IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 0206

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	James KOMNINAKIS
Date of birth:	4 July 1977
Date of death:	12 January 2020
Cause of death:	1(a) MIXED DRUG TOXICITY
Place of death:	Glen Waverley

BACKGROUND

1. James KOMNINAKIS was born on 4 July 1977, the youngest of three children to Anastasious and Efstiria KOMNINAKIS, and was 42 years of age when he passed away on 12 January 2020 at Glen Waverley.

2. James' parents emigrated to Australia from Greece in approximately 1968 settling in the Collingwood area. In about 1979 or 1980 the family moved back to Greece as his parents were homesick with James' older brother George moving back out to Australia in 1995. Around the turn of the century his parents moved back to Australia for George's wedding and took the opportunity to bring James with them.

3. Around the age of about 15 James and the group of friends he was socialising with began experimenting with illicit drugs, primarily cannabis. James then moved towards using other illicit drugs several years later whilst he was still in Greece including heroin. James' illicit drug use was a primary reason his parents moved out to Australia and brought James with them.

4. In 2001 after moving out to Australia James' made numerous attempts at breaking his addiction however over the following nearly twenty years was never successful. Whilst he remained employed fairly consistently as a stone mason and lived throughout with his parents, he also engaged in criminal activity to fund his addiction resulting in numerous criminal convictions.

5. James' had a number of girlfriends and at one stage was married with a young daughter, his illicit drug use continued to have an overwhelmingly detrimental and destructive effect upon all of these relationships. This included a Family Violence Intervention Order being taken out by Victoria Police in 2013 with no contact conditions that remained in place until his passing.

6. James rarely consulted medical professionals and as far as his family were aware, he didn't have any mental or physical health issues. His older brother George remembers his younger brother as '*a good kid who loved his family he had the support of our family and was really good when he was off drugs*'.

CORONIAL INVESTIGATION

Jurisdiction

7. James' death constituted a *'reportable death'* pursuant to section 4(2)(a) of the *Coroners Act 2008* (Vic) (**Coroners Act**), as his death occurred in Victoria and it appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.

Purpose of the Coronial Jurisdiction

8. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[1] 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.

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

10. 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.

11. 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.

12. Coroners are empowered to:

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

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

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

13. It is important to stress that 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 a finding or comment or any statement that a person is, or may be, guilty of an offence.[2] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3]

Standard of Proof

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[4] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[5]

15. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[6] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

16. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[7] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[8]

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[1] Section 89(4) *Coroners Act 2008.*
[2] 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) of the Act.
[3] *Keown v Khan* (1999) 1 VR 69.
[4] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[5] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[6] (1938) 60 CLR 336.
[7] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[8] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

CIRCUMSTANCES OF DEATH

17. On 9 January 2020 James was due to appear before Moorabbin Magistrates Court in respect of a charge of deal in property suspected to be the proceeds of crime. He however failed to appear and a bench warrant was issued for his arrest.

18. The following day approximately 7.50pm James attended Oakleigh Police Station and spoke with Senior Constable BASSETT in respect of the outstanding warrant. A check of the LEAP system also indicated that there was an outstanding application and summons in relation to a Family Violence Intervention Order.

19. Senior Constable BASSETT placed James under arrest in respect of the outstanding bench warrant and he was provided his legal rights. In Senior Constable BASSETT's opinion '*James demeanour was calm and he appeared to have a good understanding of what was occurring*'. Senior Constable BASSETT was escorted to the charge counter where a welfare check was conducted by Sergeant MURRAY.

20. The nature of the application and summons for the Family Violence Intervention Order was explained to James and he was subsequently bailed on the bench warrant to appear at the Moorabbin Magistrates Court on 24 February 2020 and released from custody. Throughout his time in custody, Senior Constable BASSETT did not observe anything remarkable about James' demeanour and no concerns were held in respect of his mental health.

21. Two days later on 12 January 2020 James was at home with his parents who left the residence between 8-8.30am. Although James was still in bed, he was definitely alive.

22. Approximately 12.30pm they returned home to find James on his bed, unresponsive. They immediately called Triple Zero and Ambulance Victoria responded with paramedics upon their arrival indicating James had been deceased for some time and no resuscitation attempts were commenced.

23. Detectives attended the location and a search of James' bedroom located a small quantity of a substance believed to be heroin, two blue tablets believed to be Xanax along with a freshly used uncapped syringe in the waste bin.

IDENTITY OF THE DECEASED

24. James KOMNINAKIS was identified through Visual Identification by his Father as detailed within the Statement of Identification dated 12 January 2020. James' identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

25. On 13 January 2020 Dr LYNCH, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an external examination on James KOMNINAKIS' body and reviewed the Victoria Police Report of Death Form 83 and a post-mortem computed tomography (CT) scan.

26. Dr LYNCH observed that '*there is the suggestion of a recent venepuncture mark on the right hand and scarring at both cubital fossae*'.

27. Dr LYNCH formulated the cause of death as *MIXED DRUG TOXICITY*.

28. Post-mortem toxicology detected the presence of 6-Monoacetylmorphine, codeine, methylamphetamine, clonazepam, mirtazapine, diphenhydramine and paracetamol. The toxicology report noted '*these results are consistent with the recent and potentially fatal use of heroin. Heroin and morphine are depressants of the CNS causing a reduced rate and depth of breathing and may cause cessation of the breathing reflex. The combination of drugs may cause death in the absence of other contributing factors*'.

FINDINGS AND COMMENT

29. Having investigated the death of James KOMNINAKIS, I make the following findings and conclusions, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was James KOMNINAKIS, born 4 July 1977; and

    (b) that James KOMNINAKIS died on 12 January 2020, at Glen Waverley, from *MIXED DRUG TOXICITY*;

    (c) in the circumstances set out above.

30. I convey my sincerest sympathy to James' family.

31. Pursuant to section 73(1A) of the Act, I direct that this finding be published on the Internet.

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

    The Family of James KOMNINAKIS;

    Coroner's Investigator, DSC Luke GRELIS; Box Hill CIU.

Signature:

SIMON MCGREGOR
CORONER
Date: 26 October 2021

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.