relation to Mr Slomczewski. Brett states that he first met Mr Slomczewski in 2009 through Peter. Mr Slomczewski was a known thief, who had spent periods of time in prison.[37]

43. Approximately 12 months prior to her death, Ms O'Sullivan told Brett that she was selling to Mr Slomczewski. Brett grew concerned that Mr Slomczewski would steal from Ms O'Sullivan and warned her to be careful around him.[38] Mr Slomczewski's drug use is confirmed in his brother's statement. Specifically, that Mr Slomczewski was known to be doing ice.[39] When Victoria Police interviewed Mr Slomczewski on 19 February 2015, Mr Slomczewski admitted to buying ice and cannabis from Ms O'Sullivan.[40]

44. On the day of Ms O'Sullivan's death, Peter saw his brother, Mr Slomczewski. Peter told Mr Slomczewski about Ms O'Sullivan's death. He states that at the time his brother seemed genuinely sad but did not ask questions or speak further of it. Peter states that at the time he did not have any suspicions but that on reflection, this was an odd response.[41]

45. A couple of days after Ms Sullivan's death, Mr Slomczewski picked Peter up in his car. When both men were seated in the vehicle, Mr Slomczewski revealed a significant amount of drugs in the centre console. Peter's statement details that he believes these drugs were in bags that had red on them and also a red back spider.[42] This description matches exhibits found at the scene of Ms O'Sullivan's death. Namely, bags of drugs found at the scene.[43]

46. Mr Slomczewski's telecommunication records for the period between 13 January 2015 and 7 February 2015, show that Mr Slomczewski contacted Ms O'Sullivan's mobile phone on several occasions prior to her death.[44] The last known voice contact between Ms O'Sullivan and Mr Slomczewski is recorded on the morning of 29 January 2015. The last known SMS

[36] Statement of Forensic Officer, Tara Jayne Seddon dated 1 June 2018 and Forensic Officer, Lisa Federle dated 4 June 2018 and Lisa Federle dated 12 June 2018, Coronial Brief.
[37] Statement of Brett Robert Eastham dated 18 June 2018, Coronial Brief.
[38] Ibid.
[39] Statement of Peter Slomczewski dated 17 July 2018, Coronial Brief.
[40] Statement of Detective Acting Senior Sergeant Leigh Howse dated 19 June 2018, Coronial Brief.
[41] Statement of Peter Slomczewski dated 17 July 2018, Coronial Brief.
[42] Ibid.
[43] Photo exhibit #90, Coronial Brief.
[44] Statement of Detective Acting Senior Sergeant Leigh Howse dated 19 June 2018, Coronial Brief.

contact is recorded on the evening of 30 January 2015, approximately five days prior to Ms O'Sullivan's death.[45]

47. A review of Ms O'Sullivan's other mobile phone call charge records between 17 January 2015 and 7 February 2015 show high volume call and SMS traffic. This traffic ended at 8.35pm on 4 January 2015, with no further outgoing call traffic or incoming answered call traffic recorded.[46]

48. Various DNA samples were obtained and analysed. Whilst Mr Slomczewski's DNA could not be excluded from the blood at the scene, multiple unrelated errors[47] in the testing processes meant that in this case, this evidence did not persuade me [48] to name Mr Slomczewski as the assailant.

49. Mr Slomczewski died in an unrelated aggravated burglary on 11 December 2015.[49]

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

50. On 9 February 2015, Traci O'Sullivan, born 1 February 1973, was identified by way of the Police report of death and fingerprint identification.

51. 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

52. On 7 February 2015, Dr Linda Illes, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine attended the crime scene. On 8 February 2015, Dr Iles conducted an autopsy upon Ms O'Sullivan's body. She subsequently reviewed the Police Report of Death for the Coroner and the Police Section 27. Dr Illes provided a written report dated 5 June 2015, in which she formulated the cause of death as '*I(a) The combined effects of blunt force injuries to the head and penetrating injuries to the neck, chest and abdomen*'.

53. Toxicological analysis of post mortem samples taken from Mr O'Sullivan identified the presence of ethanol[50], methylamphetamine and its metabolite amphetamine[51], 11-nor-delta-9-carboxy-tetrahydrocannabinol (THC- COOH)[52] and olanzapine[53].

