IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 4919

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:	**HELEN CURTIS**
Date of birth:	3 November 1953
Date of death:	19 November 2012
Cause of death:	Gunshot injuries to the head
Place of death:	West Footscray, Victoria

TABLE OF CONTENTS

HER HONOUR:

BACKGROUND

1. Helen Curtis was a 59-year-old woman who lived at West Footscray at the time of her death.

2. Ms Curtis was born on 3 November 1959, the second child born to her parents, Alfred and Valerie Curtis. She had an elder sister, Jennifer Stelline, and two younger brothers, Ronald and Gary. Following her father's employment opportunities as a driver of large earthwork vehicles and machinery, the family frequently moved and spent time in Victoria, the Northern Territory, Western Australia and South Australia. Ms Curtis settled in Victoria during her adolescence.

3. The statements provided by both her sister, Ms Stelline and daughter, Ms Jolene Unwin reflect that Ms Curtis' childhood was an unhappy one, where she endured physical and sexual abuse at the hands of her father and others. As a result, she maintained a distrust of men throughout her life.

4. Family and friends describe Ms Curtis as a friendly, caring person who was strong-willed and hard-working but found it difficult to trust others.

5. Over Ms Curtis' late adolescence and adult life she had several serious relationships, including three marriages,[1] and gave birth to three children, Tammie Feltis in 1970, Jolene Unwin in 1980 and Jaimi-Leigh Meilak in 1990. The dynamic within Ms Curtis' relationships seemed to vary between her being the victim of violence in physical and emotional forms in some instances, to her being the dominant force within the relationship and, at times, the perpetrator of violence. The available evidence suggests that the latter was true in her relationship with Phillip Bracken. Mr Bracken was submissive to Ms Curtis and was embarrassed to admit to and attempted to hide the physical abuse he was subjected to from his friends, colleagues and family.

6. Between 1997-98, during Ms Curtis' marriage to Jaimi-Leigh's father, she obtained her truck licence to drive prime movers and continued this as a business in the years that followed, accumulating several trucks and a factory in Tottenham, which she used to house and maintain the vehicles. Prior to this, in 1998-2002, Ms Curtis worked as teacher's aide to students with special needs before engaging in work as a truck driver locally and at the Footscray wharves.

[1] Ms Curtis was briefly married to a fourth man which ended after six weeks

7. Ms Curtis met and eventually commenced a relationship with Mr Bracken between 2008 and 2009, some three or four years prior to Ms Curtis' death. Initially, the two were happy and friends and family reported they were like teenagers. In 2009, as a result of injuries she sustained in a serious car accident, Ms Curtis was forced to give up her work driving prime mover trucks and became financially dependent upon Mr Bracken. Following this decline in her physical health, Ms Curtis also experienced a significant deterioration in her mental health. While she was engaged with a psychiatrist, Dr Rodger Chau, from late 2009, the sessions primarily focussed on her self-image, anxiety and physical issues. She did not disclose her relationship with Mr Bracken or any issues related to her personal life.

8. The evidence suggests Ms Curtis inflicted emotional and financial abuse against Mr Bracken. She reportedly complained that he did not earn enough money and that he was eager to please her in every way he could, for fear of her reaction. Mr Bracken's statement to police following Ms Curtis' death suggested that she became physically abusive towards him approximately three months into their relationship. He told police she became angry and aggressive for no reason and on two occasions chased him down the street with a knife. On other occasions, he stated that Ms Curtis kicked him and punched him in the face causing black eyes and swollen lips. Mr Bracken stated he lost count of the number of occasions this happened. Ms Curtis' friend, Sue Finlow, witnessed one episode where Mr Bracken suffered a split eardrum inflicted by Ms Curtis. Robert McCarthy, a friend of Mr Bracken's, stated that during the time Mr Bracken and Ms Curtis were together he observed injuries such as black eyes, bruising on his cheek and scratches on his face at various times. Ms Finlow also recounted an occasion in her statement where Ms Curtis, in a rage, attacked Mr Bracken causing him to cower in a corner, bleeding from his ear.[2]

