



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 0188

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:	DREW DAX
Date of birth:	5 September 1968
Date of death:	11 January 2015
Cause of death:	Stab injury to the neck
Place of death:	11 Princess Street, Caulfield North, Victoria
Catchwords	Homicide; family violence; master-slave relationship; death resulted directly from injury; was unexpected, violent, and not from natural causes

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HER HONOUR:

BACKGROUND

1. Drew Dax was a 46-year-old man who lived with Mr Henry Rose, his partner of almost 27 years. They both lived at 11 Princess Street, Caulfield North, (**the home**) at the time of his death.
2. Mr Dax and Mr Rose's relationship was described as a "*master-slave*" arrangement, Mr Dax being the "*master*" in the relationship. There are competing accounts as to whether the master-slave arrangement was limited to domestic slavery or also extended to sexual slavery. It was reported that Mr Rose '*enjoyed*' being physically abused by Mr Dax.
3. Mr Dax had a history of using Diazepam, pain medication and marijuana. He would also consume alcohol regularly, occasionally engaging in binge drinking. In the late 1980's, Mr Dax was convicted of assault in company, theft and intentionally causing injury.
4. Both Mr Dax and Mr Rose had experienced childhood trauma. At the age of nine years, Mr Dax was sexually and physically abused. Mr Dax's medical history included recent treatment for mental health issues including depression, bipolar disorder and post-traumatic stress disorder.
5. Dr Norman Roth had been both Mr Rose's and Mr Dax's treating physician since 1999. He described Mr Dax as being "*troubled from his childhood abuse and inclined to be verbally, rather than physically, violent*". Medical records detail that Dr Roth had referred both Mr Rose and Mr Dax variously to psychiatrists, psychologists and counsellors. However, there is no evidence that either man was engaged with such services at the time of Mr Dax's death.
6. In October 2013 and April 2014, police officers were called to attend Mr Dax and Mr Rose's home in relation to family violence incidents. In each case, Mr Rose was assessed by the attending police officers to be the affected family member and Mr Dax the perpetrator of the family violence. The October 2013 incident resulted in a three-month non-exclusion intervention order. The April 2014 incident resulted in a six-month non-exclusion intervention order with a condition attached for Mr Dax to contact the Men's Referral Service. At Mr Rose's request, no charges were laid in relation to either incident. On both occasions, Mr Rose told police officers that he no longer felt '*at risk*' or unsafe.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Mr Dax'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
8. The jurisdiction of the Coroners Court of Victoria (**CCOV**) 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
9. 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.
10. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mechanism of death.
11. 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.
12. 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.
13. Coroners are also empowered:
 - (a) to report to the Attorney-General on a death;

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.

- (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.
14. 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.
15. 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

16. On 12 January 2015, Mr Dax's body was identified by fingerprint analysis.
17. Identity is not in dispute and requires no further investigation.

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

18. On 11 January 2015, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination of Mr Dax's body and provided a written report, dated 5 March 2015. In that report, Dr Lynch concluded that a reasonable cause of death was '*stab injury to the neck*'.
19. Dr Lynch commented that he considered that the degree of force required to produce the incised injuries on Mr Dax, on a scale of '*mild/moderate/severe*', would be "*at least moderate*". Dr Lynch also commented that there was "*evidence of blunt force trauma to the right wrist and both hands*".

⁵ (1938) 60 CLR 336.

20. Toxicological analysis of the post mortem samples taken from Mr Dax were positive for ethanol (at 0.22g/100ml), benzodiazepines, ibuprofen and cannabinoids.

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

21. On the evening of Saturday, 10 January 2015, Mr Rose and Mr Dax reportedly had an argument. Mr Dax had been drinking wine and had taken a number of unknown tablets.
22. At 10.24 pm, Mr Dax was last seen alive by a pizza delivery driver.
23. At between 11.20pm and 11.30pm, a neighbour overheard an argument in the vicinity of the home.
24. The available evidence indicates that in the early hours of Sunday, 11 January 2015, Mr Rose stabbed Mr Dax. Mr Dax suffered at least 21 incised injuries.
25. At 3.19am, Mr Rose telephoned his cousin's home and told his cousin's partner that he had killed Mr Dax in self-defence.
26. At 3.22am on 11 January 2015, Mr Rose telephoned emergency services and reported that he had stabbed his partner in self-defence and thought he may have killed him.
27. At 3.33am, police and ambulance officers attended the address and located Mr Dax's body face down on the kitchen floor with apparent stab wounds to his abdomen.
28. At 3.46am, ambulance officers declared Mr Dax deceased.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Family violence

