IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 4867

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*
*Section 67 of the Coroners Act 2008*

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| Findings of: | **JUDGE SARA HINCHEY, STATE CORONER** |
| Deceased: | **Amanda DAWSON** |
| Date of birth: | 25 November 1958 |
| Date of death: | 13 October 2016 |
| Cause of death: | Head Injuries |
| Place of death: | Traralgon |
| Catchwords | Family violence homicide; death resulted directly from injury; death was unexpected, violent and not from natural causes |

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**HER HONOUR:**

**BACKGROUND**

1. Amanda Dawson was a 57-year-old woman who lived in Glengarry at the time of her death.

2. Ms Dawson was born in Sri Lanka on 25 November 1958 to English parents. Ms Dawson returned to England with her family when she was one year old. When she was three years old, Ms Dawson and her family moved to Adelaide, before returning again to England three years later. In about 1985, having qualified as a nurse, Ms Dawson migrated permanently to Australia.

3. Soon after arriving in Australia, Ms Dawson met David Dawson whilst living in Queensland. Ms Dawson and Mr Dawson were married approximately six months later.

4. Ms Dawson and her husband settled in the Latrobe Valley in Victoria. They had four children – James, Robin, Harry and Bonnie. Ms Dawson worked as a registered nurse in various hospitals and nursing homes in the Latrobe Valley. Ms Dawson experienced ongoing issues with alcohol in her life. In the last few years of her life, Ms Dawson's issues with alcohol began to affect her marriage.

5. In October 2014, Ms Dawson took up a six month nursing contract at Derby Hospital in Western Australia. Ms Dawson met Mr Lindsay Masatora at a hotel in Broome. The two developed a friendship and later commenced an intimate relationship.

6. In April 2015, Ms Dawson returned to live with her husband in Glengarry. Mr Masatora was aware that Ms Dawson was married and that she had returned to Victoria to live with her husband. Despite this, Mr Masatora began to make numerous calls to Ms Dawson's family landline. These calls were to become a source of irritation to Ms Dawson's family, and on several occasions, to Ms Dawson herself.[1]

7. On 14 May 2015, Mr Masatora relocated from Broome to Melbourne in order to be closer to Ms Dawson.

8. The available evidence suggests that from at least October 2015, Mr Masatora became fixated on his relationship with Ms Dawson.[2] He told his medical practitioner that he was worried about Ms Dawson's issues with alcohol, and that he was having difficulty sleeping due to his

[1] Coronial Brief, Statement of Material Facts, 3.
[2] Victorian Aboriginal Health Service records, Patient Summary for Lindsay Masatora, 7.

obsession with her.[3] He began to maintain a belief that Ms Dawson was having relationships with other men.[4] On 14 January 2016, Mr Masatora disclosed to his medical practitioner that he wanted to watch or follow Ms Dawson but could not do so because he did not drive and did not have the finances to travel to her home town frequently enough.[5]

9. In early May 2016, Ms Dawson assisted Mr Masatora to secure a rented flat in Morwell, a town just outside Traralgon in Victoria.

10. Mr Masatora continued to exhibit jealous and obsessive behaviour towards Ms Dawson throughout their relationship. On a number of occasions, Mr Masatora used taxis either to follow Ms Dawson or to turn up unannounced at her family home.[6] A taxi dispatch worker in Traralgon noted receiving frequent calls from a man, who was likely to have been Mr Masatora, who would ask where Ms Dawson's taxi had picked her up and dropped her off.[7] On a number of occasions Mr Masatora also called the motel that he and Ms Dawson frequented to ask whether Ms Dawson had made any other bookings there.[8]

11. On 17 May 2016, Ms Dawson and Mr Masatora enrolled in a course at TAFE in Morwell. Soon after the course started, Mr Masatora became concerned about another male student speaking to Ms Dawson in class and began taking notes about him.[9] Mr Masatora approached the teacher after class and asked him if he had noticed the way the male student was looking at Ms Dawson.[10] Mr Masatora also began repeatedly calling the male student and asking whether he had seen Ms Dawson. Mr Masatora also went to the male student's work on one occasion and asked him if Ms Dawson was there.[11]

