



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000986

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Panayotis (Peter) Pavlis
Date of birth:	1 February 1942
Date of death:	19 February 2025
Cause of death:	1a : PNEUMONIA
Place of death:	St. Vincent's Hospital Melbourne 41 Victoria Parade Fitzroy Victoria 3065
Keywords:	In Custody; Natural Causes

INTRODUCTION

1. On 19 February 2025, Panayotis (Peter) Pavlis was 83 years old when he died in St Vincent's Hospital while remanded in custody. At the time of his death, Peter was serving a 17-year term of imprisonment for the murder at Ravenhall Correctional Centre, 97 Riding Boundary Rd, Ravenhall, Victoria, 3023.
2. Peter was born in Athens, Greece and migrated with his family to Australia in 1950. Peter was reported to have left school at the age of 14 and worked primarily at Ford Manufacturing before starting a several business ventures. Peter was married to Jane Duncan in 1967 and the couple had two children.¹
3. In 2018, Peter was convicted of the murder of his former business partner and was sentenced to a term of 17 years imprisonment.
4. In 2021, Peter was diagnosed with rapidly progressing dementia and had a medical history consisting of obstructive sleep apnoea, ischaemic heart disease, diabetes mellitus and depression. Peter was immobile in the six months leading up to the fatal incident and was restricted to his bed/chair and only able to consume a pureed diet.²

THE CORONIAL INVESTIGATION

5. Peter'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.
6. 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.
7. 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

¹ *Coronial Brief*, Statement of Terry Pavlis.

² *Coronial Brief*, Statement of Dr Marc Lanteri.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned Senior Constable Mitchell Harris to be the Coronial Investigator for the investigation of Peter's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
9. This finding draws on the totality of the coronial investigation into the death of Panayotis (Peter) Pavlis 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.³
10. In considering the issues associated with this finding, I have been mindful of Peter's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

11. On 9 February 2025 at 3:15 pm, whilst the rostered nurse was attending to Peter, she noted that he had pale skin with poor capillary refill, rapid breathing and limited response to voice commands as well as difficulty being roused.⁴ Despite multiple attempts to administer medication, Peter was unable to swallow or ingest food or fluids. Due to concerned risks of aspiration, Peter's condition was discussed amongst the medical staff at Ravenhall Correctional Facility and a transfer to hospital for assessment was approved.⁵
12. An ambulance attended at 5:00 pm and collected Peter and transported him to St. Vincent's Hospital for treatment.

³ 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.

⁴ *Coronial Brief*, Statement of Registered Nurse – Gurkamal Kaur.

⁵ *Ibid.*

13. On 10 February 2025, Peter was formally transferred from Ravenhall Correctional Facility to the St Augustine's Ward at St Vincent's Hospital.
14. On 12 February 2025, Peter's deteriorating condition was discussed with his family and it was agreed that he would be provided palliative care and a syringe driver was initiated to provide him with comfort.⁶
15. On 19 February 2025 in the evening, Peter was pronounced deceased by treating medical staff at St Vincent's Hospital.⁷
16. Victoria Police members attended St Vincent's Hospital and commenced the coronial investigation by examining the circumstances of Peter's passing. No suspicious circumstances were noted and investigating members were advised on Peter's diagnosis of recent declining health and progressive dementia that contributed to the development of pneumonia.⁸

Identity of the deceased

17. On 26 February 2025, Panayotis (Peter) Pavlis, born 1 February 1942, was visually identified by their son, Terry Pavlis.
18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination on 21 February 2025 and provided a written report of his findings dated 17 March 2025.
20. Dr Bedford found evidence of documented sepsis and lung changes on a background of severe dementia.
21. Post-mortem CT scans revealed evidence of cerebral atrophy with no acute changes, coronary artery calcifications and bilateral lower lobe lung changes.
22. Dr Bedford provided an opinion that the medical cause of death was 1(a) Pneumonia and I accept Dr Bedford's opinion.

⁶ *Coronial Brief*, Statement of Dr Marc Lanteri.

⁷ *Ibid.*

⁸ *Ibid.*; Statement of Senior Constable Mitchell Harris.

FINDINGS AND CONCLUSION

23. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.⁹ Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.
24. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Panayotis (Peter) Pavlis, born 1 February 1942;
 - b) the death occurred on 19 February 2025 at St. Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065, from 1(a) Pneumonia; and
 - c) the death occurred in the circumstances described above.
25. Because Peter died in hospital whilst remanded in Ravenhall Correctional Centre at the time of his passing, his death is considered to be 'in custody' as defined by section 3 of the Act and prima facie subject to a mandatory inquest. However, having considered all of the evidence, I am satisfied by the available evidence that Peter's death was due to natural causes and pursuant to section 52(3A) of the Act, have determined not to hold an inquest.

I convey my sincere condolences to Peter's family for their loss.

⁹ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...'.

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:

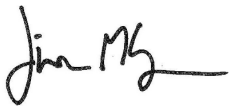
Jane Pavlis, Senior Next of Kin

Lisa Humphries, Justice Assurance and Review Office

Donna Filippich, St Vincent's Hospital

Senior Constable Mitchell Harris, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 10 November 2025

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.
