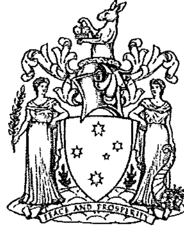

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 0054

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:	**CATHY MARY McPHEE**
Date of birth:	8 November 1954
Date of death:	3 January 2013
Cause of death:	Stab wounds to chest
Place of death:	633 Seventeenth Street, Mildura South

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HER HONOUR:

BACKGROUND

1. Cathy Mary McPhee (**Ms McPhee**) was born on 8 November 1954 and she died aged 58 years at 633 Seventeenth Street, Mildura South.

2. In 2005, Ms McPhee met Stephen McPhee (**Mr McPhee**) and they married on 30 October 2008.[1] Ms McPhee moved into Mr McPhee's property within the first year of their relationship.[2] She had previously resided at 615 Deakin Avenue, Mildura and, at the time of her death, retained ownership of this property.[3]

3. Both Mr and Ms McPhee worked as disability carers.[4] Mr McPhee changed his occupation from being a gardener to become a disability carer approximately three and a half years prior to Ms McPhee's death.[5] Both Mr and Ms McPhee had previously been married. Ms McPhee had four sons from her previous marriage with Gary Holtham; Shane, Jason, Jessie and Daniel.[6] Mr McPhee had two children from his previous marriage.[7]

4. Their marriage in the early years had been a happy one.[8] However, in the years prior to Ms McPhee's death Mr and Ms McPhee's relationship began to deteriorate,[9] and approximately 12 months prior, it began to break down.[10] Ms McPhee complained of Mr McPhee's alcohol consumption (mainly when he would drink with a neighbour), that he would be abusive towards her and that he refused to stop viewing pornographic material.[11]

5. On 8 November 2011, Mr and Ms McPhee first consulted a local psychologist with the goal of improving their relationship.[12] The couple attended six further sessions with the same psychologist; Ms McPhee alone on 27 April and 29 May 2012, Mr McPhee alone on 22 May and 17 December 2012, and the couple together on 23 October and 11 December 2012. All sessions were focussed on the relationship.

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[1] Coronial Brief, pp. 299-300.
[2] Coronial Brief, p. 301.
[3] Coronial Brief, p. 53.
[4] Sentencing remarks, pp. 4-5.
[5] Coronial Brief, p. 304.
[6] Coronial Brief, p. 52; Sentencing remarks, p. 4.
[7] Sentencing remarks, p. 6.
[8] Sentencing remarks, p. 1.
[9] Coronial Brief, p. 53.
[10] Coronial Brief, p. 301.
[11] Sentencing remarks, p. 1; Coronial Brief, p. 75.
[12] Sentencing remarks, p. 1; Coronial Brief, pp. 75-96.

6. Mr and Ms McPhee reportedly had a jealous relationship.[13] Ms McPhee believed that Mr McPhee was having an affair with a work colleague.[14] To this end, Ms McPhee hired a private investigator, who was not able to substantiate her allegations.[15] Mr McPhee admitted to flirting with his colleague, but denied an affair took place. The colleague insisted that although Mr McPhee was sometimes inappropriate with her, that this was unwelcome and that an affair did not take place.[16] Mr McPhee became defensive and aggressive when questioned about the alleged affair, and was found to be lying about some of the meetings and phone calls which he had with his work colleague, which was discovered when Ms McPhee looked at his phone.[17]

7. Throughout their relationship and in the year prior to Ms McPhee's death, Mr McPhee was possessive and controlling of her.[18] Mr McPhee would always be present when Ms McPhee saw her sons, he stopped her from visiting and calling her sons, cut off her internet, looked through her personal things including her phone, and would not allow her to talk to other males, especially her ex-husband.[19] When they went out, Mr McPhee was known to follow Ms McPhee to the toilet and wait outside the door until she came out.[20]

8. On 11 September 2012, Mr McPhee and Ms McPhee saw their lawyer to discuss financial and property arrangements for their trial separation.[21] A part of this separation plan was to build a granny flat behind Ms McPhee's 615 Deakin Avenue property to enable her to live there separately from Mr McPhee.[22] Ms McPhee had also arranged for her brother, Donald Scales, to work on her property at 615 Deakin Avenue to install a new wardrobe.[23] It is unclear, however, whether Mr McPhee fully accepted that Ms McPhee was permanently leaving him, or whether he believed the granny flat would provide Ms McPhee with some temporary space.[24]

9. In September 2012, one of Ms McPhee's sons graduated from university and she travelled to Melbourne to celebrate the event.[25] Mr McPhee also attended, unannounced, and made Ms