12. Ms Dawson and Mr Masatora were often seen together in the Traralgon area.[12] On occasions they were seen arguing with each other in the street.[13] In July 2016, having witnessed two such arguments, a friend of Ms Dawson asked her if she felt safe with Mr Masatora. Ms Dawson told the friend that she did.[14]

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[3] Ibid, 18-19.
[4] Ibid, 10.
[5] Ibid, 18.
[6] Coronial Brief, Statement of Peter Duncan, 2–4.
[7] Coronial Brief, Statement of Deborah Morris, 1.
[8] Coronial Brief, Statement of Keith Meichtry, 2.
[9] Coronial Brief, Appendix L: Photocopies of pages from purple notebook, 472.
[10] Coronial Brief, Statement of Joseph Licciardi, 114.
[11] Coronial Brief, Statement of Jason Ferguson, 110-113.
[12] Coronial Brief, Statement of Cathryn Brougham, 117-118; Statement of Maria Doganieri, 64.
[13] Coronial Brief, Statement of Cathryn Brougham, 117-118.
[14] Ibid.

13. In about June or July 2016, Mr Dawson discovered Mr Masatora hiding outside his Glengarry home.[15] Mr Dawson drove Mr Masatora to the Traralgon train station and told him that he never wanted to see him again. Mr Dawson said that Mr Masatora appeared apologetic.[16] About one month after this incident, Mr Dawson again found Mr Masatora at his Glengarry home. This time, Mr Masatora was found hiding in a spare bedroom. Mr Dawson again told Mr Masatora to leave and never come back.[17]

14. Text messages exchanged between Mr Masatora and Ms Dawson in August and September 2016 are indicative of a volatile relationship.[18] Throughout their relationship, Mr Masatora repeatedly sent messages to Ms Dawson asking to know her whereabouts, requesting to see her, and telling her how much he loved and needed her.[19] At times, Ms Dawson responded to these messages affectionately.[20] At other times, she requested that Mr Masatora stop contacting her and leave her alone.[21]

15. On 3 October 2016, Ms Dawson sent Mr Masatora a message which read 'its over'.[22] Mr Masatora replied, 'Please don't leave me i will get very depressed and parish'.[23] Text messaged exchanged in the following days indicate that Mr Masatora and Ms Dawson reconciled soon afterwards. They continued to exchange messages up until Ms Masatora's fatal assault on Ms Dawson on 10 October 2016.[24]

## THE PURPOSE OF A CORONIAL INVESTIGATION

16. Ms Dawson's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and resulted directly from injury and was unexpected, violent and not from natural causes.[25]

17. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[26] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

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[15] Coronial Brief, Statement of David Dawson, 107-108.
[16] Ibid.
[17] Ibid.
[18] Coronial Brief, Victoria Police E-Crime Extraction report – accused mobile, 624-639.
[19] Coronial Brief, Victoria Police E-Crime Extraction report – accused mobile, 624-639.
[20] Ibid.
[21] Ibid.
[22] Coronial Brief, Victoria Police E-Crime Extraction report – accused mobile, 629.
[23] Ibid.
[24] Ibid.
[25] Section 4, *Coroners Act 2008.*
[26] Section 89(4) *Coroners Act 2008*

18. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[27] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

19. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

20. 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 relevant to the death.

21. 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*' role.

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

23. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[28] 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 that they caused or contributed to the death.

[27] *Keown v Khan* (1999) 1 VR 69
[28] (1938) 60 CLR 336

24. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

## MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

### Identity of the Deceased, pursuant to section 67(1)(a) of the Act

25. On 13 October 2016, Mr Dawson identified the deceased to be his wife, Amanda Dawson, born 25 November 1958.

26. Identity is not in dispute and requires no further investigation.

### Medical cause of death, pursuant to section 67(1)(b) of the Act

27. On 15 October 2016, Dr Paul Bedford, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Dawson's body. Dr Bedford provided a written report, dated 16 January 2017, which concluded that Ms Dawson died from subdural haematoma sustained as a result of head injuries.

