IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 4862

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**ANNE WHITELEGG**
Date of birth:	18 August 1955
Date of death:	18 September 2014
Cause of death:	Ligature Strangulation
Place of death:	Wallan, Victoria

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HER HONOUR:

BACKGROUND

1. Anne Whitelegg (**Anne**) was a 59-year-old woman who lived at Wallan, Victoria, at the time of her death.

2. Anne was born in Glasgow, Scotland. At some stage in her early life, the family moved to Derby in England where she eventually had two children from different relationships. One of Anne's children was adopted and the other, Marc Nadin, resided with his father following the couple's separation.

3. Anne met David Whitelegg (**David**) in 1994 and they were married in 2001.

4. In 2006, Anne was offered employment as a nurse at Knox Private Hospital in Melbourne and moved to Australia to pursue the position. David followed in 2007, having transferred his position in the British Army to a position in the Australian Defence Force (**ADF**).

5. Following a period living in Sydney, the couple returned to Melbourne where they settled in Wallan in 2010.

6. By 2012, the marriage suffered from long term problems stemming from stress David was experiencing at work, combined with a growing intolerance for Anne's drinking. In more recent times, the couple's problems included the aggravation of a neighbourhood dispute that David was involved in, which had resulted in an Intervention Order being granted in favour of the neighbour. During this period of time, David was psychiatrically assessed as part of a workplace investigation following an allegation of bullying against fellow ADF staff. He was diagnosed with Adjustment Disorder, put on restricted duties and his access to live ammunition was suspended. In March 2014, he was declared fit to resume full duties.

7. Anne and David's relationship became increasingly turbulent in the two years leading up to Anne's death, with frequent arguments often leading to Anne being forced to leave or leaving the house they shared for short periods of time. One common source of argument related to financial matters and Anne's spending habits. In 2012, David became angry and forced Anne to leave their house when he discovered she had reduced her working hours from full-time to part-time for health reasons. He was anxious that both of them were contributing financially and resented her working less hours than he did. Anne stayed in a Mill Park Hotel for one-to-two weeks, until she was invited back to the house. As the pattern emerged, David would

offer what seem to be acts of contrition by promising changes in his behaviour and buying Anne gifts and holidays, including a trip to Bali.

8. Despite this, David grew increasingly controlling of all financial matters, including threatening Anne that if she left him she would get nothing because everything was in his name. He also threatened Anne that if she left him he would refuse to sponsor her application for permanent residency and she would be deported.

9. The available evidence suggests that Anne was also subjected to significant emotional abuse within the relationship. David disapproved of her drinking, going out after work, the clothing she wore, her spending habits and what time she went to bed. Anne was submissive to David and believed his threats that she would struggle to survive without him. She often feared his reactions about various everyday occurrences such as letting the cat out, getting a flat battery on the car or accidentally breaking a household item.

10. After the temporary revocation of her working visa in 2013, Anne was unable to work. David was resentful of this and refused to give her money to live. She began accumulating debt on credit cards. By October 2013, the visa issue was resolved and she resumed paid employment, however in June 2014 she confessed the debt to David and he again forced her to leave the house, this time without her phone, car or clothes. The conditions of her return, as dictated by him, included that her salary was to be paid directly to his account, she would be given an allowance of $10 per day and would need to reduce her drinking.

11. In July 2014, Anne was advised that her position had become redundant due to the closure of the hospital. Following the cessation of her employment at the hospital, she engaged in cleaning services for friends on a casual basis. In August, David forced out Anne of the house and she sought refuge with friends, whom she told David had become angry because she had fallen asleep in front of the television and may have damaged it. She confided in friends, particularly Mr Downes,[1] that when she threatened to leave him, David said, "*I will kill you before I let you take half my money.*" Anne eventually returned to the house, but told Mr Downes that she planned to leave David and was going to present him with a number of options in relation to providing for her financially to start again, or alternatively seeking a commitment from him to seek help for his mental state if they continued their relationship.

