IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002896

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF SIMAILE MASILA-LIUTOLO

Findings of:	Coroner David Ryan
Delivered on:	21 September 2023
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	19 September 2023
Counsel Assisting the Coroner:	Lindsay Spence, Principal In-House Solicitor, Coroners Court of Victoria
Chief Commissioner of Police:	Andrew Imrie of Counsel instructed by the Victorian Government Solicitor's Office
Keywords:	Police contact – use of force – oleoresin capsicum foam

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INTRODUCTION

1. On 29 May 2022, Simaile Masila-Liutolo was 35 years old when he died at a property in Vine Court, Robinvale, in northwest Victoria. He is survived by his parents, Alani Masila and Latai Masila-Liutolo, his two brothers, his wife, and their three children.

BACKGROUND

2. Simaile was born in Auckland, New Zealand on 1 April 1987. He and his family moved to Australia when he was two years old and they settled in Robinvale. Simaile was described by his family as a happy and mischievous child who had a particular affection for his mother.

3. Simaile finished school at the end of Year 9 before obtaining employment as a labourer and farm hand. About 10 years later, he ceased employment after being diagnosed with a significant heart condition which required regular treatment, including a number of hospital admissions.

4. Simaile's medical history included dilated cardiomyopathy (possibly amphetamine related), atrial fibrillation, pulmonary hypertension, congestive cardiac failure, cholecystectomy, asthma, chronic obstructive pulmonary disease, smoking and obesity. Simaile was known to have used illicit drugs for many years and had a significant criminal history.

5. In 2002, Simaile married his wife and they had three children together. They separated in February 2021 in the context of domestic violence and Simaile moved in with his parents at Vine Court, Robinvale. His wife stated that "*Simaile couldn't come to terms that the relationship was over and would be aggressive toward me*".[1] Simaile's behaviour towards his wife had escalated in the months prior to his death and there was a Family Violence Intervention Order (**FVIO**) in force which prevented Simaile from contacting his wife.

[1] CB80.

6. Victoria Police sought to apprehend Simaile in the weeks leading to his death in relation to a number of matters, including escalating breaches of the FVIO and aggravated burglary. He had been actively avoiding and evading police and had driven away from police after testing positive at a roadside drug test on 25 May 2022. Simaile had stated to an associate that he was aware he was wanted by police, that he had a firearm and "*won't go down without a fight*".[2]

7. Just after 12.00am on 29 May 2022, Simaile entered the loungeroom of his wife's home. She recalled that he was "*upset about the separation and that I didn't want to be with him anymore*" and behaved in an angry and threatening manner.[3] She repeatedly asked him to leave but he refused so she retreated to her room with her daughters (her son was not home at the time).

8. At around 7.00am, Simaile's wife dropped him at his parents' house as he stated that he would not leave until she agreed to do so. Prior to leaving, she notified Victoria Police via text that Simaile had been at her house. Once the texts were received, Victoria Police contacted her and then made attempts to locate Simaile throughout the day but were unsuccessful.

9. Between 3.00pm to 4.00pm, Simaile's parents arrived home from a church function and found that their son had returned. Latai encouraged Simaile to get help.

10. At around 4.30pm, Simaile's wife and her daughters drove to Latai and Alani's place looking for her wallet which she thought Simaile may have taken with him. Her daughters went inside and returned, advising that Simaile did not have the wallet. Simaile then came outside and was yelling angrily and pointing at his wife. They then drove away and went to the supermarket.

[2] CB127.
[3] CB81; CB86-87.

11. At 5.19pm, Latai texted Simaile's wife and advised that her son was at their house and requested that she notify the police. Latai stated that "*I did not want to betray him, but I was thinking that he needed to stop and I thought that if the police got him, it would be time for him to stop, and clean up and get his life back on track*".[4] Simaile's wife saw the text message after arriving home from the supermarket and immediately contacted police.