28. Dr Bedford noted that the post mortem examination confirmed the presence of subdural haematoma. Dr Bedford commented that, following this head injury, there had been a lack of blood flow to the brain tissue, which resulted in the findings of global cerebral ischaemic injury, or as it is more commonly referred to, 'brain death'.

29. Toxicological analysis of an ante-mortem specimen taken from Ms Dawson's body were found to be non-contributory.

30. I accept the cause of death proposed by Dr Bedford.

### Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

31. On 10 October 2016, Ms Dawson and Mr Masatora met in the carpark of the Traralgon Neighbourhood House. At some point during the meeting, Mr Masatora struck Ms Dawson twice to the head with his fist, causing her to lose consciousness.[29]

32. After some hesitation, Mr Masatora called for an ambulance. Ms Dawson was transported to the Alfred hospital where she underwent urgent decompressive cranial surgery. The surgery

[29] *The Queen v Masatora* (2017) VSC 277 [5].

was not successful and Ms Dawson never regained consciousness. Three days later, on 13 October 2016, Ms Dawson was declared to be dead.[30]

## COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

*33.* The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by a person within an intimate personal relationship is particularly shocking, given that it is expected to be a place of trust, safety and protection.

*Family violence*

34. For the purposes of the *Family Violence Protection Act 2008* (Vic) (**FVPA**), the intimate personal relationship between Ms Dawson and Mr Masatora was one that falls within the definition of '*family member*' as set out in the FVPA. Mr Masatora's fatal assault on Ms Dawson constituted an act of physical abuse towards a family member, and therefore falls within the meaning of '*family violence'* for the purposes of the FVPA. On this basis, the death of Ms Dawson was considered to have occurred in the context of family violence.

35. As a result, I requested that the Coroners Prevention Unit (**CPU**)[31] examine the circumstances of Ms Dawson's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[32]

36. In 2012, the Victorian Department of Health and Human Services published the *Family Violence Risk Assessment and Risk Management Framework*, also known as the *Common Risk Assessment Framework* (**CRAF**). The CRAF details a number of evidence based risk factors which have been found to impact on the likelihood and severity of family violence.[33] These risk factors are divided into three categories: those which relate to the victim of family violence, those which relate to the perpetrator, and those which relate to the relationship.

37. CPU identified the presence of two victim specific risk factors in this case. Ms Dawson struggled with alcohol abuse and had sought treatment on a number of occasions for her

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[30] Ibid.

[31] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

[32] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian community

[33] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition.

alcoholism, which is detailed further below.[34] Medical records from St John of God Pinelodge Clinic also suggest that Ms Dawson suffered from depression.[35] The CRAF identifies alcoholism and depression as factors that were likely to increase Ms Dawson's vulnerability to family violence.

38. CPU identified the presence of four perpetrator specific risk factors in relation to Mr Masatora. Mr Masatora's medical records indicate that he had a history of mental illness. Notes from his general practitioner indicate that Mr Masatora '*alluded to suicidal ideation*' in an appointment on 15 January 2016.[36] Mr Masatora exhibited obsessive and jealous behaviour towards Ms Dawson, and regularly stalked her, as detailed above. Mr Masatora was unemployed at the date of the fatal incident.[37] The CRAF identifies suicidal ideation, obsessive/jealous behavior, stalking behavior, and unemployment as factors that were likely to increase the risk that Mr Masatora would perpetrate family violence.