[1] *Coronial Brief*, Statement of Stuart Downes, 166

THE PURPOSE OF A CORONIAL INVESTIGATION

12. Anne's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[2]

13. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] 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.

14. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to 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 relevant 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 "*prevention*" role of the Court.

18. 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

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[2] Section 4 *Coroners Act 2008*
[3] Section 89(4) *Coroners Act 2008*
[4] *Keown v Khan* (1999) 1 VR 69

(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.

19. 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*.[5] 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.

20. 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 A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Coroners Act 2008

21. On 23 September 2014, the Deceased was visually identified by her friend, Jacques Moss, as being Anne Whitelegg, born 18 August 1955.

22. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Coroners Act 2008

23. On 21 September 2014, Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Anne's body. Dr Burke provided a written report, dated 21 October 2014, which concluded that she died from *'Ligature strangulation'*.

24. Dr Burke commented that Anne exhibited an abraded injury to the neck, suggesting the application of a ligature such as a belt with a buckle.

25. Toxicological analysis of post mortem specimens taken from Anne identified the presence of ethanol (alcohol) in her blood at a concentration level of 0.14 grams per 100 millilitres, but were negative for other common drugs or poisons.

26. I accept the cause of death proposed by Dr Burke.

[5] (1938) 60 CLR 336

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Coroners Act 2008

27. On 18 September 2014, Anne attended the Hidden Valley residence of her friend, Frances Lowe, and spent two hours house cleaning that morning. After completing the cleaning, she attended a local supermarket and bought some food before returning to have lunch and a chat with Ms Lowe. She left Ms Lowe's house at approximately 3.00pm.

28. Anne telephoned David at 4:53pm, by which stage he was on his way home from work. The couple argued during that conversation. David was angry that Anne did not make more effort to find permanent employment and only wanted to work part-time. The argument continued when he arrived home. The available evidence suggests that Anne had been drinking alcohol, which was often when she threatened to leave him and take half of the assets.

29. David became angry with Anne about her drinking and refusal to work full-time. The argument escalated to the point that David assaulted Anne, strangling her until she died. The report of the Forensic Pathologist suggested that a ligature was used, although the item itself was not found.

30. In the hours and days following Anne's murder, David went about finalising much of his affairs, including making several large transfers of money to his mother in the United Kingdom, surrendering a pet cat to the RSPCA and writing letters to both his mother and solicitor. He responded to communication Anne received on her phone, telling her friends that she was unwell. He also contacted his workplace to take leave. The evidence suggests that at some stage on 20 September 2014, David attempted suicide by way of carbon monoxide poisoning, using his car in the garage of their home. David became ill as a result of the attempted suicide, vomiting on his return to the house.

31. At approximately 11:20am on 21 September 2014, David contacted a funeral director and informed him of Anne's death. The funeral director's staff then contact emergency services.

32. Paramedics arrived at the home at approximately 11:35am and found Anne lying on her back on the kitchen floor. They subsequently confirmed her to be deceased.

COMMENTS PURSUANT TO SECTION 67(3) OF THE CORONERS ACT 2008

Criminal Proceedings

33. On 27 May 2016, in the Supreme Court of Victoria, David entered a plea of guilty to murdering Anne. On 20 July 2016, Justice Dixon imposed a sentence of 18 years' imprisonment with a non-parole period of 14 years.

Family Violence

34. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by a family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

35. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Anne and David fell within the definition of '*family member*'[6] under that Act. Moreover, David's actions in strangling Anne and causing her death constitutes 'family violence.'[7] Additionally, this final act of family violence against Anne was committed in the context of an existing history of emotional, physical and financial abuse occurring within the relationship, perpetrated by David against Anne.