29. 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.
30. For the purposes of the *Family Violence Protection Act 2008*, the intimate personal relationship between Mr Dax and Mr Rose was one that fell within the definition of 'family member'. Moreover, the actions of Mr Rose causing Mr Dax's death constituted 'family violence' as there was a history of emotional abuse which culminated in physical violence which ultimately caused Mr Dax's death.

31. As a result, I requested that the Coroners Prevention Unit (CPU)⁶ examine the circumstances surrounding Mr Dax's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).⁷
32. The CPU identified the presence of known risk factors for family violence including: a history of family violence, mental health issues, misuse of alcohol and other drugs and past childhood abuse. Available evidence suggests that both Mr Dax and Mr Rose had not engaged with services to address their needs in these areas. It is unclear how much the power and control dynamic of the master-slave relationship contributed to confusing the boundaries of their relationship and their understanding of acceptable behavior. It is possible that this confusion contributed to exacerbating their risk factors.
33. The VSRFVD identified that Mr Dax's death occurred in circumstances whereby friends and family identified having witnessed family violence in the form of emotional abuse. Previously, Coroners have made comments and recommendations in relation to the under-reporting of family violence due to concern for possible repercussions for the victim and the perception that outside involvement may exacerbate a situation (which the victim appears to be managing).
34. In the Finding into the death of Nicole Joy Millar,⁸ the Former State Coroner, Judge Ian Gray,⁹ recommended that Victoria Police, together with Crime Stoppers, conduct a trial extending the 'Say Something' campaign to family violence. At that time, Crime Stoppers highlighted budgetary constraints as a barrier to implementing this action.
35. A public awareness campaign promoting the definition of family violence in the broader community may assist family and friends of victims of family violence to better understand what constitutes family violence. Such a campaign may also assist them to identify when people are at risk and encourage them to seek assistance. However, I note that due to the nature of the "*master-slave*" relationship in this case, the people close to Mr Dax and Mr Rose would

⁶ 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.

⁷ 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.

⁸ COR 2010 2064.

⁹ Judge Ian Gray retired as the State Coroner in December 2015.

likely have had difficulty differentiating behaviour that gave rise to concerns of family violence from that of consensual, “*master-slave*” interactions.

36. The Royal Commission into Family Violence (**the Royal Commission**) made a number of recommendations emphasizing the vulnerability of same sex couples and inadequacy of services and supports available to them. The Royal Commission’s recommendations 166-168 relate to research, funding and evaluation of services available to the Lesbian, Gay, Bisexual, Transgender and Intersex (**LGBTI**) community and of responses to same sex family violence in Victoria. Recommendation 169 relates to the Victorian Government’s commitment to remove any capacity for accommodating same sex family violence or for service providers to discriminate against LGBTI Victorians.
37. I support the Royal Commission’s recommendations regarding same sex family violence and support services for vulnerable LGBTI Victorians.
1. Despite the presence of a number of known risks factors for family violence, the CPU identified limited opportunities for the legal system, health system or family violence service providers to intervene to reduce the risk of family violence between Mr Rose and Mr Dax.
2. I am satisfied, having considered all of the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION

38. 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 Drew Dax, born 5 September 1968;
 - (b) the death occurred on 11 January 2015 at 11 Princess Street, Caulfield North, Victoria, from a stab wound to the neck; and
 - (c) the death occurred in the circumstances described above.
39. I convey my sincerest sympathy to Mr Dax’s family.
40. Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this Finding be published on the internet.
41. I direct that a copy of this finding be provided to the following:

- (a) John Barratt, Senior next of kin.
- (b) Detective Senior Constable Tom Hogan, Victoria Police, Coroner's Investigator.

Signature:



JUDGE SARA HINCHEY

STATE CORONER

Date: 12/12/2016

