CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jean-Louis Langlois
Hearing dates:	20 July 2023
Date of Findings:	20 July 2023
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, unidentified human remains, New South Wales Police Force Fingerprint Operations, fingerprint impressions and examination, National Automated Fingerprint Identification System, Modified Henry Classification System
File number:	1997/56628
Representation:	Ms C Xanthos, Coronial Advocate Assisting the Coroner
Findings:	Jean-Louis Langlois died sometime between about 31 December 1996 and 8 January 1997. The cause of Mr Langlois' death was immersion, with alcohol intoxication and doxepin toxicity being significant conditions contributing to the death. The available evidence does not allow for any finding to be made as to the place or as to the manner of Mr Langlois' death.

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1. Introduction

1.1 On the evening of 8 January 1997 the naked body of an unidentified male person was found on the shores of Wanda Beach in Cronulla. A set of fingerprint impressions were taken from this person and the New South Wales Police Force (**NSWPF**) made a number of enquiries in an attempt to the identity this person. However, the person's identify was not established at the time.

1.2 On 14 July 1997, an inquest into the death of this person was held. A finding was made that the person had died from the effects of immersion but no finding could be made as to the circumstances in which the person died.

1.3 On 9 July 2021, the fingerprint impressions taken from the deceased male person were re-examined using technology which was not available in 1997. This examination identified a positive match with a set of fingerprints taken from Jean-Louis Langlois by the NSWPF on 26 October 1989.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 As set out in more detail below, the evidence gathered in this case establishes that the deceased male person found on Wanda Beach on 8 January 1997 is Jean-Louis Langlois. However, the initial investigation conducted after Mr Langlois was discovered, and the further investigation conducted after July 2021 when Mr Langlois was identified have not been able to establish the manner of his death; that is, the circumstances in which he died. In addition, given that Mr Langlois fingerprints were available to the NSWPF from October 1989 it was not immediately clear why a positive match was not made in January 1997, and why it took until the July 2021 for a positive match to be made. For all these reasons, an inquest was required to be held.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Mr Langlois' background and personal circumstances

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the

preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Tragically, very little is known about Mr Langlois life or his family members. However, it is hoped that what is set our briefly below acknowledges Mr Langlois' life in a meaningful way.

3.2 Mr Langlois was born on 4 June 1946 in Avignon, France. At some stage he studied architecture. He later formed a relationship with, and subsequently married, Minouchka Langlois.

3.3 Mr Langlois and his wife arrived in Australia in February 1971 and Mr Langlois became an Australian citizen on 13 November 1975. Although his wife was able to quickly find work, Mr Langlois struggled to find employment. Colin Griffiths, a close friend who had previously met Mr Langlois whilst travelling through France, observed that Mr Langlois's mental health deteriorated during this period. The relationship between Mr Langlois and his wife ended sometime later and his wife departed Australia.

Deterioration of Mr Langlois' mental health

3.4 Following this, Mr Langlois continued to have difficulties finding employment and lived an itinerant lifestyle, staying at various short-term accommodations in the King's Cross area. During this period he also experienced financial difficulties, accumulating large amounts of debt and borrowing money from friends.

Mr Griffiths observed that Mr Langlois's mental health continued to deteriorate. Mr Griffith describes an occasion when Mr Langlois arrived at his house in the middle of the night by taxi "*half naked and carrying his personal items in a plastic bag*". Mr Griffiths took Mr Langlois to hospital where he was admitted. During the course of his admission, Mr Langlois's mental health appeared to improve but then deteriorated again following his discharge. Mr Griffiths attempted to seek assistance for Mr Langlois from a number of different mental health services. Despite this, Mr Langlois later developed a dependence on alcohol and used illicit substances.

3.5 NSWPF records indicate that during this period, Mr Langlois was regularly admitted to hospital for issues relating to his mental health. For example, on 17 January 1989, Mr Langlois presented to hospital and complained of persecution from undefined persons. He was noted to be confused with a blunted affect and reported having had numerous "*breakdowns*" in the past. Mr Langlois was noted to have a depressed mood with thought content concentrated around persecution, stress and inability to cope, but expressed no suicidal ideation. He was referred for a psychiatric consult at a specialist mental health facility.