*The significance of stalking behaviour towards an intimate partner*

39. There is no evidence to suggest that Ms Dawson considered herself to be a victim of family violence, and no evidence to suggest that there had been any physical assaults prior to the fatal incident. It is possible that Ms Dawson was not aware of the full extent of Mr Masatora's stalking. Even if she had been aware, it is likely that she would not have understood the risk that his stalking behaviour posed to her. Both Mr Masatora and Ms Dawson may have been assisted by greater public awareness that intimate partner stalking is a form of family violence, and that it is also a significant perpetrator risk factor in relation to the risk of future family violence, including lethal violence.

40. Submissions to the Royal Commission into Family Violence (the **Royal Commission**) noted that '*many in the community perceive partner stalking as less serious than stranger stalking*.' The 2013 National Community Attitudes Towards Violence Against Women Survey (NCAS) results showed that in 2013, of the 17,517 participants surveyed, 85% '*agreed that a man keeping track of his partner's location, calls or activities without her permission is serious behaviour*.' However, only 65% of those surveyed agreed that such behaviour was '*never acceptable*,' 21% believed that it was '*rarely*' acceptable and 15% believed it was '*sometimes*' acceptable. This indicates that while there is a general

[34] St John of God Pinelodge Clinic medical records.
[35] St John of God Pinelodge Clinic medical records, Mental Health Risk Assessment dated 2 June 2015.
[36] Victorian Aboriginal Health Service records, Patient Summary for Lindsay Masatora, 19.
[37] Coronial Brief, Appendix J: Field Interview Conducted with the Accused, 381.

acknowledgement that this behaviour is serious, many people still believe such action is acceptable within intimate partner relationships.

41. The CRAF identifies stalking as a risk factor which can indicate an increased risk of a victim being killed or almost killed.[38] This is backed up by research which has found '*a strong association between stalking and subsequent lethal/near lethal abuse*'.[39] This research also noted that in 15% of the cases of femicide and attempted femicide they examined there was '*prior stalking but no prior domestic violence*'[40] and that '*49% of the attempted or actual homicide victims who were not physically abused were stalked*'.[41] This highlights '*how important it is to recognise the serious risk of deadly harm presented by stalking behaviours alone*'.[42] Ultimately the study concluded that it '*is essential to include stalking in risk models for intimate partner violence against women and in risk assessments to apprise women of their danger*'.[43] Stalking has also been noted by the NSW Domestic Violence Death Review team to be a key risk factor in male perpetrated intimate partner homicide.[44]

42. For the above reasons, I support the inclusion of stalking as a risk factor in the CRAF and any new family violence risk assessment models currently under development in response to Recommendation 1 of the Royal Commission. I also support the inclusion of information about stalking as a form of family violence and significant perpetrator risk factor within the public information provided via the new website developed through the implementation of Recommendation 10 of the Royal Commission.

**CPU's Assessment of Adequacy of Service Contact**

*St John of God Pinelodge Clinic*

43. Ms Dawson attended the St John of God Pinelodge Clinic (**Pinelodge Clinic**) on a number of occasions, prior to and during the time that she was in a relationship with Mr Masatora, for the treatment of alcohol abuse. Her last admission to the Pinelodge Clinic for rehabilitation was in November 2015.[45] On each occasion when Ms Dawson was admitted to

[38] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition, 27.
[39] Judith McFarlane, Jacquelyn C Campbell and Kathy Watson, 'Intimate Partner Stalking and Femicide: Urgent Implications for Women's Safety' (2002) 20(1-2) *Behavioural Sciences and the Law* 64-65.
[40] Ibid 65.
[41] Ibid 66.
[42] Ibid 66.
[43] Ibid 67.
[44] New South Wales Domestic Violence Death Review Team (2015) *Annual Report: 2013-2015.*
[45] St John of God Pinelodge Clinic medical records.

the Pinelodge Clinic, staff conducted a risk assessment, which focussed on mental health risks, on the date of her admission and again on the date of her discharge. Neither of these assessments indicated that Ms Dawson had any significant risks with respect to her mental health.