9. Ms Curtis' medical history included complications from breast enlargement surgery and lasting injuries resulting from her involvement in two serious car accidents. In 1976, she underwent breast augmentation surgery. The silicone implants began to leak and Ms Curtis was subsequently diagnosed with Raynaud's disease which led to the removal of her implants in 1990. The first car accident occurred around 1991, from which she suffered long-term injuries to both her knees and other injuries, some of which worsened her Raynaud's disease, requiring ongoing medical treatment. The evidence also suggests that she began a dependence on alcohol after this first accident. She stopped for a period of time, but relapsed following the second car accident. The second car accident occurred in 2009 and resulted in the partial

[2] Statement of Sue Finlow, *Coronial Brief*, p.190

loss of vision in one of her eyes and further injuries to her knees. The injuries caused bleeding to the retina of her right eye and ultimately affected her ability to read and drive at night. Following the second accident, Ms Curtis became anxious of motor vehicles both as a passenger and a driver. Her ability to drive prime movers had been a source of pride and financial independence for Ms Curtis and she grieved the loss of this and her generally active lifestyle.

10. In the years prior to Ms Curtis' death, the available evidence suggests that Ms Curtis was suffering daily, both from a significant physical pain as well as a deterioration in her mental health. She had been diagnosed with bipolar disorder and the evidence suggests she had a dependence on alcohol. In late 2010, Dr Chau referred Ms Curtis to the Melbourne Clinic for assessment and detoxification from alcohol. She was assessed but declined treatment. Her depression caused her to be sad and reclusive and experience difficulty sleeping. She also experienced periods of excessive spending, purchasing items online and attending the post-office in West Footscray daily to collect packages.

11. In the period from 2010 to 2011, she reported experiencing anxiety and panic attacks with increasing severity and spoke to Dr Chau about suffering continuous physical pain as well as angry outbursts which sometimes caused her to smash things. She was prescribed a number of medications in an attempt to stabilise her mental state, including an antidepressant (citalopram), an anxiolytic (alprazolam) and a mood stabiliser (sodium valproate). Approximately two weeks prior to her death, Dr Chau changed her medication and began prescribing her clonazepam which reportedly caused a noticeable change in her behaviour.[3] Her friend, Ms Sue Finlow, stated that during this time Ms Curtis did not seem like herself and was constantly tired.[4]

12. Prior to her death, Ms Curtis and Mr Bracken seemed to be separated although living under the one roof. Family and friends stated that, after approximately Christmas 2011, the couple slept separately after Ms Curtis suspected Mr Bracken had been unfaithful. Despite this, the couple continued to attend functions together and cared for each other on a day-to-day basis.

[3] Statement of Dr Rodger Tan Fai Chau, *Coronial Brief*, p.161
[4] Statement of Sue Finlow, *Coronial Brief*, p.188 [16]

THE PURPOSE OF A CORONIAL INVESTIGATION

13. Ms Curtis' 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.[5]

14. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[6] The Act provides for a system whereby reportable deaths are independently investigated to ascertrain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

15. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[8] or to determine disciplinary matters.

16. The expression "*cause of death*" refers to the medical cause of death,[9] incorporating where possible, the mode or mechanism of death.

17. For coronial purposes, the phrase "*circumstances in which death occurred*,"[10] 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.

18. 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 Court's "*prevention*" role.

19. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[11]

---

[5] Section 4 *Coroners Act 2008*
[6] Section 89(4) *Coroners Act 2008*
[7] *Keown v Khan* (1999) 1 VR 69
[8] Section 69(1)
[9] Section 69(1)(b)
[10] Section 69(1)(c)
[11] Section 72(1)

(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;[12] 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.[13] These powers are the vehicles by which the prevention role may be advanced.

20. 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*.[14] 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.

21. 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 Act

22. On 19 November 2012, Ms Curtis was visually identified by Phillip Bracken's father, Michael Bracken, to be Helen Curtis, born 3 November 1953.

23. 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 Act

24. On 20 November 2012, Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Curtis' body. Dr Burke provided a written report, signed 14 December 2012, which concluded that Ms Curtis died from a '*gunshot injury to the head*.'