[13] Sentencing remarks, pp. 6-7; Coronial Brief, p. 79.
[14] Sentencing remarks, p. 1; Coronial Brief, p. 76.
[15] Sentencing remarks, p. 1; Coronial Brief, pp. 88-93.
[16] Coronial Brief, pp. 94-100.
[17] Coronial Brief, pp. 76-79.
[18] Coronial Brief, pp. 52-61, 101-105 and 124.
[19] Coronial Brief, pp. 53-56; 102.
[20] Coronial Brief, p. 101.
[21] Sentencing remarks, p. 1; Coronial Brief, p. 83.
[22] Coronial Brief, p. 84.
[23] Coronial Brief, p. 117.
[24] Coronial Brief, pp. 79 and 84.
[25] Coronial Brief, pp. 56 and 78.

McPhee leave the house and stay at a local motel. Mr McPhee was present during the limited time Ms McPhee saw her sons that weekend. Mr McPhee also took Ms McPhee's car and she was unable to travel in this vehicle.[26] Ms McPhee told her son Jason that she and Mr McPhee argued extensively the night he arrived in Melbourne and that she was worried he would hurt her.[27]

10. By 11 December 2012, Ms McPhee regarded the marriage as over, and Mr McPhee became very aggressive and angry upon hearing this.[28] During their counselling session on the same day, Mr McPhee made threats to kill himself. Ms McPhee's fear of Mr McPhee was evident to the psychologist during this session. The psychologist reported that he was concerned about Ms McPhee's safety and suggested that she obtain a family violence intervention order.[29] While these concerns and recommendation are not documented in the medical records they are reported in the psychologist's statement.

11. On 17 December 2012, Mr McPhee attended a counselling session alone and expressed worry over the relationship. The intention was for another counselling session to occur with both Mr and Ms McPhee after Christmas.[30]

12. Although fights and arguments between Mr and Ms McPhee had largely been verbal in nature,[31] it is clear that Ms McPhee feared for her safety in the months leading up to her death. For instance, Ms McPhee's son, Jason Holtham, reports that in December 2012, while at their home, Mr McPhee pointed a knife at Ms McPhee and told her to take the knife and stab him.[32] Similarly, Caroline Cramp, Ms McPhee's close friend, reports that in November 2012, when Mr McPhee came back from drinking with the next door neighbour, Mr and Ms McPhee had an argument and Mr McPhee held a knife to her throat and stated, "*If I can't have you no one else will have you and we'll go together.*"[33] Ms Cramp states that she felt that Ms McPhee was in fearful of Mr McPhee,[34] as did her son, Jason.[35] Ms McPhee had also advised her private investigator that she was in fear for her life, and that one night

[26] Coronial Brief, p. 123.
[27] Coronial Brief, p. 56.
[28] Sentencing remarks, p. 1; Coronial Brief, p. 79.
[29] Coronial Brief, pp. 79-80.
[30] Medical Records dated 17 December 2012.
[31] Sentencing remarks, p. 8, Court of Appeal, pp 2-3, Coronial Brief, pp. 302-303.
[32] Coronial Brief, p. 56.
[33] Coronial Brief, p. 102.
[34] Coronial Brief, pp. 101-105.
[35] Coronial Brief, p. 56.

before going to Melbourne she had left the house and slept in the car as she feared for her safety.[36]

13. On 29 December 2012, Ms McPhee drove to Melbourne to spend New Year's Eve with her sons and to have a break.[37] During this time Mr McPhee repeatedly called her,[38] and she had to explain to him what she was doing and who she was with.

14. On 2 January 2013, Ms McPhee rang Ms Cramp[39] and stated that she did not want to return to her home to face Mr McPhee as she was trying to work out how to tell him that she wanted to leave him.

THE PURPOSE OF A CORONIAL INVESTIGATION

15. Ms McPhee's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria, and was unexpected, violent, resulted from injury and not from natural causes.[40]

16. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[41] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

17. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[42] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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

19. 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 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.

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[36] Coronial Brief, p. 91.
[37] Coronial Brief, pp. 102 and 117.
[38] Sentencing remarks, p. 2; Coronial Brief pp. 57-59 and 307-315.
[39] Coronial Brief, p. 102.
[40] Section 4 *Coroners Act 2008.*
[41] Section 89(4) *Coroners Act 2008.*
[42] *Keown v Khan* (1999) 1 VR 69.

20. 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.

21. 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.

22. 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*.[43] 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.

23. In writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all of the witness statements 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*

24. On 6 January 2013, the Deceased was visually identified by her son, Jason Holtham, to be Cathy Mary McPhee, born 8 November 1954.

