IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 5843

FINDING INTO DEATH WITHOUT INQUEST

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

The finding into the death of Catherine Elizabeth Browning, dated 9 December 2015, is hereby amended pursuant to section 76 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**CATHERINE ELIZABETH BROWNING**
Date of birth:	10 August 1966
Date of death:	19 December 2013
Cause of death:	Stab wounds to the chest and neck
Place of death:	3 Natisone Place, Skye, Victoria
Catchwords	Family violence homicide; death resulted directly from injury; was unexpected, violent, and not from natural causes

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HER HONOUR:

BACKGROUND

1. Catherine Elizabeth Browning (**Mrs Browning**) was a 47-year-old woman, who lived with her two daughters and recently estranged husband at 3 Natisone Place, Skye, Victoria, (**the family home**) at the time of her death.

2. Mrs Browning was married to Brian Browning for 21 years prior to her death. However, they had separated nine days prior to Mrs Browning's death. Despite this, they had both remained living at the family home.

3. There was no history of family violence in Mr and Mrs Browning's relationship and no reports to Victoria Police of family violence incidents prior to Mrs Browning's death.

4. Mr and Mrs Browning reportedly both gambled, occasionally beyond their means, and engaged in binge drinking. In the weeks prior to Mrs Browning's death, Mr Browning reportedly suffered from a decline in his mental health, in relation to the separation, and this was affecting his ability to sleep.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mrs Browning'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.[1]

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] 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.[3]

7. 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

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[1] Section 4 *Coroners Act 2008.*

[2] Section 89(4) *Coroners Act 2008.*

[3] See Preamble and s 67, *Coroners Act 2008*.

[4] *Keown v Khan* (1999) 1 VR 69.

investigation, or to determine disciplinary matters.

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

9. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all of the circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate to be considered relevant to the death.

10. 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.

11. 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.

12. 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.

13. 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.

[5] (1938) 60 CLR 336.

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

14. On 19 December 2013, Amy Browning visually identified Mrs Browning's body as being that of her mother, Catherine Elizabeth Browning.

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

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

16. On 19 December 2013, Dr Yeleina Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination of Mrs Browning's body and provided a written report, dated 28 March 2014. In that report, Dr Baber concluded that a reasonable cause of death was '*Stab wounds to the chest and neck*'.

17. Dr Baber commented that the force required to inflict the stab wounds was "*at least 'severe', based on the anatomical structures injured*" and that there was some natural disease present, which had not contributed to death.

18. Toxicological analysis of the post mortem samples taken from Mrs Browning were negative for common drugs or poisons.

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

19. On the evening of 18 December 2013, Mrs Browning attended a Christmas party at Mordialloc. On arriving at the family home at 11.15pm, Mrs Browning went to bed in her daughter's bedroom.

20. Just after 6.00am on 19 December 2013, Mr Browning got out of bed and went into the kitchen, where he obtained a knife with an 18cm blade from the knife block.

21. Mr Browning then went into the bedroom where Mrs Browning was sleeping. He tapped her on the shoulder and then immediately stabbed her 15 times to the upper body, upper chest, neck and throat area.

22. Mrs Browning screamed and attempted to defend herself from the attack. On hearing her mother screaming, their daughter Amy went toward the bedroom. As she approached the bedroom, Amy saw her father walking out of the bedroom with a bloodied knife in his hand. Mr Browning threw the knife on the floor, said the word "*bitch*" and walked away.

23. Amy yelled "*what have you done?*", but Mr Browning did not reply. Amy then went into the room to assist her mother, who had already stopped breathing.

24. Police and ambulance officers attended the family home a short time later. Mrs Browning was unable to be revived and was declared deceased.

25. Mr Browning was found sitting at a garden setting in the backyard. When police officers asked him what happened, Mr Browning replied "*I've killed my wife*".