36. I requested that the Coroners' Prevention Unit (**CPU**)[8] examine the circumstances of Anne's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[9]

37. The CPU identified the several known risk factors for family violence in this case. There had been several periods of separation between the two during the course of their relationship, most notably between 2007 and 2008 when the couple separated due to David's concerns about Anne's drinking, although they did see each other while living apart during that time. Mental health issues also pervaded the relationship, which can be traced back to a breakdown suffered by David in December 2013, related to criticisms of his work performance. In 2014, David was diagnosed with Depression and Adjustment Disorder through an ADF psychiatric assessment and further evidence throughout the investigation indicated he suffered from a

[6] *Family Violence Protection Act 2008,* section 8(1)(a) identifying as a spouse or domestic partner
[7] *Family Violence Protection Act 2008*, section 5(1)(a)(i)
[8] 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
[9] 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

Delusional Disorder which manifested in paranoid behaviour. Anne had, herself, expressed suicidal ideation in the past.

38. A history of family violence in various forms existed in the relationship, perpetrated by David against Anne. The abuse materialised in the form of physical, emotional and economic abuse, as well as controlling behaviour. David tightly controlled the couple's finances and made threats to kill Anne, which I have referred to earlier,[10] rather than share the marital asset pool on their separation. Anne had confided in friends that David had pushed her to the ground on one occasion, but was disinclined to take the matter further for fear that it may change the way their friends viewed him. She also told friends that he had threatened to kill her during their relationship and threatened to withdraw his sponsorship of her application for permanent residency in Australia if she left him.

39. In addition to economic abuse, David was also concerned about both of them adequately contributing to their retirement and was frustrated that Anne had accumulated credit card debt and was not in permanent, full-time employment, which interfered with his retirement plan. Reportedly, Anne suffered from alcohol dependence and this issue was the cause of many arguments between the two. The statements indicate that she was trying to hide the full extent of the problem from David.[11]

40. The literature in relation to the perpetrators of spousal homicide confirms that the most extreme level of danger of lethal violence against the woman exists in the period where a suggestion or threat exists that she may leave the relationship. It is this sense of either emotional or physical abandonment which most often leads to a man killing his spouse.

41. A study looking at the statistics in New South Wales found that 45 percent of women killed by their husbands were either in the process of leaving, or had left, their husbands. The same study looked at the separation duration and showed that, of the 45 percent, 47 percent were killed within two months of separation and 91 percent within a year.[12] The evidence suggests that Anne had been drinking on the night she was killed and that it was often under the influence of alcohol that she threatened to leave David and take a share of the marital assets.

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[10] At [10]
[11] *Coronial Brief*, Record of Interview
[12] Aldridge, M.L & Browne, K.D. (2003) 'Perpetrators of Spousal Homicide: A Review', *Trauma, Violence & Abuse*, 4(3), 265-76

She had recently reported to friends that she had expressed the idea of leaving the relationship to David, which led to him threatening to kill her.[13]

42. Anne's death, and deaths similar to hers, demonstrates that a broader public awareness of the definition of family violence is needed within our community. Statements in this case suggest that a number of people close to Anne became concerned about the level of risk that David posed to her. At certain times, Anne confided in friends about their disagreements, her growing fears about his mental state and her plans to leave the relationship. At other times, friends witnessed her defend and admire her husband. Amongst her trusted friends, there was an awareness that David had forced her to leave the house on several occasions, kept her in hotel accommodation or with friends with limited resources, in apparent attempts to control her behaviour. A public awareness campaign directed to the definition of family violence would assist family and friends of those experiencing family violence to identify what constitutes family violence, aid in identifying when those close to them are at risk and when to encourage them to seek assistance.

Third party reporting of family violence

43. This case highlights the difficult and often dangerous predicament family violence presents to family, friends and others who become aware of it, or suspect it is occurring. Coupled with this are recurring indications within the relevant research, that female victims of family violence are more likely to disclose the violence to family or friends, rather than authorities or specialist services. Many times third parties feel, understandably, ill-equipped to assist or are concerned that any intervention may increase the danger for the victim or themselves.

44. Previously, this Court has supported proposed measures to support and educate third parties seeking to report family violence, using programs such as the 'Say Something' campaign, developed by Crime Stoppers. The 'Say Something' campaign encouraged young people who witness acts of violence to report them confidentially. It had been proposed to expand this program to encompass family violence reporting, although Crimes Stoppers lacked the funding to broaden the initiative to target family violence.