25. Identity is not disputed and requires no further investigation.

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

26. On 7 January 2013, Dr Jacqueline Lee, a Forensic Pathologist, practising at the Victorian Institute of Forensic Medicine, conducted an autopsy on Ms McPhee's body. Dr Lee

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[43] (1938) 60 CLR 336.

provided a written report, dated 11 April 2013, which concluded that a reasonable cause of death was '*stab wounds to chest.*'[44]

27. The report detailed that the first chest wound was 15 to 17 centimetres deep and perforated the heart, the second the second was 12 to 15 centimetres deep and perforated the diaphragm, liver, pancreas and splenic vein.

28. Toxicological analysis of the post mortem samples taken from Ms McPhee identified the presence of ethanol (alcohol) at 0.09g/100mL (blood-alcohol level).[45] No other common drugs were identified.

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

29. On 3 January 2013, Ms McPhee returned to Mildura after visiting Melbourne. Prior to returning home, Ms McPhee met Ms Cramp at a shopping centre at approximately 2.00pm to give her various photos and items relating to her Melbourne trip that she did not want Mr McPhee to see.[46]

30. After meeting Ms Cramp, Ms McPhee arrived at her home, at 633 Seventeenth Street, Mildura South, between 2.30pm and 3.00pm.[47] Mr McPhee was agitated because Ms McPhee had not been answering his calls.[48] Mr McPhee helped Ms McPhee unpack the car, then they sat on the front patio initially discussing how they would begin the New Year on a positive note.[49] However, soon they started drinking and fighting,[50] Ms McPhee said she was going to leave him, that she did not love him like she used to and she could not trust him. The argument was similar to many previous arguments.[51] During the argument Mr McPhee had a shower and returned to the patio. Mr McPhee tried to kiss Ms McPhee, he pulled her onto his lap but she pushed him away saying that she did not want to do that.[52] Mr McPhee felt upset and rejected.[53]

31. Mr McPhee said he was going to get another beer and walked around the back of the house to an outside fridge, during which time Ms McPhee went inside the house and laid on the

[44] Medical Examination Report of Dr Jacqueline Lee dated 11 April 2013, p. 13.
[45] Toxicology report.
[46] Sentencing remarks, p 2, Coronial Brief, pp. 103-104.
[47] Coronial Brief, p. 318.
[48] Coronial Brief, p. 315.
[49] Sentencing remarks, p. 2; Coronial Brief, p. 319.
[50] Sentencing remarks, p. 2; Coronial Brief, pp. 303, 319, 370-371.
[51] Coronial Brief, pp. 321, 327.
[52] Coronial Brief, p. 324.
[53] Coronial Brief, p. 325.

couch. They started to have another disagreement. By this stage, Mr McPhee had consumed approximately six or seven cans of beer, and he states that he could not remember exactly what they said to each other during this argument.[54] He said that the argument was no worse than previous ones, but Mr McPhee says he just '*snapped*'.[55]

32. Just after 8.00pm,[56] Mr McPhee went into the kitchen, opened the cupboard and grabbed a 28 centimetre knife, with a 16 centimetre blade, from a knife holder. Ms McPhee was lying on her back listening to music, but facing away from the kitchen so she could not see Mr McPhee.[57] Mr McPhee then stood above Ms McPhee and stabbed her in the chest area.[58] Ms McPhee held her hands out, screaming, and grabbed the knife with her hands. Ms McPhee said to Mr McPhee "*I love you, Steve, I love you*",[59] while trying to stop him, but he stabbed her a second time, at which point she started gurgling.[60]

33. Mr McPhee panicked and before calling the ambulance, he removed Ms McPhee's skirt to wipe the fingerprints and blood from the knife.[61] Mr McPhee called the ambulance and said that Ms McPhee had stabbed herself in the chest, he then followed the instructions from the '000' operator to stem blood flow from the wounds and gave Ms McPhee mouth to mouth resuscitation.[62]

34. At approximately 8.30pm, police officers arrived and ambulance officers attended soon thereafter. Ms McPhee was not able to be resuscitated and she was declared to be deceased.

35. Mr McPhee initially lied to the police officers about how Ms McPhee sustained her fatal injuries, but later admitted to having stabbed her.[63]

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

36. 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.

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[54] Coronial Brief, pp. 326, 369.
[55] Coronial Brief, p. 298.
[56] Coronial Brief, pp. 358-359.
[57] Sentencing remarks, pp. 2-3; Coronial Brief, pp. 333-336.
[58] Coronial Brief, p. 338.
[59] Coronial Brief, pp. 345, 348.
[60] Coronial Brief, p. 345.
[61] Sentencing remarks, pp. 2-3; Coronial Brief, p. 348.
[62] Sentencing remarks, pp. 2-3; Coronial Brief, pp. 256-267 and 351, 348.
[63] Sentencing remarks, p. 3.

