IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006763

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Dalibor Pantic

Delivered On:	17 December 2025
Delivered At:	Coroners Court of Victoria Southbank Melbourne
Hearing Dates:	1 July 2025
Findings of:	Coroner Leveasque Peterson
Counsel Assisting the Coroner:	Ms Courtney Davies
Keywords:	Homicide, body not recovered

INTRODUCTION

1. Dalibor Pantic (**Dale**), was born in Serbia in 1980. He was the first child for Jovan and Ruzica Pantic and he had a younger sister, Bozana. They were a close knit and supportive family. In 1994, the Pantic family moved to Australia.

2. Dale was described by family and friends as a source of strength and pride, who provided comfort and support to his family. He was a devoted father to his five children.

3. Dale was last seen alive on 10 April 2019.

INVESTIGATION AND SOURCES OF EVIDENCE

4. This finding draws on the totality of the coronial investigation into the death of Dalibor Pantic including evidence contained in the coronial brief as prepared by Coroner's Investigator, Detective Senior Constable Jen Black.

5. All of this material, together with the inquest transcript, will remain on the coronial file.[1] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

6. The purpose of a coronial investigation of a '*reportable death*'[2] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

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[1] From the commencement of the *Coroners Act 2008*, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[2] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[3] Section 67(1).

7. Dale's death falls within the definition of reportable death, specifically section 4(2)(a) of the *Coroners Act 2008* (Vic) (**the Act**) which includes an unexpected, unnatural or (relevantly) violent death. Section 52(2)(a) requires that I hold an inquest into the death where I suspect the death was due to a homicide – the act of an individual killing another individual whether that conduct was criminal (i.e. constituted the offence of murder).

8. The *'cause'* of death refers to the 'medical' cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the *'circumstances'* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[4]

9. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention' role.[5]

10. Coroners are empowered to report to the Attorney-General in relation to a death; 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 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.[6] These are effectively the vehicles by which the coroner's prevention role can be advanced.[7]

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[4] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[5] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[6] See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.

[7] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

11. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[8]

BACKGROUND

12. At the age of 26, Dale was first introduced to methamphetamine. He became a regular user of the drug.

13. In 2000, Dale met Katerina Pavlovic. The couple married and had two daughters. Although they subsequently separated, the couple remained friends until Dale's death.

14. In 2014, Dale moved to Lakes Entrance in an effort to stop his drug use. While there, Dale started a relationship with Malina Teohaere. Together over the following years, Dale and Malina had three children.

15. When Dale moved to Lakes Entrance he also met Sam Blake (**Sam**), through a mutual associate. Sam subsequently supplied Dale with drugs.

16. Initially Dale and Sam had a good relationship, however after a falling out over money the friendship cooled.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

17. On 9 April 2019, Sam attempted to contact Dale multiple times, through both calls to his mobile and text messages.

18. Sam was trying to obtain money from Dale that Dale had borrowed and failed to repay. Dale did not respond to any of Sam's contact attempts until Sam sent him a proposal that Dale could clear his debt with Sam if he drove Sam to Melbourne. Dale agreed to this, and he made plans to meet Sam at his grandparents' farm later that day.

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[8] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

19. While Sam was arranging a meeting with Dale, he told other witnesses that his real intention was to take Dale's car from him when they met, in order to satisfy Dale's debt to Sam.

20. On 10 April 2019, Dale bought Easter gifts for his children and then left his house to meet Sam.

21. Attempts by his partner to call his mobile after this were all unsuccessful.

22. Dale was not seen alive again. His body has never been recovered.

VICTORIA POLICE INVESTIGATION

23. On 12 April 2019, after Dale failed to return home as expected, Malina began asking friends and associates whether they knew of Dale's location or movements. When her enquiries provided no satisfaction Malina formally reported Dale to Victoria Police as a missing person.

24. Victoria Police members subsequently commenced an investigation into Dale's disappearance.

25. Police enquiries eventually led to Sam as a person of interest in Dale's disappearance, and He was questioned on a number of occasions, and he provided police with multiple different accounts of his interactions with Dale. The overarching assertions he made were that Dale had visited him on 10 April 2019 and had driven away.

26. Police also conducted proof of life enquiries including checks on activity on Dale's bank accounts and mobile phone activity, however given the lack of proof of life police became increasingly concerned for Dale's welfare.

ARREST AND INTERVIEW OF SAM BLAKE

27. On 18 September 2019, as a result of information compiled throughout the ongoing investigation into the disappearance of Dale, Victoria Police executed a search warrant on

a number of premises associated with Sam and he was arrested and interviewed in relation to Dale's murder.

28. On 10 November 2021 Sam was charged with the murder of Dale Pantic.

29. On 12 July 2023, Sam pleaded guilty to killing Dale on or about 10 April 2019. Although no specific cause of death was alleged at the time, it was found that Sam had committed an unlawful and dangerous act that caused Dale's death.

30. Prior to sentencing Sam provided a final statement stating that he:

    a) Struck Dale with a nearby piece of wood after a physical altercation;

    b) Transported and deposited Dale's body into the Avon River; and

    c) Disposed of Dale's mobile phone and other physical evidence.

31. Following receipt of this new information, an extensive search was conducted for Dale's body which, regrettably, proved unsuccessful given the passage of time and other factors.

32. On 16 July 2024, Sam Blake was sentenced to a term of imprisonment of nine years with a minimum of six to be served before being eligible for parole.

FINDINGS AND CONCLUSION

33. Having applied the applicable standard of proof to the available evidence, I find that:

    a) the identity of the deceased was Dalibor Pantic, born 10 August 1980,

    b) the death occurred on or about 10 April 2019 from an undetermined cause; and

    c) the death occurred in the circumstances described above.

ORDERS AND DIRECTIONS

Pursuant to section 73(1), this finding is to be published on the Coroners Court of Victoria website in accordance with the rules.

I extend my sincere condolences to Dale's family for their loss.

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

Ms Malina Teohaere, Senior Next of Kin

Detective Senior Constable J Black, Coroner's investigator

Signature:

Coroner Leveasque Peterson

Date: 09 February 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.