CORONIAL INVESTIGATION

12. Simaile's death constitutes a "*reportable death*" under section 4(2)(c) of the *Coroners Act 2008* (**the Act**), as immediately before his death he was considered to be a "*person placed in custody or care*". The definition of "*person placed in custody or care*" in section 3(1) of the Act includes a person who a police officer is attempting to take into custody or who is dying from injuries sustained when a police officer attempted to take the person into custody. Section 52(2)(b) of the Act requires that an inquest be held into Simaile's death. In the circumstances, I considered it appropriate to hold a summary inquest which occurred on 19 September 2023.

13. At the hearing, a summary of the evidence was provided to the Court by Principal In-house solicitor, Lindsay Spence. The individual witnesses who provided statements in the brief were not required to give evidence at the inquest as, after carefully considering all of the material in the brief, I was satisfied that there were no significant factual disputes or controversies which remained unresolved in order for me to make the findings required under section 67 of the Act. The Chief Commissioner of Police was given an opportunity to make submissions in relation to the evidence.

14. The Coroners Court of Victoria is an inquisitorial court.[5] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

[4] CB91.
[5] Section 89(4) of the Act.

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

16. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

17. 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.

18. Coroners are empowered to:

    (a) report to the Attorney-General on a death;[6]

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[7] and

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[8]

19. These powers are the vehicles by which the prevention role may be advanced.

20. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[9] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[10]

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[6] Section 72(1) of the Act.
[7] Section 67(2) of the Act.
[8] Section 72(2) of the Act.
[9] Section 69(1) of the Act. 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) of the Act.
[10] *Keown v Khan* (1999) 1 VR 69.

21. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[11]

22. A directions hearing was held on 21 June 2022 at which it was confirmed that Victoria Police had assigned Senior Sergeant Jason Poulton to be the Coroner's Investigator for the investigation into Simaile's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence which included relevant footage from the Body Worn Cameras (**BWC**) of Victoria Police members. Expert evidence was also obtained in relation to the potential contribution of oleoresin capsicum (**OC**) foam to Simaile's death.

23. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

24. Sergeant (**Sgt**) Zeph Sweep and First Constable (**FC**) Alex Vinten (**Robinvale 354**) arrived at Vine Court at 5.26pm and they activated their BWC. They had both had previous dealings with Simaile and knew him to be an "*unpredictable*" and "*extremely high risk offender*" who had a "*hatred of police*" and may be armed.[12] They were also concerned about his escalating behaviour. In the preceding days, they had been planning how they might apprehend Simaile in a safe and effective manner, taking into account the tactical options available to them, including OC foam.

25. FC Vinten went in the door at the side of the house and asked "*Where's Simaile?*". Someone responded from within the house that he was "*out back*".[13] Sgt Sweep then heard a loud bang at the rear of the property "*which sounded to me like somebody was jumping the back fence*".[14] He then walked to the rear of the house and saw Simaile running through the backyard of the neighbouring property. They yelled at Simaile to "*stop,*

[11] (1938) 60 CLR 336.
[12] CB137; CB154.
[13] CB154.
[14] CB141.

police, stop!". Sgt Sweep then lost sight of Simaile and requested assistance from the police airwing over the radio.

26. Sgt Sweep and FC Vinten searched for Simaile through the two adjacent backyards, where FC Vinten located Simaile hiding in a shed. FC Vinten drew his firearm and yelled to Simaile, "*Get your fucking hands up, hands up, police don't move, get on the fucking ground!*". Sgt Sweep then deployed OC foam through the open doorway of the shed. FC Vinten noted that the foam was "*mostly ineffective*".[15]

27. As Simaile exited the shed covered in OC foam, FC Vinten observed that he was carrying a knife and yelled out "*backup, backup, knife, knife*". Sgt Sweep and FC Vinten then retreated and repeated their direction to Simaile to get on the ground and also directed him to drop the knife.