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[45] Statement of Detective Leading Senior Constable Kyle Ashley Simpson dated 3 September 2018, Coronial Brief.
[46] Statement of Detective Leading Senior Constable Kyle Ashley Simpson dated 3 September 2018, Coronial Brief.
[47] Subsequently identified, corrected and scrupulously documented back at the laboratory.
[48] See reference 11.
[49] See COR 6241 of 2015.

54. I accept Dr Illes' opinion as to cause of death.

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

55. On 5 February 2015 at approximately 3.00pm, Ms O'Sullivan was visiting her family at Shirley's house. Shirley states that her daughter was unusually agitated and fidgety that day. When questioned about whether something was wrong, Ms O'Sullivan did not answer and left at approximately 4.15pm.[54]

56. Analysis of Ms O'Sullivan's bank transactions show that her last purchase was on 5 February 2015 at 4.42pm at IGA Xpress, 54-56 Mahogany Avenue, Frankston North. Closed circuit television (CCTV) taken from IGA Xpress confirm this transaction[55] and Ms O'Sullivan walking back in the direction of her residence.[56]

57. Ms O'Sullivan's house backed onto the Peninsula Kingswood Country Golf Club (the golf club). On 6 February 2015 at approximately 8.30am, the green keeper of the golf club, Laurette Neale Perry, was up near the fence line backing Ms O'Sullivan's house.[57]

58. Ms Perry heard an unusual noise and thought it might have been a dog or cat being attacked by a snake. The noise briefly stopped before starting again. Ms Perry grew concerned that an animal was in distress and proceeded to investigate by looking over the fences and into the adjoining residential yards. She believed that the sound was coming from Ms O'Sullivan's house.[58]

59. Ms Perry called out, 'hello, is everything all right?' or words to that effect. There was no response. Ms Perry went back to her duties but when she turned around and looked back at Ms O'Sullivan's house, she noticed that one of the blinds had been pulled down. As she left the area, the noise started again and sounded as though it was coming from the other side of Ms

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[50] Alcohol is the common term for ethanol. The legal limit for blood alcohol for fully licensed car drivers is 0.05% (gram/100 mL).
[51] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine. One of these, methylamphetamine, is often known as "speed" or "ice".
[52] D^9- Tetrahydrocannabinol (THC) is the active form of cannabis (marijuana).
[53] Olanzapine is indicated for the treatment of schizophrenia and related psychoses. It can also be used for mood stabilisation and as an anti-manic drug.
[54] Statement of Shirley O'Sullivan dated 18 June 2018, Coronial Brief.
[55] Statement of Detective Leading Senior Constable Kyle Ashley Simpson dated 3 September 2018, Coronial Brief.
[56] CCTV photographic references, pp. 278-279, Coronial Brief.
[57] Statement of Laurette Neale Perry dated 11 February 2015, Coronial Brief.
[58] Ibid.

O'Sullivan's house. When Ms Perry looked at the house for the last time, she noticed that the blind had been put back up.[59]

60. On 7 February 2015 at 10.13am and 11.38am, Brett attempted to call Ms O'Sullivan's mobile phone but it was switched off. After failing to get into contact with Ms O'Sullivan, Brett took R over to Ms O'Sullivan's house.[60]

61. When Brett and R arrived, he noticed a man near Ms O'Sullivan's letterbox, walking towards her front door. Brett recognised the man as being a friend and/ or customer of Ms O'Sullivan's. Brett told the man that Ms O'Sullivan was not answering her phone. Before he answered Brett, the man's phone rang and he walked away.[61]

62. Investigations revealed the man to be Duncan Richard Gigl. Mr Gigl had driven to Ms O'Sullivan's house to obtain marijuana.[62] Mr Gigl's arrival at Ms O'Sullivan's house at around the same time as Brett and R is corroborated by Ms O'Sullivan's neighbour, Barry Narramore. Mr Narramore arrived home at approximately 11.10am. He states that he did not see Mr Gigl's car when he arrived home and would have noticed it, had it been parked in the Court.[63]

63. Mr Narramore also states that his wife believed that she last saw Ms O'Sullivan three days prior to the discovery of her body. He states that when leaving for work, Ms O'Sullivan's lights were always on. On the previous two occasions that he left for work, the lights were not on and he thought this to be strange.[64] This lends itself towards Ms O'Sullivan's death likely being on 5 or 6 February 2015.