25. Dr Burke commented that the deceased suffered a gunshot injury behind the left ear. The post-mortem examination showed two gunshot injuries to the left side of the abdomen. Dr Burke commented that either of these injuries alone would be considered lethal. A further gunshot

[12] Section 67(3)
[13] Section 72(2)
[14] (1938) 60 CLR 336

injury to the right upper abdomen was found, as well as two gunshot injuries to the right wrist and left hand.

26. Toxicological analysis of post mortem specimens taken from the deceased identified the presence of a blood alcohol concentration of 0.08 grams per 100 millilitres, as well as the presence of tramadol, 7-aminoclonazepam and clonazepam.

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

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

28. On 19 November 2012, Ms Curtis had spoken to her friend, Ms Finlow, at approximately 9:30am and again at 1:22pm regarding to arrange to meet her later that day. On both occasions, Ms Finlow stated that she sounded groggy and not her usual self.

29. In his record of interview, Mr Bracken stated that the same day between 1.30pm and 2.00pm, Ms Curtis became aggressive towards him, pushing and hitting him, telling him that she hated his father and screaming that she was going to shoot his father.

30. Ms Curtis retrieved a firearm from her vehicle parked in the driveway of their home in Sunshine Road, West Footscray, and fired a shot towards the fence while she was in the backyard. She picked up the empty shell from the bullet and threw it over the fence. She took the gun and told Mr Bracken she was going to drive to his father's house and that he should stay home.

31. Ms Curtis left the house at approximately 2.00pm to drive to Mr Bracken's parents' home on Clive Avenue in West Footscray where his father, Michael Bracken, resided. Michael Bracken encountered Ms Curtis yelling at the front gate of his home saying, "*I want to see you, I want to say something to you*." Michael Bracken advised her to "*go away and cool off*" and that he was not interested in speaking to her as she appeared angry and was screaming. He stepped out of the gate with the intention of entering the front yard when she pushed the gate and began punching and kicking him. At one point, she tried to grab him around the neck and he pushed her away and walked onto Clive Street.

32. Michael Bracken stated that Ms Curtis said to him, "*there is nowhere to hide, I will bloody kill you, and I will kill your wife*." Ms Curtis reportedly followed him for a short distance by foot down the street before returning to her car. There, she briefly conversed with a neighbour, Brooke O'Donnell, to whom she said "*[she was] pissed off…with the smart arse comments from him all the time*." Ms Curtis left that conversation and once again began walking in

Michael Bracken's direction. He was waiting near a white boat parked opposite his home, hoping she would calm down. She returned to her car and drove up onto the nature strip in the direction that Michael Bracken was located. He became fearful that she would run him over and walked around the boat onto Clive Street. Ms Curtis followed in her car, slowly, along the nature strip back onto Clive Street. She followed him in her car, threatening to kill him and his wife, and parked her car approximately 20 to 30 metres away from where he was standing.

33. Michael Bracken then told Ms Curtis he intended to call Mr Bracken over to the house. She told him not to bother as she was calling Mr Bracken herself. At 2.19pm, the evidence suggests Ms Curtis called and spoke to Mr Bracken, with a nearby Telstra worker overhearing her say, "*you better get in the car and get down here*." Mr Bracken states she also told him, "*I've been around your dad's house and I just strangled your dad and bashed him up*" and "*you better get around here*." In a subsequent call to Mr Bracken she is reported to have said, "*if you don't get around here, I'm gonna kill him*."

34. Mr Bracken arrived at Clive Street at approximately 2.27pm and followed Ms Curtis' car along the street before both stopped their vehicles in the middle of the street and exited them, leaving the drivers doors open. Ms Curtis approached Mr Bracken and he then followed her toward Michael Bracken who asked him to take her home, stating that he did not want her there and that she had threatened to kill both him and his wife, Sandra. The available evidence suggests that, at some stage, he walked toward her vehicle and retrieved the gun. Ms Curtis stumbled and fell to the ground and he stood over her while she looked up at him. He then shot her at close range, multiple times to her torso, arms and head regions.

35. As Dr Burke's report states, Ms Curtis died of those gunshot injuries. Either major injury to the head or torso would have been fatal.