44. In the absence of any disclosures of family violence, symptoms or injuries suggesting that Ms Dawson was a victim of family violence, Pinelodge Clinic could not be expected to have taken any further action to support Ms Dawson in relation to family violence. Accordingly, the services provided by the clinic with respect to the family violence appear to have been appropriate in the circumstances.

*Victorian Aboriginal Health Service*

45. Mr Masatora commenced visiting the Victorian Aboriginal Health Service (**VAHS**) in August 2015 seeking treatment for mental health issues and the continuation of his prescription for Risperidone. From August 2015 to April 2016, Mr Masatora visited the VAHS 11 times for appointments with general practitioners and psychiatrists. Mr Masatora was assessed by the VAHS as suffering from a '*psychotic disorder with delusional content, depressed mood and marked anxiety*' or potentially a '*delusional disorder – jealous type*.'[46]

46. Mr Masatora spoke about his relationship with Ms Dawson in the majority of his interactions with the VAHS. He identified the relationship as a source of stress for him and detailed his concerns about Ms Dawson having relationships with other people.[47] Notes provided by the VAHS suggest that risk assessments were often conducted when Mr Masatora made such disclosures. These assessments revealed that Mr Masatora had no malicious thoughts, suicidal or homicidal ideation.[48] He denied having any aggressive or violent intentions towards Ms Dawson and in March 2017 assured his psychiatrist that he would never harm Ms Dawson.[49]

47. Although Mr Masatora disclosed to his psychiatrist in January 2016 that he wanted to follow Ms Dawson, the psychiatrist appears to have questioned Mr Masatora's disclosure in January and determined that he did not have the means to engage in following Ms Dawson at that time.[50]

[46] Victorian Aboriginal Health Service records, Patient Summary for Lindsay Masatora, 18, 23.
[47] Ibid 7, 10-11, 13, 15, 17-20, 24-25.
[48] Ibid.
[49] Ibid 18, 22-23.
[50] Ibid.

48. Mr Masatora's engagement with the VAHS decreased after he moved to Morwell in May 2016. On the few occasions that Mr Masatora did attend the service, his presentation was not sufficiently concerning to warrant any additional action or risk assessments being taken by VAHS staff. As such, the services provided by the VAHS appear to have been appropriate in the circumstances.

*Criminal proceedings*

49. On 10 October 2016, Mr Masatora was arrested at the scene and later charged with murder in relation to Ms Dawson's death. This charge was later downgraded to manslaughter, to which Mr Masatora pleaded guilty.

50. On 24 May 2017, Mr Masatora was sentenced to 7 years' imprisonment, with a non-parole period of 4 years and 9 months.[51]

51. In his sentencing remarks, Justice Forrest observed that:

> *'Amanda Dawson had every right to conduct a relationship with you and every right to call it off, or to defer resolving it. You had every right to disagree with her – to put your side of things. But you have no right to beat her.'*[52]

52. Justice Forrest continued:

> *'This court has an obligation to impose sentences that spell out in the clearest possible terms that violence within a relationship will not be tolerated. It is most often carried out by stronger males on their weaker female partners. It is cowardly and contemptible. General deterrence, denunciation and punishment must assume importance in the sentencing balance.'*[53]

## FINDINGS AND CONCLUSION

53. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Amanda Dawson, born 25 November 1958;

[51] *The Queen v Masatora* (2017) VSC 277.
[52] *The Queen v Masatora* (2017) VSC 277. [14].
[53] *The Queen v Masatora* (2017) VSC 277. [15].

(b) the death occurred on 13 October 2016, at The Alfred Hospital in Melbourne, as result of head injuries; and

(c) the death occurred in the circumstances set out above.

54. I convey my sincerest sympathy to Ms Dawson's family and friends.

55. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

(a) Mr David Dawson, senior next of kin.

(b) Detective Senior Constable Vincent Schalken, Victoria Police, Coroner's Investigator.

(c) Detective Inspector Tim Day, Homicide Squad, Victoria Police.

Signature:

**JUDGE SARA HINCHEY**

**STATE CORONER**

Date: 20 June 2018