28. Simaile collapsed to the ground onto his back before rolling onto his front and propping himself up on his forearms. On the BWC footage, the knife can be clearly seen in Simaile's right hand. Sgt Sweep and FC Vinten continued to issue directions to Simaile to drop the knife but he kept it clenched in his right hand. FC Vinten then deployed a continuous burst of OC foam for between 8 to 9 seconds which completely covered Simaile's face and head. At this stage Sgt Sweep was providing cover with his firearm.[16]

29. Sgt Brett McLoughlan (**Robinvale 251**) arrived at the scene at this stage and was warned by FC Vinten that Simaile still had a knife. FC Vinten then said, "*Simaile just pull the knife out brother, Simaile c'mon mate, put your hands behind your back brother*". Simaile continued to move his head and his feet for a short period while FC Vinten continued to direct him to put his hands behind his back and that they would look after him. Then FC Vinten stated, "*I think he's out but he's still got that knife on his chest*".

[15] CB155.

[16] The evidence of Sgt Sweep and FC Vinten in relation to this sequence of events was not consistent in some respects with the BWC footage but I am satisfied that the accounts provided in their statements were honestly drawn from their memories of the incident. In such heightened and stressful circumstances, it is understandable and unsurprising that a person's memory of events is not always the same as what is objectively recorded.

30. It had been broadcast over the police radio that the police were "*in a bit of a stand-off*" with Simaile and that he was on the ground but had refused to let go of the knife. The Divisional Patrol Supervisor (**Mildura 265**) directed the members at the scene to maintain their distance, keep observing him.[17] FC Vinten approached Sgt Sweep saying at this point "*it's a curved knife, I believe his knuckles are in it … … I think he's unconscious but I can't, I can't be sure*".

31. At around 5.31pm, when it appeared that Simaile was unconscious, Sgt McLoughlan approached and prodded him with his baton but Simaile appeared unresponsive. He then directed that Simaile be handcuffed and the knife was recovered and thrown clear.

32. Simaile was rolled into the recovery position and police proceeded to provide an emergency response. Cardiopulmonary resuscitation (**CPR**) was commenced at 5.33pm. Ambulance Victoria arrived at 6.01pm and took over the emergency response but despite their best efforts, Simaile could not be revived. He was declared deceased at 6.42pm.

OTHER INVESTIGATIONS

33. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

34. Victoria Police conducted an Operational Safety Critical Incident Review (**OSCIR**) and prepared a report of its findings.

35. The following relevant findings were contained in the OSCIR report:

    (a) The relevant Victoria Police policies, procedures, guidelines, and training in respect of the incident are adequate;

    (b) Police involved in the incident complied with the relevant Victoria Police policies, procedures, guidelines and training; and

[17] Exhibit 32.

(c) The actions, behaviours and decision making by police employees was appropriate in the incident;

36. The OSCIR Report contained no recommendations.

SCOPE OF THE INQUEST

37. The scope of the inquest was identified as follows:

1. Examination of the conduct of Victoria Police at Vine Court, Robinvale on 29 May 2022 including:

a. Appropriateness of the use and level of force used by Sgt Sweep and FC Vinten; and

b. Whether the use and level of force used by Sgt Sweep and FC Vinten was in accordance with the applicable training, policies and procedures; and

c. Whether the use and level of force used by Sgt Sweep and FC Vinten was causal to Simaile's passing.

IDENTITY OF THE DECEASED

38. On 2 June 2022, Simaile Masila-Liutolo was identified via fingerprint comparison.

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

MEDICAL CAUSE OF DEATH

40. On 30 May 2022, Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy and prepared a report of his findings dated 22 December 2022.

41. Dr Young found an enlarged heart and other findings, including coronary artery atherosclerosis, which were consistent with Simaile's diagnosis of dilated cardiomyopathy. Dr Young noted that dilated cardiomyopathy is a form of heart disease which has numerous causes including, chronic amphetamine use.