36. Emergency services were called and attended at approximately 2.54pm and confirmed Ms Curtis' death.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Criminal Proceedings

37. On 5 February 2014, following a trial before Justice Maxwell in Supreme Court of Victoria, Mr Bracken was acquitted of the murder of Ms Curtis. At trial, Mr Bracken alleged his shooting of Ms Curtis occurred in self-defence of his father, and that he had been the victim of ongoing family violence, both physical and emotional, throughout his relationship with Ms Curtis.

Family Violence

38. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by family members against each other are particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

39. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Ms Curtis and Mr Bracken fell within the definition of "*family member*"[15] under that Act. Moreover, Mr Bracken's actions in shooting Ms Curtis and causing her death constitutes "*family violence.*"[16] Ms Curtis' also perpetrated physical family violence against Mr Bracken during their relationship.

40. I requested that the Coroners' Prevention Unit (**CPU**)[17] examine the circumstances of Ms Curtis' death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[18]

41. The CPU identified several known risk factors for family violence in this case. Ms Curtis was suffering from a combination of mental and physical ailments against the context of substance abuse, her experience of interpersonal violence and sexual abuse, as well as having been both the victim and perpetrator of family violence throughout her life. Although Ms Curtis was receiving psychological assistance, it appears their discussions addressed her body image issues, anxiety and lack of self-worth in relation to her inability to work, rather than issues pertaining to her relationship, personal trauma or family violence. The available evidence suggests that, despite Ms Curtis having a problem with alcohol, she was resistant to treatment.

42. The evidence regarding the status of the relationship between Ms Curtis and Mr Bracken in the months before her death is unclear. While it appears that Ms Curtis was financially dependent upon Mr Bracken and continued to live with him, family members of Ms Curtis suggest the two were separated at the time, while Ms Finlow and Mr Bracken himself believed that the relationship continued.

---

[15] *Family Violence Protection Act 2008*, section 8(1)(a) identifying as a spouse or domestic partner
[16] *Family Violence Protection Act 2008*, section 5(1)(a)(i)
[17] 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
[18] 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

43. Prior to her death, the available evidence further suggests Ms Curtis perpetrated family violence upon Mr Bracken intermittently. It is unknown what caused the conflict between Ms Curtis and Mr Bracken's father, Michael, on the day of her death.

44. It is clear that an opportunity for prevention existed in this case, in that addressing the family violence occurring within Ms Curtis' and Mr Bracken's relationship, regardless of each parties' gender or role, may have prevented Ms Curtis' death. Notwithstanding the fact that Mr Bracken had limited service contact with health and specialist services, friends and colleagues were aware that Mr Bracken was experiencing family violence. Mr Bracken's interview with police following Ms Curtis' death suggests embarrassment and shame prevented him from reporting the violence to police. Similarly, he stated that he did not consider applying for a Family Violence Intervention Order for fear of not being believed and evoking further anger from Ms Curtis.

45. Family violence permeated the circumstances of Ms Curtis' life as well as her death, not only in the manner of her death and within her relationship but also in her childhood. The Royal Commission into Family Violence (**the Royal Commission**) report[19] noted, albeit in the context of women in custody which remains applicable here, that:

"*Evidence presented to the Commission suggests that family violence looms large in the childhood and early years of many of these women and might disproportionately affect them in their adult life*."[20]

46. The Royal Commission's report underscores the existence of research suggesting a strong link, more so than in the case of men, between women's violent behaviour and risk factors such as a history of physical, psychological and sexual abuse. As referred to earlier, there is evidence to suggest Ms Curtis experienced each of those forms of abuse, beginning in her childhood at the hands of her father, then progressively through her adolescent and adult relationships.

47. The information gathered by this Court suggests that since 2000, there have been 20 recorded cases of homicides committed by the victim of family violence against the historical perpetrator of family violence. Little research seems to be available in the wider community regarding intimate partner homicide involving violence by the victim. The available evidence in this case suggests that Ms Curtis suffered from sustained trauma from various periods of abuse, resulting

[19]Victoria, Royal Commission into Family Violence, *Volume V: Report and recommendations*, chapter 34 (2016)
[20] Ibid, 237

in an enduring and severe distrust of men. In Ms Curtis' case, these factors were complicated by her physical and mental health ailments.