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

26. 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

27. For the purposes of the *Family Violence Protection Act 2008* (Vic), the intimate personal relationship between Mrs Browning and her husband Mr Browning was one that fell within the definition of 'family member'. Moreover, recent separation has been established as a factor that increases the risk of family violence homicide[6]. On this basis, the death of Mrs Browning was considered to have occurred in the context of family violence.

28. As a result, I requested that the Coroners Prevention Unit (**CPU**)[7] examine the circumstances of Mrs Browning's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[8]

29. The CPU identified the presence of known risk factors for family violence, including alcohol misuse, financial difficulties and a recent separation. The available evidence suggests that Mr and Mrs Browning were having problems in their relationship, characterised by frequent arguments about their finances, which culminated in a mutual decision to separate.

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[6] Wilson M, Daly M. Spousal homicide risk and estrangement. *Violence and Victims*. 1993, Vol. 8, No. 1, pp. 3-16.

[7] 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.

[8] 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.

30. The CPU identified that there was no indication that Mr Browning intended to harm Mrs Browning, nor did Mr or Mrs Browning seek any assistance in relation to the separation and therefore there were no opportunities for intervention.

31. Following Mrs Browning's decision to end the marriage, which Mr Browning was reportedly reluctant to agree to, Mr Browning was described as appearing upset and depressed. He had also begun smoking again. Mr Browning's daughter, Amy, had identified a deterioration in Mr Browning's mental health and suggested that he should see a doctor and obtain some sleeping tablets. Instead, Mr Browning obtained Restavit over the counter at a chemist. Amy's encouragement of her father to seek assistance is to be commended. Tragically, Mr Browning did not seek professional support or intervention.

32. The "*R U OK?*" campaign seeks to prevent suicide by encouraging family, friends and colleagues who notice someone appears not to be coping well, to ask that person whether or not they are okay. The CPU suggested that the "*R U OK?*" campaign could be adapted by Victorian family violence services for development of a similar awareness campaign in relation to (primarily) women in high risk situations, such as at separation. A campaign of this style could encourage friends, family and colleagues to ask a person whether they believe they need a safety plan.

Criminal proceedings

33. Mr Browning was arrested at the scene and later charged with murder in relation to Mrs Browning's death.

34. Mr Browning's legal counsel submitted at the trial that Mr Browning was suffering from a mental impairment and adverse effects of the drug Restavit at the time he killed Mrs Browning. The jury rejected that proposition. The Court rejected the possibility of a drug-induced psychosis, but accepted that Mr Browning's mental state could have been compromised by taking four to six Restavit tablets. Justice Lasry took this into account in relation to moderation of the sentencing considerations of specific and general deterrence.

35. Justice Lasry remarked that:

"there exists a fundamental community expectation that domestic violence be denounced and denounced in the strongest of terms… In Felicite v R,[9] *Redlich JA noted that, in the context of*

[9] [2011] VSCA 274.

spousal murder "the principles of general deterrence, denunciation and just punishment will ordinarily be given primacy in sentencing for the murder of a domestic partner in a domestic setting even when there are present, circumstances of provocation or great emotional distress"; and

the Court of Appeal has made clear (that) a murder committed in circumstances of domestic strain and tension is not to be regarded as falling into a less serious category.[10]

36. On 9 October 2014, Mr Browning was sentenced to 18 years' imprisonment, with a non-parole period of 14 years.

37. In the course of my investigation, having considered all of the available evidence, I did not identify any prevention matters arising from the circumstances of Mrs Browning's death.

38. I am also satisfied, having considered all of the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION

39. 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 Catherine Elizabeth Browning, born 10 August 1966;

    (b) the death occurred on 19 December 2013 at 3 Natisone Place Skye, Victoria, from stab wounds to the chest and neck; and

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

40. I convey my sincerest sympathy to Mrs Browning's family and friends.

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

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

    (a) Amy Browning, senior next of kin.

    (b) Sergeant Miranda Stubbs, Victoria Police, Coroner's Investigator.

[10] *R v Gojanovic (no 2)* [2007] VSCA 152.

(c) Detective Inspector Michael Hughes, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 9 December 2016