3.6 Mr Langlois also had a number of interactions with the NSWPF in relation to relatively minor alleged offences concerning property damage during this same period. He was often dealt with pursuant to applicable mental health legislation provisions.

Obtaining Mr Langlois' fingerprint records

3.7 On 25 October 1989, Mr Langlois was arrested and charged with allegedly causing relatively minor damage to a vehicle that had been parked at McMahons Point. As part of the charging process, Mr

Langlois's personal details (including his age, height, date of birth and country of origin) were recorded and his fingerprints were taken by ink and roller on 26 October 1989 (**the 1989 Fingerprint Record**) at North Sydney police station.

The 1989 Fingerprint Record was converted to a digital record on the version of the National Automated Fingerprint Identification System (**NAFIS**) which was in operation at the time. NAFIS is a computerised database of fingerprint records that is used to search and store both record and latent fingerprints. Detective Chief Inspector Ian Rowney, the Manager of NSWPF Fingerprint Operations, explained that although NAFIS is a useful tool in searching latent fingerprints, it does not establish a fingerprint identical occasion. This function is performed by a fingerprint expert.

3.8 The 1989 Fingerprint Record was, however, not filed manually via the modified Henry Classification system as this process had been discontinued by 1989. Detective Chief Inspector Rowney explained that this was due to "*the general reliability, speed and accuracy of NAFIS*".

Mr Langlois' further admissions to hospital

3.9 On 27 December 1989, Mr Langlois travelled to France and later returned to Australia on 25 June 1990. Following his return, Mr Langlois again presented to hospital on a regular basis for mental health issues. He also had a number of further interactions with the NSWPF between October 1992 and September 1996 including, relevantly:

(a) On 31 October 1992, Mr Langlois attended hospital complaining of having allegedly being assault. It was noted that Mr Langlois had a manic depressive illness of "*many years*" and that he was taking doxepin;

(b) On 19 February 1993, Mr Langlois was admitted to hospital complaining of a fractured wrist after falling whilst intoxicated;

(c) On 22 December 1994, Mr Langlois was again admitted to hospital complaining of a hiatus hernia. During this admission, Mr Langlois reported smoking 50 to 100 cigarettes a day and drinking a bottle of wine a day; and

(d) On 26 March 1996, Mr Langlois was admitted to hospital complaining of detoxification from alcohol.

3.10 Mr Langlois last came under the notice of the NSWPF on 12 September 1996 in relation to a minor accidental fire at the accommodation where he was residing. He was taken to hospital for treatment for smoke in relation.

4. Discovery of Mr Langlois and initial police investigation

4.1 At around 6:15pm on 8 January 1997, two members of the public were running along the water's edge at Wanda Beach in Cronulla when they came across an object in the sand which they originally thought was a log. Upon closer inspection, they realised that they had in fact discovered the body of a deceased male person. The person was located in shallow surf approximately 1.5 kilometres north

of Wanda Beach Surf Club. The person was naked and not immediately identifiable. Emergency services were notified.

4.2 After arriving at the scene, NSWPF officers conducted a search of the immediate area which did not locate any clothing or property items that might assist with identifying the deceased person.

4.3 Further investigation conducted by the NSWPF included:

(a) a canvas conducted of the surrounding area, including residential homes in the vicinity;

(b) enquiries made regarding missing persons reported in the local area;

(c) enquiries made with the NSWPF Missing Persons Unit (as it then was) to ascertain whether any persons with the same physical description missing persons with the same physical description; and

(d) information regarding the physical description of the male person, the circumstances in which he was found and a computerised reconstruction of his face was distributed to a number of accommodation services and mental health services seeking information but not produce any result.

4.4 In addition to the above, media articles were published in regional and national newspapers regarding the discovery of the deceased person but this also did not elicit any information from the public as to the person's identity.