45. In an effort to address the barriers that third parties face in obtaining access to information about family violence, and providing information and assistance to victims of family violence, the Royal Commission into Family Violence (**the Royal Commission**)[14] reviewed the

[13] *Coronial Brief,* Statement of J Moss, 60
[14] Victorian Royal Commission Into Family Violence, *Final Report* (2016) http://www.rcfv.com.au/Report-Recommendations

available resources for third parties, the 'Say Something' campaign among them. Crime Stoppers proposed the development of "*a single, confidential, central reporting portal to capture all non-immediate family violence crime intelligence, into which all types of informants... [could] provide information.*"[15]

46. At its conclusion, predominantly by way of recommendations 10 and 37, the Royal Commission encouraged the adoption of a model whereby third parties (as well as victims and perpetrators of family violence) can access information via a website, to assist in recognising family violence and how to seek help, both in the crisis period and in the longer term.[16] This Court is advised that the Victorian Government has selected "The Lookout"[17] website as the most suitable existing site with the capacity to develop into a space for the delivery of accessible information for those experiencing, witnessing and being affected by family violence. The Court is also informed that, in line with the Royal Commission's recommendation, the website is scheduled to be finalised by March 2018.[18]

47. Further, through the introduction of Support and Safety Hubs[19] (**SSHs**) at 17 locations across Victoria, a central point will be created for the family violence response network, which will:

    (a) receive police referrals, referrals from non-family violence services, including family and friends, as well as self-referrals;

    (b) provide a single, area-based entry point into local specialist family violence services, perpetrator programs and integrated family services and link people to other support services;

    (c) perform risk and needs assessments and safety planning using information provided by the recommended state-wide central information point;

    (d) provide prompt access to the local Risk Assessment and Management Panel;

    (e) provide direct assistance until the victim, perpetrator and any children are linked with services for longer term support;

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[15] Crimes Stoppers Victoria, Submission to the Royal Commission into Family Violence (May 2015) 23
[16] Victorian Royal Commission into Family Violence, Recommendation 10
[17] http://www.thelookout.org.au
[18] <http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=12>
[19] Victorian Royal Commission into Family Violence, Recommendation 37

(f) book victims into emergency accommodation and facilitate their placement in crisis accommodation;

(g) provide secondary consultation services to universal or non-family violence services; and

(h) offer a basis for co-location of other services likely to be required by victims and any children.[20]

48. This Court is informed that the Department of Premier and Cabinet, with Family Safety Victoria, is currently collaborating with partner agencies to design and implement SSHs state-wide. The completion date for this adopted recommendation is forecast to be 31 March 2021, with a staged roll-out of the SSHs from the end of 2017 onward.

49. In light of the comprehensive nature of the Royal Commission's work in this regard, I support the recommendations put forward, specifically in this case as they relate to the issue of assisting third parties to educate and assist both perpetrators and victims of family violence.

50. In Anne's case, education and information via a website such as "The Lookout," may have provided an initial avenue for the family members and friends to assist her. Ultimately, the SSHs provide an opportunity to report concerns and create more tangible opportunities for intervention and prevention. The circumstances of this case suggest that the SSH model may have provided an immediate outlet for those close to Anne to raise their concerns about the treatment she was reporting, in the context of her unwillingness to report it to authorities herself.

FINDINGS AND CONCLUSION

51. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Anne Whitelegg, born 18 August 1955;

(b) that the death occurred on 18 September 2014, at 11 Cavallo Crescent in Wallan, Victoria, from ligature strangulation; and

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

[20] Victorian Royal Commission into Family Violence, *Summary and Recommendations* (2016) 55

52. I convey my sincerest sympathy to Anne's family.

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

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

    (a) Marc Nadin, Senior next of kin;

    (b) Detective Senior Constable Miranda Stubbs, Coroner's Investigator;

    (c) Peter Lauritsen, Chief Magistrate; and

    (d) Homicide Detective Inspector Tim Day, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 11 April 2018