



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006760

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Dimitra Dubrow
Deceased:	Irene Winifred Porter
Date of birth:	31 October 1927
Date of death:	Unknown
Cause of death:	Unascertained
Place of death:	Unknown
Keywords:	Missing person-suspected death

INTRODUCTION

1. On 16 August 1969, Irene Winifred Porter (**Irene**) was 41 years old when she went missing. At the time of her disappearance, Irene was residing with her husband, Keith Porter, and their three children Julie, Phillip and Janice, in Coleraine, Victoria.
2. Little is known about Irene's medical history save that she was being treated by her General Practitioner for abdominal pain and was due to undergo an operation. It is believed that Irene was in a depressed state of mind prior to her disappearance.

THE CORONIAL INVESTIGATION

3. On 20 November 2024, Irene's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. Under section 3 of the Act, death includes suspected death.
4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
6. Victoria Police assigned an officer to be the Coronal Investigator for the investigation of Irene's death. The Coronal Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.
7. This finding draws on the totality of the coronial investigation into the death of Irene Winifred Porter including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.¹

8. The coronial investigation of a suspected death differs significantly from most other coronial investigations which commence with the discovery of a deceased person's body or remains. The focus in those cases is on identification of the body or remains, a forensic pathologist's examination and advice to the coroner about the medical cause of death and, where possible, the circumstances in which the death occurred.
9. Absent a body or remains, the coronial investigation focuses on the last sighting of the person suspected to be deceased; any subsequent contact with family, friends or authorities; and any evidence of proof of life since the last sighting. In such cases, the coronial investigation must first endeavour to establish, on the balance of probabilities, whether the person suspected to be deceased – is deceased. Such proof of death often relies on the absence of evidence that the person is alive, such as physical searches for the person; a lack of contact with known friends, family or colleagues; a lack of banking or like activities; and the lack of an “electronic footprint” that is usually evident with innumerable modern everyday activities. It also relies on other circumstantial evidence such as the prevailing environmental conditions and the individual attributes of the person suspected to be deceased, including their state of health.

CIRCUMSTANCES OF DISAPPEARANCE:

10. The Missing Person Report for Irene dated 18 August 1969, indicated that on 16 August 1969, Irene left her residence with her daughter, Julie, to complete some shopping in Coleraine around 9am.
11. After making some purchases, Irene asked Julie to place the parcels in the car. Irene then attended the bus depot and purchased a ticket to Hamilton. She boarded the bus and was seen in Gray Street Hamilton around 12pm that day by other residents of Coleraine.
12. When Irene failed to return home, she was reported missing by her husband Keith, to Coleraine Police.

¹ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

13. On 17 August 1969, a purse, coat and shoes were located on a beach in Warrnambool that were subsequently confirmed to be Irene's. The items were located on the beach, west of the Hopkins River. At 4pm that afternoon, a further report was received of a woman wearing similar clothing to that of Irene as having been seen on a beach in Warrnambool.
14. Warrnambool Search and Rescue Squad and the St John's Ambulance Brigade conducted a land and sea search of the area. Nothing was located in relation to the disappearance.
15. At the time, Detective John Manley investigated Irene's disappearance and released information to the local media detailing that, police considered that Irene may have drowned in the area as the belongings were located slightly above the high-water mark.

POLICE INVESTIGATION

16. The missing person investigation for Irene remained with local police and the Missing Person Unit until 2004 when it was reviewed by Operation Bellier, a taskforce created to review long-term missing person investigations. Searches were conducted including;
 - a) Updated person checks;
 - b) Victorian Birth Deaths and Marriage checks;
 - c) Change of name checks;
 - d) Interstate and Territory checks;
 - e) Unidentified human remains reports examined.
17. Despite these checks, no further information was established to assist the investigation.
18. In 2017, primacy of the missing person investigation was allocated to the Hamilton Crime Investigation Unit. Periodical review was conducted of the investigation up until November 2024, when Detective Senior Constable Craig Wastell (**DSC Wastell**) took carriage of the matter.
19. Upon contact with the Coroner's Court, it was identified that a DNA profile had not been obtained from the next of kin to be placed on the Victorian Missing Person DNA Database and the National Missing Person Coordination Centre database. This was subsequently completed on 3 December 2024 with the DNA profile lodged on the above databases for

comparison against any unknown deceased individuals. As a result of that analysis, there were no comparable profiles identified.

20. DSC Wastell noted that extensive enquiries were conducted to locate records of the investigation conducted at the time of Irene's disappearance and as it progressed. Unfortunately, no records were able to be identified even after contacting the following;
 - a) Victoria Police Archive Services Centre (VPASC)
 - b) Coleraine Police Station
 - c) Hamilton Police Station
 - d) Warrnambool Police Station
 - e) Operation Bellier Task Force
21. DSC Wastell noted that attempts to locate any medical records for Irene were also unsuccessful due to the lapsed time since her disappearance. Further, police members involved in the investigation are now deceased with no records or diaries that belonged to them that may assist.
22. Updated checks were conducted with the Registry of Births, Deaths and Marriages Victoria which confirmed that there were no records of Irene's death and no records to indicate a change of name.

FINDINGS AND CONCLUSION

23. Irene went missing at the age of 41. Today, she would be 98 years old, and I am satisfied that she is deceased. Further, I am satisfied that there are no further avenues of investigation reasonably open at this stage to elicit further evidence about the cause and circumstances of her death.
24. The evidence does not enable me to be satisfied as to the exact circumstances or cause of Irene's death. The evidence demonstrates that Irene left her hometown due to possible ongoing medical and/or mental health issues. She travelled by bus to Hamilton and onto Warrnambool where she attended a beach near the Hopkins River entrance. From here, it is possible that she entered the water and drowned, that she became lost or injured and passed away from exposure to the elements, or that she took her own life.

25. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Irene Winifred Porter, born 31 October 1927;
 - b) the death occurred on an unknown date; and
 - c) the death occurred in the circumstances described above.
26. It is acknowledged that Irene’s disappearance has been distressing for her family and they have not had an opportunity to have greater clarity in relation to the exact circumstances of her passing.

I convey my sincere condolences to Irene’s family for their loss.

Pursuant to section 73(1B) 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:

Phillip Porter, Senior Next of Kin

Detective Senior Constable Craig Wastell, Coronial Investigator

Signature:



Coroner Dimitra Dubrow

Date: 19 June 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 investigation. 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.