5. Initial attempts at fingerprint identification

5.1 On 10 January 1997, a set of 10 inked fingerprint impressions were obtained from the unknown male person and recorded on a fingerprint card (**the 1997 Fingerprint Record**) by Detective Senior Constable Brian Worboys. The 1997 Fingerprint Record was conveyed to NSWPF Fingerprint Operations where two searches were conducted:

(a) an electronic search using NAFIS; and

(b) a manual search using the Modified Henry Classification System against hardcopy fingerprint records.

5.2 Both searches failed to identify the deceased person.

5.3 Detective Senior Constable Worboys subsequently completed a fingerprint identification statement indicating that the deceased male person was "*not known*" against existing NSWPF fingerprint records.

6. Post-mortem examination

6.1 A post-mortem examination was conducted on 10 January 1997 by Dr Peter Bradhurst, forensic pathologist. Dr Bradhurst noted that there was early decomposition of the head, neck and trunk, and that there was wrinkling of the skin of the hands and feet indicating that the body had been in water for between 4 to 10 days. Dr Bradhurst did not identify any suspicious findings and recorded the interim cause of death as "*consistent with immersion*".

6.2 Toxicological analysis identified a blood alcohol concentration of 0.168 g/100mL, suggesting the possibility of intoxication but with some uncertainty as to whether this concentration could be accounted for by post-mortem redistribution. In addition, a toxic concentration of doxepin (a tricyclic antidepressant) was also detected, together with low levels of diazepam and nordiazepam.

6.3 Dr Alain Middleton, a forensic odontologist, examined the deceased male person's dentition and made certain observations regarding their condition, and also noted that the deceased male person was likely 25 to 50 years old. However, no identification could be performed by comparison with dental records.

6.4 In the final autopsy report dated 27 March 1997, Dr Bradhurst noted that there was no evidence of any suspicious injury or any sign of violence. The coronary arteries were noted to be free of atheroma and had good patency throughout, and no structural abnormality was detected. Dr Bradhurst confirmed his opinion that the body had been in the water for approximately 4 to 10 days. Ultimately, Dr Bradhurst opined that the cause of death was consistent with immersion, with alcohol intoxication and doxepin toxicity being significant conditions contributing to the death.

7. Mr Langlois' passport

7.1 On 24 May 1997, David James attended Kings Cross police station and handed in Mr Langlois's passport. Mr James told police that Mr Langlois had been staying at his residence in Potts Point and had left his passport behind. Mr Jones requested police to return the passport to Mr Langlois or to the Consulate of France. It should be noted that Mr Jones did not report Mr Langlois as a missing person at this, or any other, time.

7.2 Subsequent enquiries made in December 2021 with the Consulate General of France did not identify any record in relation to Mr Langlois's passport. However, it was indicated that retention of passport files are only retained for 10 years following the expiration date of a passport.

8. Previous inquest proceedings

8.1 On 14 July 1997, Magistrate Hand held an inquest regarding the death of the unknown male person. Various documents were tendered into evidence including the autopsy report, statements from various police officers and a report from the "*fingerprint specialists unit*". No witnesses were called to give evidence.

8.2 His Honour concluded that the person died on or about 8 January 1997 in the Pacific Ocean off Sydney from the effects of immersion. His Honour was unable to make a finding as to the person's identity or the circumstances in which he came to enter the water.

9. Positive identification of Mr Langlois

9.1 In 2020, Fingerprint Operations commenced a project to re-examine fingerprint evidence holdings in relation to historic unidentified missing persons. According to Detective Chief Inspector Rowney, "*the broad aim of the project was to locate available deceased person fingerprint records and re-search these records using the modern NAFIS fingerprint searching technology and image comparison software*".

9.2 On 9 July 2021, the fingerprint evidence for the deceased male person was re-examined at Fingerprint Operations. This involved the 1997 Fingerprint Record being scanned digitally and searched on NAFIS. This search resulted in a positive identification of the 1997 Fingerprint Record as belonging to Mr Langlois. A fingerprint identification statement confirming this match was completed by Detective Sergeant James Mulholland and sent to the Coroner on 9 July 2021. The NSWPF Missing Persons Registry was also advised of this positive identification.