64. R tried the front door and found that both the security door and the front door were unlocked. Brett states that usually, Ms O'Sullivan kept both doors locked and he was surprised that on this day, they were unlocked.[65] This lends itself toward the likelihood that Ms O'Sullivan knew her attacker and let the person into her house, not locking up behind her. I can only speculate on this, based on accounts of Ms O'Sullivan's behavioural patterns and therefore, cannot be satisfied to the requisite standard that this is fact.

65. R proceeded to run into the house and down to Ms O'Sullivan's bedroom. Brett followed.[66]

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[59] Ibid.
[60] Statement of Brett Robert Eastham dated 7 February 2015, Coronial Brief.
[61] Ibid.
[62] Statement of Duncan Richard Gigl dated 8 February 2015, Coronial Brief.
[63] Statement of Detective Leading Senior Constable Paul Roberts dated 3 August 2018, Coronial Brief.
[64] Statement of Barry Narramore dated 7 February 2015, Coronial Brief.
[65] Statement of Brett Robert Eastham dated 7 February 2015, Coronial Brief.
[66] Ibid.

66. Brett and R entered Ms O'Sullivan's bedroom and found Ms O'Sullivan deceased.[67] Ms O'Sullivan was wearing the same clothing she had been wearing the last time she was sighted.[68] Family members have stated that they consider it out of character for Ms O'Sullivan to have been in the same clothing. Specifically, to not have changed before going to bed. This again lends itself towards Ms O'Sullivan's death likely being on 5 or 6 February 2015.

67. There was a mixture of splattered and transfer blood surrounding Ms O'Sullivan, indicating that there had been a struggle prior to her death.[69]

68. Victoria Ambulance arrived at the scene at 12.02pm and verified that Ms O'Sullivan was deceased.[70] Victoria Police arrived shortly after.[71]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

69. Despite an extensive criminal investigation conducted by Victoria Police, no person or persons have been identified,[72] to date, as being responsible for causing Ms O'Sullivan's death.[73] Whilst that investigation identified, to my satisfaction, that Mr Slomczewski was the person most likely to have caused Ms O'Sullivan's death, the level of this likelihood did not reach the *Briginshaw* 'balance of probabilities' standard required by the *Coroners Act 2008*, and so I have not named him.

70. Having reviewed that investigation, however, I am satisfied that no further investigation which I am empowered to undertake, would be likely to result in the identification of the person or persons who caused Ms O'Sullivan's death. Whilst any investigation can be subsequently reopened if new evidence materialises, this particular investigation will now be closed, as all known avenues have been explored.

71. I acknowledge the persistent difficulties faced by those who deal with drug dependent and mentally ill loved ones. The effects of both drug dependency and mental illness stretch beyond the sufferer, oftentimes placing an enormous burden on the shoulders of family members who are at the frontline. I therefore, acknowledge the ongoing support provided by Ms O'Sullivan's family and commend them on their continued efforts at supporting her.

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[67] Ibid.
[68] Photo exhibit #42-44, Coronial Brief.
[69] Photo exhibit #42-85, Coronial Brief.
[70] Statement of Timothy James Gilham dated 1 July 2015, Coronial Brief.
[71] Statement of Constable Nathan Watkins dated 4 August 2015, Coronial Brief.
[72] To the *Briginshaw* standard, per reference 11.
[73] Ibid.

FINDINGS AND CONCLUSION

72. Having investigated the death of Traci O'Sullivan and having held an Inquest in relation to her death between 5 February 2015 and 7 February 2015, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) The identity of the deceased was Traci O'Sullivan, born 1 February 1973;

    (b) The death occurred between 5 February 2015 and 7 February 2015 at 7 Timbertop Court, Frankston North Victoria 3200 from 7 Timbertop Court, Frankston North Victoria 3200; and

    (c) The death occurred in the circumstances described above.

73. I convey my sincerest condolences to Ms O'Sullivan's family for their loss.

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

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

    (a) Ms Shirley O'Sullivan, senior next of kin.

    (b) Ms Mia Janssen of Peninsula Health, interested party

    (c) Detective Leading Senior Constable Kyle Simpson, Coroner's Investigator, Victoria Police.

Signature:

SIMON McGREGOR

CORONER

Date: 12 August 2019