IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

COR 2021 002011

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Shane Ronald Dennis Brown

Delivered On:	16 February 2023
Delivered At:	Coroners Court of Victoria, 64 Kavanagh Street Southbank, Victoria
Hearing Dates:	31 January 2023
Findings of:	Coroner Leveasque Peterson
Police Coronial Support Unit:	Senior Constable Jeff Dart
Keywords:	Methamphetamine toxicity, assault, stab wounds, cause of death

I, Coroner Leveasque Peterson, having investigated the death of Shane Ronald Dennis Brown, and having held an inquest in relation to this death on 31 January 2023 at Melbourne find that:

a) the identity of the deceased was Shane Ronald Dennis Brown (**Shane**) born on 31 August 1990; and

b) the death occurred on 20 April 2021 at Henry Street, Melton by methamphetamine toxicity in the setting of a stabbing.

I further find, under section 67(1)(c) of the ***Coroners Act 2008*** (**'the Act'**) that the death occurred in the circumstances outlined below.

BACKGROUND

1. Shane Ronald Dennis Brown was born in 1990 to Linda and Ronald Brown. He was younger brother to Tim.

2. Shane was also a father of two children, together with Bianca Kerr.

3. Shane was 30 years old when he passed away from Methamphetamine toxicity in the setting of a stabbing incident on Tuesday, 20 April 2021.

4. Shane started using drugs when he was around thirteen or fourteen years old and subsequently started getting into trouble at school and with the law. Ultimately, this behaviour escalated and Shane served terms of imprisonment for numerous offences.

5. Despite being a regular user of illicit drugs until his death, evidence suggests Shane made several attempts to cease his habit. Between July 2016 and March 2019 Shane would regularly attend Health Works Community Health Centre in Footscray, and later 'Q1 Medical' in Melton, in an effort to stop using drugs.

6. In 2015 Shane met Bianca through friends and they formed a friendship which over time turned into a relationship. Shane kept in contact with Bianca during a term of imprisonment and upon release moved in with Bianca and her parents. Bianca subsequently became pregnant with their first child.

7. During Bianca's pregnancy the couple moved to New South Wales. Whilst there, Shane was able to avoid drugs and ceased use for a period of time, but after about five months they moved back to Victoria and Shane started using again.

8. Shane was ultimately arrested upon his return to Victoria and served a period of imprisonment.

9. After his release from prison Shane and Bianca moved to Darley, Victoria, and shortly after Bianca fell pregnant with their second child who was born in January 2021.

10. During the second pregnancy Shane was again able to stop using drugs, however shortly after the birth the couple moved back to Melbourne and Shane fell into old patterns including drug use.

11. Shane did his best to keep his drug use away from Bianca and their children and would not use at home. However when he was using Shane would disappear for days at time and return to their home or his mother's house to recover.

CORONIAL INVESTIGATION

Jurisdiction

12. Shane's death was reported to the Coroner as it fell within the definition of a reportable death in the Coroners Act 2008, as his death occurred in Victoria and it was as result of violent incident.

Purpose of the Coronial Jurisdiction

13. The jurisdiction of the Coroners Court of Victoria is inquisitorial. The role of the Coroner is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

14. The role of the Coroner is to establish the facts. It is not the Coroner's role to apportion blame, determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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

16. For coronial purposes, the phrase “circumstances in which death occurred,” refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally related 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 Court’s “prevention” mandate.

18. Coroners are empowered:

    a. to report to the Attorney-General on a death;

    b. to 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. to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.

19. These powers are the means by which by which the Court’s prevention role may be advanced.

Standard of Proof

20. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. 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.

21. In determining these matters, I am guided by the principles enunciated in Briginshaw v Briginshaw. 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.

22. 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. 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.

23. In this instance I determined that it was appropriate to deal with the matter by way of an inquest and I heard from two witnesses, Detective Sergeant of the Homicide Squad, Victoria Police, and Dr Brian Beer of the Victorian Institute of Forensic Medicine (**VIFM**).

Sources of Evidence

24. This finding draws on the totality of the material produced during the coronial investigation. That is, the court records maintained during the coronial investigation, the Coronial Brief and further material sought and obtained by the Court, and the evidence adduced during the inquest.

25. In writing this finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It is important to note the absence of reference to any particular aspect of the evidence does not mean that it has not been considered.

CORONIAL INVESTIGATION AND INQUEST

26. Victoria Police appointed Senior Constable Jake Ferguson as the Coronial Investigator and compiled a brief of evidence which was comprised of witness statements, documentary exhibits and multimedia exhibits.

27. An inquest was held on 31 January 2023 at Melbourne.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

28. On Monday, 19 April 2021 Shane arrived at his mother's house at around 9.00pm. At the time he was having relationship issues with Bianca and according to his mother, he appeared to be feeling down.

29. His mother last saw him at 10:30pm before going to bed and he was gone when she got up the next morning at approximately 7.00am.

30. At 12.44pm on Tuesday, 20 April 2021 Shane called his friend, Jack Llewellyn, saying he was on his way to Melton and they agreed to meet.

31. Shane arrived in the Melton area at around 1.25pm and collected Jack, dropping him off at a friend's house a short time later and leaving.

32. At 2.47pm Shane called his friend, Anastacia Tsasouris, and they also agreed to meet, with Shane arriving at her unit, number 3 of 24 Henry Street, Melton, a short time later. Anastacia lived at the unit with members of her family and a housemate, Robert Falzone.