9.3 Following this positive identification further investigation was conducted by the NSWPF, including:

(a) enquiries with a number of financial institutions which revealed no recent financial activity in any account held by Mr Langlois;

(b) enquiries with Medicare and the Pharmaceutical Benefits Scheme (**PBS**) which revealed no activity by Mr Langlois since 31 December 1996 when he obtained a prescription for doxepin; and

(c) enquiries with the NSW Registry of Births, Deaths and Marriages; NSWPF and other interstate law enforcement authorities; and NSW and interstate government electoral, housing, utilities agencies and commissions which revealed no recent record of activity concerning Mr Langlois.

10. Delay in establishing a positive fingerprint identification for Mr Langlois

10.1 Although Mr Langlois's 1989 Fingerprint Record was stored on NAFIS as at January 1997, it is evident that a NAFIS search at that time did not return a positive identification. Detective Chief Inspector Rowney has expressed the following opinion as to the reasons for this:

(a) The overall quality of the 1997 Fingerprint Record was poor "*due to a large degree of distortion and smudging generated through the ink and roll capture process*". Detective Chief Inspector Rowney explained that this method is typically "*prone to overdevelopment and smudging of the individual fingerprint impressions*". Further, the poor results were "*likely exacerbated by the physical state of [Mr Langlois's] friction ridge skin*" at the time of the examination, "*with the presence of wrinkling associated with both age and prolonged water submersion evident in all of the recorded finger impressions*". Detective Chief Inspector Rowney also noted that "*there were a large number of factors including displacement, rotation, heavy distortion and the*

unnatural presence of creases in the skin which significantly contributed to the inability of the system to extract accurate minutiae and proposed Mr Langlois as a candidate for matching".

(b) No palm or slap (plain) impressions were recorded in 1997. Slap impressions are a sequence of all eight fingerprints taken at the same time. The absence of these impressions reduced the manual and automated searching options available to identify the fingerprints at that time. Further, the absence of such impressions, together with the quality of the impressions and the technology limitations at the time created what Detective Chief Inspector Rowney described as a "*snowballing effect*" in relation to the ability of NAFIS to propose candidates for a possible match.

(c) When the 1997 Fingerprint Record was digitised, in preparation for being searched on NAFIS, a 1990s scanner was used which led to further degradation and loss of the original image quality (which was already of low quality).

(d) The 1989 fingerprint impressions were, overall, of poor quality and also subject to similar image degradation when digitised.

(e) Detective Chief Inspector Rowney gave evidence describing the overall quality of the 1989 Fingerprint Record and the 1997 Fingerprint Record both as being a "*4 out of 10*".

(f) The NAFIS search in 1997 used a computerised searching tool that was introduced in 1985. Detective Chief Inspector Rowney describes the 1985 version of NAFIS as "*a rudimentary searching tool which was heavily dependent on the skill of the operator and the quality of the fingerprint impressions*". Detective Chief Inspector Rowney expressed the view that "*small variations of input quality resulted in large-scale algorithm errors meaning that candidates could easily be missed or overlooked*".

10.2 Detective Chief Inspector Rowney also identified a number of changes and advances made in fingerprint identification technology since 1997:

(a) The version of NAFIS in use in 1997 was "1980s vintage technology [which] did not have anywhere near the accuracy or flexibility of the present system in its ability to accurately match low quality fingerprint images". The NAFIS system was upgraded in 2001 and Detective Chief Inspector Rowney gave evidence that a third iteration of the system was upgraded recently in June 2023. The current NAFIS algorithm is described as "*vastly superior accurately extracting minutiae and resolving identifications, even in the poorest quality fingerprint images*".

(b) Using the same example of grading described above, Detective Chief Inspector Rowney gave evidence that even with fingerprint records that are "*2 out of 10*", the current version of NAFIS is sophisticated enough to resolve identifications and propose candidates for matching.

(c) Use of sticky labels, digital photography and mobile phone technology now allows for consistently good quality fingerprint images, including palms, to be recorded. This allows for a full and accurate search of the NAFIS database, and for finger sequence errors to be detected more easily and rectified.