Male victims of family violence

48. Ms Curtis' death, and deaths similar to hers, highlight both the need to make sure adequate support exists for victims of family violence of both genders, within intimate partner relationships, and exemplifies the stigma which remains associated with being a male victim. There appears to be a void in the support services available which focus on men as victims of family violence, rather than as perpetrators.

49. The Australian data referred to in the Royal Commission's report[21] reflected that men constitute approximately one quarter of victims of family violence in heterosexual intimate partner relationships. Nonetheless, the data also showed that violence by women toward men is generally less severe than that by men toward female partners.[22]

50. I take this opportunity to support the Royal Commission's conclusions and related recommendations in relation to male victims, that the family violence system needs to respond more adequately to support the needs of male victims, without diverting resources from women and children in this regard. Specifically, Recommendation 180 which states:

"*The Victorian Government publicise and promote the Victims Support Agency in any information campaign relating to family violence as the primary source of assistance for male victims. The agency should also provide appropriate online resources for male victims…*"[23]

51. Further to this, at Recommendation 181, that:

"*The Victims Support Agency continue to receive all police referrals (L17 forms) relating to male victims, including after the establishment of the Support and Safety Hubs. The agency and all other relevant support services should develop joint arrangements to ensure that male victims of family violence are supported in obtaining the help they need…*"[24]

52. A cornerstone of the new measures to assist both victims and perpetrators of family violence is the introduction of Support and Safety Hubs (**SSH**) by the Victorian Government. This Court

[21] Victoria, Royal Commission into Family Violence, *Volume V: Report and recommendations*, (2016), 205
[22] Ibid
[23] Ibid, 212
[24] Ibid

is advised that, while they will be primarily focussed on female victims, the SSHs also plan to work closely with the Victim Support Agency to assist male victims.

53. It is important that the suite of measures being proposed and implemented by the Victorian Government pursuant to the Royal Commission's findings contemplates support for victims and perpetrators, regardless of gender or situation. In expressing this view, I am mindful of the Royal Commission's recommendation 142, which states:

"The Victorian Government ensure that family violence community awareness and prevention programs use language, imagery and messaging that reflect the diversity of the Victorian community… Inclusiveness of diversity should also be an important consideration for corporate and philanthropic funder of such programs funders of such programs and activities."[25]

Third party reporting of family violence

54. 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.

55. In an effort to address the barriers third parties face in obtaining access to information about family violence and providing information and assistance to victim and perpetrators of family violence, the Royal Commission reviewed the available resources for third parties and endorsed a model set out in the combined operation of recommendations 10 and 37 of its report.

56. Recommendation 10 focussed on facilitating access to the appropriate information to identify and assist those experiencing family violence, both during crisis periods and in the longer term.[26] This Court is advised that the Victorian Government has selected "*The Lookout*"[27] 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

[25] Ibid, 83
[26] Victorian Royal Commission into Family Violence, Recommendation 10
[27] http://www.thelookout.org.au

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.[28]

57. Further, through the introduction of SSHs[29] 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;

(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.[30]

58. 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.

[28] <http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=12>
[29] Victorian Royal Commission into Family Violence, Recommendation 37
[30] Victorian Royal Commission into Family Violence, *Summary and Recommendations* (2016) 55

59. 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.

60. In Ms Curtis' case, education and information via a website such as "*The Lookout*," may have provided an initial avenue for the family members and friends to provide specialist service referrals to assist her in addressing her anger and trauma, while also encouraging Mr Bracken to seek support.

61. 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 both Ms Curtis and Mr Bracken to raise their concerns about the treatment Mr Bracken was reporting and the behaviour Ms Curtis was exhibiting in the context of each parties' unwillingness to disclose the violence and to seek specialist help themselves.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Helen Grace Curtis, born 3 November 1953;

    (b) the death occurred on 19 November 2012 on a roadway outside 44 Clive Street in West Footscray, Victoria, from gunshot injures to the head; and

    (c) the death occurred in the circumstances described above.

63. I convey my sincerest sympathy to Ms Curtis' family.

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

    (a) Joelene Unwin, senior next of kin;

    (b) Detective Senior Sergeant Stephen McIntyre and Sergeant Tamara Chippindall, Coroner's Investigators;

    (c) Peter Lauritsen, Chief Magistrate; and

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

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 14 March 2018