42. Toxicological analysis of post-mortem samples detected the presence of methylamphetamine, kavain[18] and bisoprolol.[19] Capsaicin[20] was also detected in the blood. Dr Young noted that acute effects of amphetamine use may include cardiac arrhythmia, coronary artery spasm and sudden cardiac death.

43. Dr Young did not find evidence of any injuries which may have caused or contributed to death.

44. Dr Young stated that:

> "*In the absence of other factors, the degree of heart disease seen in the deceased is capable of causing death. With the addition of acute and chronic methylamphetamine use, a possible heightened emotional state in the context of drug consumption, and even any degree of physical exertion, this combination is likely to have precipitated a fatal cardiac arrhythmia (*"*heart attack*"*).*
>
> *OC foam (*"*pepper spray*"*) is an incapacitating agent, in which the active ingredient is oleoresin capsicum. It can cause a burning sensation on the skin, closure of eyes, reflex cough, and decreased coordination, but does not usually have any life threatening conditions. However, given the autopsy findings, it is not possible to rule out, or confirm, the role of OC foam in this man's death.*"

45. Dr Young formulated the cause of death as "*1(a) Dilated cardiomyopathy and coronary artery atherosclerosis, in the setting of drug consumption (methylamphetamine, kava)*".

46. I accept Dr Young's opinion.

[18] Kavain (kava, kawain) is a kavalactone, a group of chemicals detected in root of the plant *Piper methysticum*. Adverse effects of kavain include asthenia, ataxia, decreased consciousness, slurred speech, vertigo and vomiting.
[19] Bisoprolol is a synthetic beta-blocker indicated for hypertension.
[20] The active ingredient in oleoresin capsicum (OC).

POLICIES & PROCEDURES

47. Part 3.2 of the Victoria Police Manual (**VPM**) chapter on *Operational Safety and Use of Force* provides that any force used by a police member must comply with the legal principles of section 462A of the *Crimes Act 1958* which provide as follows:

> "*A person may use such force not disproportionate to the objective as her or she believes on reasonable grounds to be necessary to prevent the commission, continuance or completion of an indictable offence or to effect or assist in effecting the lawful arrest of a person committing or suspected of committing any offence.*"

48. The VPM chapter on *Operational Safety and Use of Force* also provides that:

> "*when considering which tactical option to choose, members should be mindful that their goal is to minimize the overall harm caused by their actions or the actions of others. Where the use of force is required, the random arrangement of tactical options encourages members to escalate and de-escalate the choice of equipment or tactics in accordance with the direction the incident is taking, the objective and the information available to them*".

49. Part 6.3 of the VPM chapter on *Operational Safety Equipment* provides the following in relation to the use of OC aerosols:

> "*OC aerosols should only be used where there are reasonable grounds to believe the use is necessary and proportionate in situations (i) of violence or serious physical confrontation or (ii) where violent or serious physical confrontation is imminent*".

50. The Tactical Operations Model provides that "*optimum effectiveness with OC aerosol is achieved by spraying directly at the subject's face so that the product can affect the eyes, nose and lungs*".

51. The Oleoresin Capsicum Manual (**OC Manual**) provides as follows in relation to the deployment of OC foam:

> "*When operated, a one second burst is deployed followed by a short assessment of the effect. If there are no visible effects upon the subject, a further one second burst is to be deployed. If there is still no effect, the member should consider resorting to an alternative tactical option*".[21]

52. The Centre for Operational Safety of Victoria Police advised during the OSCIR review that applying too much OC foam can be counterproductive in some instances, as the weight of the foam will assist it to simply drip off the subject before it takes effect. Accordingly, shorter bursts are the preferred method of deployment. They advise that the timing of the deployment of bursts of OC foam is not included in police training. [22]

EXPERT EVIDENCE

53. The Court obtained an expert report dated 25 June 2023 from Professor Alison Jones, Specialist Physician and Clinical Toxicologist and Director of Medical Education at Fiona Stanley Hospital in Perth. Professor Jones relevantly stated as follows:

- A longer duration of spraying in this case than that suggested in the OC Manual likely indicates that a higher OC dose was used than intended to be initially deployed in subjects;

- Higher doses carry increased risk of adverse clinical effects such as lacrimation and respiratory irritation causing cough and bronchospasm. Simaile's history of asthma, smoking, obesity and chronic obstructive pulmonary disease would have made him more susceptible to pulmonary irritant effects of OC;

- Simaile's heart condition made him more susceptible to potential cardiac arrhythmogenic effects from OC;

[21] The Chief Commissioner of Police submitted that the OC Manual does not contain a mandatory set of prescriptive rules, rather it is an information guide used in police training. Further, the Chief Commissioner advised that the OC Manual is currently being reviewed.
[22] CB396.

- Even in the absence of OC spray, Simaile may have died from a sudden cardiac arrythmia; and

- She agreed with the cause of death formulated by Dr Young.

54. In relation to police policy and training, Professor Jones stated that general principles on the proportionate use of force by law enforcement provide some general guidance that the use of chemical irritants should be limited. She stated that police should also be trained in the dangers of chemical irritants, guidelines on the safe utilisation of chemical irritants and other risk factors. She further stated that OC sprays used by police officers should be used according to written policy.

55. The Court obtained an expert report dated 12 July 2023 from Dr Dimitri Gerostamoulos, the Head of Forensic Sciences & Chief Toxicologist at VIFM. Dr Gerostamoulos relevantly stated as follows:

- The blood concentrations of capsaicin and its metabolite dihydrocapsaicin detected in Simaile's system were approximately 26 ng/mL and 7ng/mL, respectively;

- There are no reports available in the scientific literature documenting concentrations of capsaicin in deceased persons;

- The toxicology analysis confirms the exposure of OC spray in Simaile's system;

- It is not possible to opine the significance of the concentrations of capsaicin and dihydrocapsaicin in the deceased;

- The presence of other drugs such as methylamphetamine and kavain can exacerbate any cardiac abnormalities associated with exposure to OC spray; and

- No firm scientific data currently substantiates any causal relationship between deaths and capsaicin exposure.

USE OF FORCE

56. I am satisfied that Sgt Sweep and FC Vinten had clear grounds to arrest Simaile on 29 May 2022. Further, it was reasonable and appropriate for them to prepare for any confrontation on the basis that he was an unpredictable and high-risk offender who may be armed.

57. Sgt Sweep deployed OC foam towards Simaile when he confronted him inside the shed in the backyard at 9 Vine Court. I consider that this use of force was appropriate in the circumstances given that:

- Simaile was wanted by police in respect of a number of matters including escalating breaches of an Intervention Order involving violent and threatening behaviour and an aggravated burglary;
- Sgt Sweep and FC Vinten were aware that Simaile was an unpredictable and high-risk offender who had been actively evading apprehension by Victoria Police;
- Sgt Sweep and FC Vinten were aware of intelligence that suggested Simaile may be armed and did not intend to "*go down without a fight*";
- There were reasonable grounds for Sgt Sweep to believe that the use of force was necessary to respond to a potentially violent and imminent confrontation in a confined area; and
- The choice of OC foam as a tactical option in the circumstances was proportionate to the perceived threat.

58. FC Vinten deployed OC foam towards Simaile after he had exited the shed and fallen to the ground. I consider that this decision to use force was appropriate in the circumstances for the following reasons:

- All the reasons identified in the previous paragraph that applied to Sgt Sweep's first deployment of OC foam;

- FC Vinten observed that Simaile had a knife in his hand when he exited the shed;

- FC Vinten provided repeated directions to Simaile to "*put his hands up*", "*get on the ground*" and "*drop the knife*" which were not complied with or were ignored; and

- Although Simaile was on the ground, the knife remained in his right hand and he had raised himself on his forearms from where he could potentially rise to his feet, noting at this point that FC Vinten stated "*stay down brother*" as Simaile propped himself up on his forearms.