(d) Detective Chief Inspector Rowney gave evidence that the current version of NAFIS ensures that only fingerprint records of sufficient quality are submitted to allow for accurate searching to be performed and for candidates to be proposed.

(e) In 1999, the NSWPF transitioned to digital fingerprint capture via the "Livescan" system, which replaced ink and roller as the fingerprint capture method. This has "*led to consistently improved quality of fingerprint records which has almost eliminated the possibility of a missed person identification*".

(f) In 2001, there was an upgrade to the NAFIS system which provided for a modern interface which was integrated to Livescan for real-time identification results.

(g) Fingerprint operations now utilise a forensic information management system that allows for "*the timely receipt of job[s] relating to processing all reviews of deceased persons case files*".

(h) Fingerprint Operations is continuing to work with the Missing Persons Registry to identify existing fingerprint records which are suitable for a forensic review. Detective Chief Inspector Rowney notes that the "*aim of this review will be to identify any other unidentified deceased persons with fingerprints currently on the NAFIS and retain these records indefinitely on NAFIS to be searched via any future technical capability upgrades*".

10.3 Detective Chief Inspector Rowney gave evidence that whilst it is likely that the NAFIS search in 1997 resulted in some candidates for a possible match being proposed, it is not possible to know now whether any of those candidates was the 1989 Fingerprint Record. In addition, Detective Chief Inspector Rowney gave evidence that the 1989 Fingerprint Record was not filed manually via the modified Henry Classification system. This is because the system was in the process of being discontinued in 1989 with the perception that the reliability, speed and accuracy of the NAFIS system "*could not get any better*". Detective Chief Inspector Rowney gave evidence that if the 1989 Fingerprint Record had been filed manually in 1989 this would have increased the likelihood of a positive fingerprint identification match, using the modified Henry Classification system, being made in 1997.

10.4 Detective Chief Inspector Rowney explained that whilst the 1997 Fingerprint Record was digitised for purposes of the NAFIS search, it was not stored. This was a result of the practice at the time which was to only store fingerprint records relating to criminal law charges and proceedings. This is because "*fingerprints relating to other matters such as deceased persons were not back captured due to early concerns around physical data storage space*". In addition, it was considered that as the fingerprint records related to a deceased person it was unlikely that any further fingerprint record would be obtained to allow for further comparison.

10.5 It is clear from the above that in January 1997 there were a number of practical and technological limitations which reduced the likelihood of a positive fingerprint identification being established for Mr Langlois. Advancements in technology have eliminated these limitations which allowed for the positive identification being made in July 2021, and has also allowed for other historic fingerprint records being identified for forensic review using current-day tools and methods.

11. When and where did Mr Langlois die?

11.1 Mr Langlois' PBS records indicate that a prescription of doxepin for Mr Langlois was filled on 31 December 1996. Whilst there is no direct evidence that Mr Langlois collected this prescription, there is equally no evidence to suggest that this prescription was collected by another person. Given the previous prescriptions of doxepin to Mr Langlois, it is most likely that Mr Langlois followed this same procedure and collected his prescription on 31 December 1996. This event represents the last time that Mr Langlois was known to be alive.

11.2 It is evident that Mr Langlois' body was discovered on 8 January 1997. However, what occurred between 31 December 1996 and 8 January 1997 is not known. This period of time is consistent with the opinion expressed by Dr Bradhurst that Mr Langlois had been in water for between 4 and 10 days by the time he was discovered at Wanda Beach. Detective Sergeant Jane Scrivens, the officer in charge of the investigation since 2021, gave evidence that police enquiries did not identify evidence of any activity by Mr Langlois or any signs of life between 31 December 1996 and 8 January 1997. Therefore, it is most likely that Mr Langlois died sometime between 31 December 1996 and 8 January 1997.

11.3 The circumstances in which Mr Langlois entered the water are not known. Although Mr Langlois was found on a beach in Cronulla the location, where he died is unclear on the available evidence. Mr Langlois may have entered the water in the Cronulla area. However, Detective Sergeant Scrivens gave evidence that the NSWPF police investigation did not identify any connection that Mr Langlois had with the Cronulla area, or any reason for him to travel there.

