

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2001 / 2310

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of: DENIS STEPHEN KELLY

Delivered On: 1 May 2014

Delivered At: Coroners Court of Victoria
Level 11, 222 Exhibition Street
Melbourne 3000

Hearing Dates: 1 May 2014

Findings of: CAITLIN C ENGLISH, CORONER

Police Coronial Support Unit Leading Senior Constable King Taylor

I, CAITLIN CREED ENGLISH, Coroner having investigated the death of DENIS STEPHEN KELLY

AND having held an inquest in relation to this death on 1 May 2014

At Melbourne

find that the identity of the deceased was DENIS STEPHEN KELLY

born on 4 December 1938

and the death occurred on or about 27 July 2001

at Footscray Park, Footscray

from:

1 (a) HEAD, NECK AND CHEST INJURIES

in the following circumstances:

Background

1. The deceased Mr Denis Kelly was 62 years old when he died. He was the youngest of 12 children, and was born 4 December 1938. He grew up in Moonee Ponds. He left school at age 16 and worked in sales.
2. His sister, Brenda Walsh described her brother as a *'gentle person who loved music, wrote poetry and loved the theatre. He was a smart man, but reclusive.'* She described him as dropping away from the family *'for reasons we didn't know in 1989.'* Brenda described him as struggling with his sexuality and speaking at length with him about being homosexual and that Mr Kelly had sought counselling. She knew he had been in a long term same sex relationship for about 20 years, which ended in the mid 1980's. She stated:

'Denis just seemed to drop off the earth in 1989. He stopped accepting my phone calls and I lost touch with him. When I last tried to speak to Denis, he was living in a unit in Commercial Road, Prahran.'

3. As Mr Kelly's death occurred in Victoria and I suspect his death was the result of homicide, I am mandated to hold an inquest into his death pursuant to section 52(2)(a) *Coroners Act* 2008 (Vic).

Circumstances of death

4. On 27 July 2001 Mr Kelly's body was located by Ms Charmaine Brough floating in the Maribyrnong River adjacent to Footscray Park. Ms Brough observed the body to be tangled in orange plastic.

5. Police investigations of the scene led investigators to conclude Mr Kelly was assaulted by unknown persons in Footscray park the evening prior or in the early hours of 27 July 2001 and after being fatally assaulted, he was wrapped in temporary fencing material and thrown into the river. Mr Kelly's body was tangled in a length of orange plastic barrier tape and two metal 'star' pickets.
6. Police believe Mr Kelly was a homeless person who slept in Footscray Park, utilising various park shelters. During their search of the park, the investigators found what they believe to be Mr Kelly's abode, within a covered pergola, with a makeshift newspaper bed, items of clothing and toiletries. A local resident, Sid Taylor described seeing Mr Kelly (whom he knew as 'Steve') at Footscray Park over the previous four years. He described seeing him when he walked his dogs. He would see 'Steve' listening to his radio, or reading on a bench in the park. Another local Footscray resident James Bolvan saw Mr Kelly at 4.30pm on 26 July 2001. He described Mr Kelly as walking near the playground equipment listening to a small transistor radio. He recognised him having seen him regularly when walking his dog over the previous five weeks.

The Autopsy Report

7. Dr David Ranson performed an autopsy on Mr Kelly on 27 July 2001. In his very thorough report, he made the following comments:
 1. *The autopsy revealed evidence of extensive trauma to the head with evidence of blunt injury to the side of the head, the back of the head, the top of the head, the forehead region, the nose region, the region of the cheeks, the region of the upper lip and the region of the ears. The head injuries were associated with subarachnoid haemorrhage around the brain as well as cortical contusions.*
 2. *Internally the injuries to the face were associated with "Le Fort" fractures type 1, 2 and 3 which are injuries involving applications of considerable force to the front of the face in its lower, middle and upper parts.*
 3. *Severe injuries were present to the neck with rupture of strap muscles, haemorrhage into strap muscles, fracturing of the thyroid cartilage (Adam's apple) and fracturing of the hyoid bone. Oedema and haemorrhage was present in the vicinity of the vocal cords. These injuries were associated with external signs of injury to the skin of the neck and the fracturing of the*

laryngeal structures together with the rupture and haemorrhage of strap muscles is a feature of blunt force crushing injury to the front of the neck.