COMPLIANCE WITH TRAINING, POLICIES & PROCEDURES

59. I am satisfied that there were reasonable grounds for Sgt Sweep and FC Vinten to believe that the use OC foam was necessary on the basis that violence or serious physical confrontation was potentially imminent. Further, I consider that the use of OC foam as a tactical option was reasonable and proportionate in the circumstances. They were clearly motivated to avoid the use of lethal force if possible. It follows that I consider that the deployments of OC foam by both Sgt Sweep and FC Vinten were in compliance with the policy requirements in the VPM (which include the statutory requirements).

60. FC Vinten's deployment of OC foam was for a period of 8-9 seconds in a continuous stream which resulted in Simaile's face becoming completely enveloped in OC foam. This was a high dose in the circumstances and Professor Jones noted that higher doses increase the risk of adverse clinical effects. This deployment was not consistent with the guidance in the OC Manual which provides that a one second burst be deployed, followed by a further one second burst, if necessary, before consideration of alternative tactical options if they are ineffective.

61. I am not critical of FC Vinten in relation to his deployment of OC foam in the circumstances as the Chief Commissioner of Police conceded in submissions that the timing of the deployment of bursts of OC foam is not included in police training. Further, it is accepted that the provisions of the OC Manual should be interpreted in a way which provides operational flexibility. Notwithstanding that flexibility, I am satisfied that the expert evidence and the OSCIR Report generally support a practice of shorter burst times for the deployment of OC foam.

CONTRIBUTION OF OC FOAM

62. I am satisfied that Simaile died from cardiac arrythmia precipitated by his underlying heart disease, combined with his methylamphetamine use and his physical exertion experienced during his apprehension. The evidence of Dr Young, Dr Gerostamoulos and Professor Jones does not enable me to conclude that the deployment of OC foam by police in the circumstances caused or contributed to his death. As stated by Professor Jones, Simaile may have died from a sudden cardiac arrythmia even in the absence of any OC foam.

FINDINGS AND CONCLUSION

63. I am satisfied that Sgt Sweep and FC Vinten acted reasonably and professionally in the discharge of their duties on 29 May 2022. They coordinated their response to the unfolding circumstances and sought to clearly communicate and negotiate with Simaile in a way which would reduce the likelihood of the necessity to use lethal force.

64. Simaile's death was witnessed and experienced directly by his family, members of Victoria Police and paramedics from Ambulance Victoria in very distressing circumstances. It has devastated his family and also impacted the first responders. It was a heightened and emotionally charged scene which presented management challenges for police. I am conscious that the Court is examining events in detail which in reality unfolded rapidly in a high pressure and stressful environment. Nevertheless, the circumstances provide a valuable opportunity for reflection which may inform operational planning and training in the future.

65. Having held an inquest into Simaile's death, I make the following findings, pursuant to section 67(1) of the Act:

(a) the identity of the deceased was Simaile Masila-Liutolo, born on 1 April 1987;

(b) the death occurred on 29 May 2022, at 9 Vine Court, Robinvale, Victoria;

(c) from dilated cardiomyopathy and coronary atherosclerosis, in the setting of drug consumption (methylamphetamine, kava); and

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

RECOMMENDATIONS

66. Pursuant to section 72(2) of the Act, I make the following recommendations:

(a) The Chief Commissioner of Police bring to the attention and raise awareness for all police members the deployment guidance in respect of OC aerosols (including OC foam) as contained within the Victoria Police Oleoresin Capsicum Manual.

(b) The Chief Commissioner of Police include guidance in relation to the timing of the deployment of bursts of OC foam in police training.

I convey my sincerest sympathy to Simaile's family.

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

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

Latai Masila-Liutolo, Senior Next of Kin

Chief Commissioner of Police, c/o the Victorian Government Solicitor's Office

Senior Sergeant Jason Poulton, Coroner's Investigator

Professional Standards Command, Victoria Police

Signature:

Coroner David Ryan
Date: 21 September 2023

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.