33. The unit is one of three on the block of land. Unit 3 is the middle unit on the block.

34. Shane parked his car in the driveway of the address. When he arrived there was already a number of vehicles in the driveway. Already at the house were Anastacia, Robert Falzone, Danny Debono, Travis Matthews and Taelah Walgers.

35. A short time later Matthew Jeffrey and Natasha Van De Heyde, arrived and also parked in the driveway.

36. When Matthew arrived he approached Travis and Taelah and started an argument about a prior incident. Taelah left him arguing with Travis and went inside.

37. At this time Shane, who was standing with Danny outside the address, punched Danny in the face and a fight began between the two with both parties exchanging blows and scuffling.

38. During the scuffle Shane produced an object in his hand, which he motioned toward Danny in a stabbing motion a couple times. Danny began to bleed from his left arm.

39. Danny became enraged. He grabbed a walking stick left by one of the attendees, and swung it at Shane, striking him a number of times.

40. Travis and Matthew were yelling at the two to stop, and Matthew moved in in an attempt to break them apart and put his arm between the pair, pulling away quickly to find that he had suffered a wound to his forearm, which was bleeding heavily.

41. Travis and Matthew retreated inside and used a blanket from Anastacia's room to wrap Matthew's arm in an attempt to stop the bleeding.

42. Matthew then returned outside, raised the axe handle and swung at Shane.

43. The fight between the Shane and Danny stopped and Taelah got inside Shane's vehicle and drove away. Matthew and Natasha also left.

44. Shane walked inside unit 3 and called out for help. Anastacia and Robert were inside however both left the house shortly after they saw Shane collapse on the kitchen floor.

45. Anastacia and Courtney drove Danny to Melton Health Services where he received treatment for the wound to his left arm.

46. Shane was located unconscious on the kitchen floor a short time later by Anastacia's mother, Sarah, who had been called by Robert.

47. Sarah called 000 and commenced CPR on Shane.

48. Emergency Services from both Fire Rescue Victoria and Ambulance Victoria arrived shortly after and took over resuscitation attempts, however Shane could not be revived, and he was pronounced deceased at 3.46pm.

VICTORIA POLICE INVESTIGATION

49. Victoria Police attended and processed the scene. Senior Constable Jake Ferguson of the Homicide Squad was the appointed investigator.

50. A number of people that were present during the incident were approached by police however they refused to provide statements or assist with the police investigation.

51. It is not known what initiated the altercation between Shane and Danny.

52. Ultimately criminal charges were not pursued by Victoria Police against Danny or Matthew in relation to the death of Shane Brown.

53. In relation to the decision not to charge anyone with offences concerning Shane's death, Senior Constable Ferguson explained that in the early stage of the investigation, Danny was initially questioned and charged with offences relating to the incident, however, the preponderance of the evidence suggested Shane had initiated the confrontation. Witnesses also provided evidence that throughout the altercation Shane was in fact on top of Danny as the aggressor.

54. There was no evidence to contradict the proposition that Danny acted in self-defence. Victoria Police considered that the burden of proof in relation to relevant criminal charges concerning Shane's death would not be discharged.

55. In relation to Matthew's involvement in the events Senior Constable Ferguson gave evidence that criminal charges were also considered for Matthew.

56. Matthew was arrested, charged and held in custody on other charges arising from his conduct on the day, however in relation to Shane's death, the available evidence confirmed that Matthew's involvement amounted to having witnessed the altercation and attempting to intervene between the deceased and Danny. In those circumstances a claim that Matthew acted in defence of another, being Danny, was likely to be accepted and therefore no charges were issued.

IDENTITY OF THE DECEASED

57. On 22 April 2021, Shane was identified by means of a fingerprint comparison. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

58. Dr Brian Beer, a forensic pathologist at VIFM, performed an autopsy on Shane on 21 April 2021.

59. During autopsy Dr Beer found 6 puncture wounds just penetrating the skin, a minor superficial wound to the left eyebrow and 5 wounds with deeper penetration to an approximate 40mm depth into the soft tissue.

60. Dr Beer commented, "[T]here were multiple superficial stab wounds. There would have been minor haemorrhage from the deeper stab wounds, but this would not have caused significant blood loss".

61. He further stated, "Overall, the injuries sustained – either the stab wounds or the scalp laceration with primary blood loss do not explain the death. In a young 'relatively fit' male, the blood loss apparent should not have been significant."

62. Toxicological analysis of samples taken revealed Shane had a blood concentration of 5.7 milligrams of methylamphetamine per litre, 0.5 milligrams of amphetamine per litre and 4.1 milligrams of pregabalin per litre.

63. Dr Beer commented, "The levels of methylamphetamine detected were significantly raised at levels where sudden cardiac arrhythmogenic death due to hyperadrenergic stimulation is the most probable explanation for his collapse and cardiac arrest, particularly in the setting of an immediately prior altercation/fight also contributing to his hyperadrenergic state".

64. Taking into account all available information, Dr Beer provided an opinion that a reasonable formulation for the cause of death was, '*1(a) Methamphetamine toxicity in the setting of a stabbing.'* I accept and adopt Dr Beer's opinion.

I order that this finding be published on the Internet

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

Linda Brown, Senior Next of Kin

Ronald Brown, Senior Next of Kin

Destan Dikbas, Victims of Crime Assistance Tribunal

Senior Constable Jake Ferguson, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date: 30 May 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.