11.4 Equally, Mr Langlois may have entered the water at some other location either proximate to, or some distance away from Cronulla. In her statement, Detective Sergeant Scrivens refers to the possibility that Mr Langlois may have entered the water at some other location than Cronulla. The available evidence simply does not allow for any conclusion to be made in this regard. Therefore, it is not possible to make any finding in relation to the place of Mr Langlois's death.

11.5 The autopsy did not identify any pathology to indicate that Mr Langlois died from a sudden and unexpected medical event due to an underlying, or previously undiagnosed, medical condition. The autopsy also did not identify any traumatic injury that explains death. Therefore, given the circumstances in which Mr Langlois was found, it is most likely that the cause of Mr Langlois' death was immersion, with alcohol intoxication and doxepin toxicity being significant factors contributing to the death.

12. What was the manner of Mr Langlois' death?

12.1 The evidence establishes that following the breakdown of his marriage, and his continuing difficulties in gaining employment, Mr Langlois experienced a deterioration in his mental health, from at least 1989. This coincides with Mr Langlois coming under the increasing notice of the NSWPF and presenting to hospital on a regular basis during the same. During these presentations, Mr Langlois reported, and was observed to have, a number of mental health issues for which he was prescribed medication and referred for psychiatric review. These presentations are consistent with Mr Griffiths' observations of Mr Langlois' unusual behaviour on occasions.

12.2 Apart from the challenges that Mr Langlois faced with his mental health, and how to manage these challenges, it is also evident that Mr Langlois was developing, or had developed, a dependency on alcohol. In addition, other aspects of his life relating to his accommodation and finances were becoming increasingly problematic. The overall impression of Mr Langlois' functioning during this period is that it was gradually deteriorating, with daily living becoming increasingly chaotic and difficult to manage.

12.3 As noted above, the findings from the autopsy do not suggest that Mr Langlois died of natural causes. Whilst this possibility cannot be entirely excluded, the challenges faced by Mr Langlois instead raise a number of legitimate questions regarding the manner of, or the circumstances surrounding, his death. Did Mr Langlois intentionally inflict his own death by jumping from a height into the ocean, ultimately causing his body to be brought to the shore at Wanda Beach? Or did Langlois experience some form of misadventure, which may have been contributed to by the toxicological findings at autopsy, resulting in him entering the water accidentally and becoming incapacitated?

12.4 The available evidence is, regrettably, not sufficient cogent or reliable to answer either question, or indeed, the overall question regarding the manner of Mr Langlois' death. This is not due to any deficiency in the NSWPF investigation conducted initially after January 1997, and again after July 2021. Rather, the limitations with the available evidence can be attributed to the passage of time, the absence of any identified relatives and friends who might have provided further information regarding Mr Langlois' background and movements, and what little is known about Mr Langlois' life as a whole.

12.5 Ultimately, the available evidence does not allow for any conclusion to be reached as to the manner of Mr Langlois's death.

13. Findings pursuant to section 81(1) of the Act

13.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Inspector Tina Xanthos for her assistance, both before and during the inquest.

13.2 I also thank Detective Sergeant Scrivens for her investigative efforts and for compiling the brief of evidence, and Detective Chief Inspector Rowney for his assistance in understanding the more technical aspects of the investigation.

13.3 The findings I make under section 81(1) of the Act are:

Identity
The person who died was Jean-Louis Langlois.

Date of death
Mr Langlois died sometime between about 31 December 1996 and 8 January 1997.

Place of death

The available evidence does not allow for any finding to be made as to the place of Mr Langlois' death.

Cause of death

The cause of Mr Langlois' death was immersion, with alcohol intoxication and doxepin toxicity being significant factors contributing to the death.

Manner of death

The available evidence does not allow for any finding to be made as to the manner of Mr Langlois' death.

14. Epilogue

14.1 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Langlois' family members and loved ones.

14.2 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
20 July 2023
Coroners Court of New South Wales