37. I requested that the Coroners Prevention Unit (**CPU**)[64] examine the circumstances of Ms McPhee's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[65]

38. The CPU identified the presence of risk factors known to increase the risk of fatal family violence between intimate partners, in particular a relationship breakdown and pending separation.[66] In addition, the CPU identified service contact with a private psychologist in the period proximate to Ms McPhee's death. Couples experiencing a relationship breakdown may seek assistance from allied health professionals, such as psychologists. Given the nature of the provision of this service, psychologists may witness or become aware of behaviour that constitutes family violence.

39. In this case, the psychologist witnessed an aggressive outburst and threat of suicide from Mr McPhee during a session where Ms McPhee indicated her intention to separate from him. In response, the psychologist provided advice to Ms McPhee about family violence intervention orders. While ultimately Ms McPhee did not take this advice, given the outcome, it demonstrates the important role psychologists have in the identification of family violence, and as a referral pathway for specialist intervention.

40. Due to the specific risks associated with pending or actual separations, it is particularly important that psychologists working in relationship counselling have appropriate knowledge and expertise in family violence. This issue was touched upon in the Royal Commission into Family Violence, where it was recommended that the Chief Psychiatrist in consultation with psychologists' peak bodies coordinate the development of a family violence learning agenda for all psychologists. I agree with this recommendation and encourage the learning agenda to include issues specific to relationship counselling.

41. On 22 October 2013, Mr McPhee pleaded guilty to one charge of murder and was convicted and sentenced to 20 years of imprisonment with a non-parole period of 16 years.[67]

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[64] 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.

[65] 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-focussed recommendations aimed at reducing the incidence of family violence in the Victorian community.

[66] Johnson, H. & Hotton, T (2003). Losing Control: Homicide Risk in Estranged and Intact Intimate Relationships. Homicide Studies 7:58. Found at http://hsx.sagepub.com/content/7/1/58.

[67] Sentencing remarks, pp. 9-10.

42. On 24 July 2014, on appeal, Mr McPhee was re-sentenced to 18 years of imprisonment with a non-parole period of 13 years.[68]

43. I note and adopt the following sentencing remarks of His Honour Justice Priest:

> *"Murder is the most serious offence on the criminal calendar. In sentencing you, I must have regard to the nature and gravity of the offence here committed. Although your actions were unpremeditated and spontaneous, you clearly acted out of anger and, no doubt, alcohol played its part. It was not news to you that your wife wanted a separation, although you may not have wanted one. You went along with the idea of it and, indeed, up until that day, had acted reasonably and somewhat responsibly in working on your marital issues and working towards a trial separation. You had spent that afternoon with your wife convivially enjoying each other's company and, it seems, to a point, discussing the state of your marriage without rancour. Your wife did nothing to provoke you, although you say she must have said something. She was defenceless and must have been taken utterly by surprise by your attack. She was doing no more than lying on the couch in the sanctuary of her own home.*
>
> *Your explanation that you "snapped" masks the reality that you acted out of anger when you stabbed your wife not once but twice, and in the face of her cries for you to stop, although I accept that this must have all happened very quickly. Although the marriage had its strains and you had reacted aggressively in the presence of the psychologist, the marriage was not marked by violence, you have no history of violence and you have no prior convictions for violence or, indeed, any other offences, and you are regarded as a person of good character. I accept then that this conduct was totally out of character for you and, apart from "snapping", as you describe it, is otherwise inexplicable, which only serves to compound the great tragedy of this crime both for Mrs McPhee, her family and, indeed, for you."* [69]

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

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Cathy Mary McPhee, born 8 November 1954;

    (b) Ms McPhee died on 3 January 2013, at 633 Seventeenth Street, Mildura South, Victoria, from stab wounds to the chest;

    (c) that Mr McPhee caused Ms McPhee's death;

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

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[68] Court of Appeal decision, p. 8.

[69] Sentencing remarks, pp. 8.

46. I convey my sincere condolences to Ms McPhee's family and friends at her tragic and untimely death.

47. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

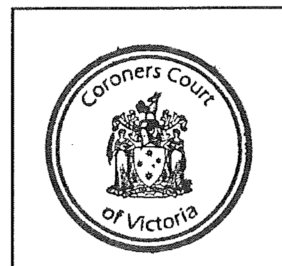
48. I direct that a copy of this finding be provided to the following:

    (a) Mr Jason Holtham, senior next of kin.

    (b) Detective Sergeant Graham Ross (Homicide Squad), Coroner's Investigator.

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

Signature:



JUDGE SARA HINCHEY

STATE CORONER

Date: 5-SEP- 2016