4. *The pattern of fractures to the ribs suggests very considerable force being applied to the front of the chest and indeed the left side of the chest externally appeared collapsed. The multiple fractures to the front and sides of the upper ribs on both sides had resulted in downward displacement of the front of the chest and this had resulted in squeezing of the heart between the sternum or breast plate and the spinal column. This squeezing had resulted in rupture of the heart, rupture of the epicardium and tearing of areas within the lung. These injuries had bled such that approximately 2,900 ml of blood was found free in the thorax cavity.*
5. *In addition to the injuries to the chest there was also evidence of haemorrhage into the mesentery in the back of the abdomen and in the diaphragm and falciform ligament of the liver.*
6. *The autopsy revealed a mild degree of cardiac enlargement comprising left ventricular hypertrophy in association with a mild to moderate degree of coronary artery atherosclerosis. There was no evidence of any recent ischaemic damage to the heart.*
7. *The pattern of injuries seen to this man's head, chest and neck were very severe and comprised major applications of blunt force together with crushing injury. The nature and degree of these injuries were of a type often seen where an individual dies as a result of a high speed motor vehicle accident.*
8. *Examination of the lungs and upper airways revealed no evidence of any frothing or any watery fluid.*
9. *The characteristics of the injuries to the heart are such that they would result in substantial loss of blood volume within a very short time interval such that death would ensue within a matter of a few minutes following the rupture of the heart.*
10. *Both the injuries to the head area, the neck area and the chest area were associated with significant haemorrhage indicating that blood pressure would have been present at the time these injuries were inflicted.*

8. He concluded his report with a specific finding of the medical cause of death as Head, Neck and Chest Injuries.
9. During the autopsy, Dr Ranson took a series of medical swabs and specimens. An anal swab has been examined by Kathryn Bradley from the Victorian Police Forensic Centre, which has identified the presence of spermatozoa. A DNA profile of the spermatozoa confirms it is that of Mr Kelly and is that of an unknown person.

Police Investigation

10. Extensive police investigations have included media releases, information caravans and door to door canvassing. Police have explored a history of previous assaults and criminal offences which have occurred in the same park. An appeal for witnesses prompted several reports of similar style assaults by witnesses who contacted police and nominated persons of interest.
11. From the blood found at the scene, police believe the body of Mr Kelly was moved from the southern side of the park and dragged to the Maribyrnong River, where it was deposited in the water. Further, given the injuries which Mr Kelly sustained, Police investigators assume that more than one person was involved in the murder of Mr Kelly.
12. The police investigation identified a number of suspects in respect of possible involvement with the death of Mr Kelly, however no tangible connections between any of these suspects and Mr Kelly have been established, nor has any motive for the murder been determined.
13. Police are of the view that the origins and/or the significance of some items and trace material found within the crime scene and upon Mr Kelly have not been clearly established.

Conclusion

14. At my request, the Coroners Prevention Unit (CPU)¹ identified the frequency of homicides of homeless persons in Victoria during the period 1 July 2000 to 31 December 2013 using the National Coronial Information System (NCIS) and the CPU Surveillance Database. Four deaths of this type have occurred in addition to the death of Mr Kelly.² In addition, the CPU searched the scientific research literature on this issue. While there is limited research describing the relationship between homelessness and homicide, the homeless are reported

¹ The Coroners Prevention Unit ('CPU') 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.

² Court Reference Numbers: 20022088; 20033686; 20061972; 20140062

as amongst the most vulnerable group in the community. Research also shows that people become homeless for a number of reasons including limited affordable housing, domestic violence, financial crises and long-term unemployment. Homeless people are at increased risk of physical and sexual assault and commonly witness violence. They are often affected by depression, poor nutrition, mental health problems and substance misuse and disorders which increase their vulnerability to assault and homicide.

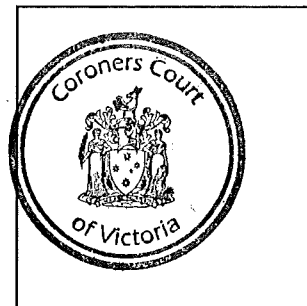

15. To satisfy section 67 *Coroners Act* 2008 I must be satisfied on the balance of probabilities as to the identity, cause of death and the circumstances in which the death occurred and to make findings accordingly.
16. I am satisfied regarding identity of Mr Kelly and the cause of his death. In view of Dr Ranson's findings I am satisfied that Mr Kelly died as a result of foul play. It is not possible to determine the identity of the person or persons responsible for his death.
17. The file at the Homicide squad will remain open and any new information that comes to light will be investigated.

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

Brenda Walsh

S/C Robert Catania, Homicide Squad

Signature:



CAITLIN ENGLISH
CORONER
Date: 1 May 2014

