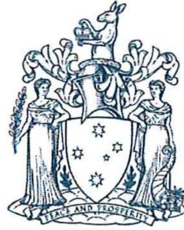

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 1790

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:	**JAMES PETER BERIAS**
Date of birth:	2 August 1980
Date of death:	6 April 2014
Cause of death:	Stab wound to the chest
Place of death:	52 Blackwood Street, Yarraville, Victoria
Catchwords	Family violence homicide; death resulted directly from injury; was unexpected, violent and not from natural causes

TABLE OF CONTENTS

Background	**1**
The purpose of a coronial investigation	**1**
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	**3**
- Medical cause of death, pursuant to section 67(1)(b) of the Act	**3**
- Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act	**4**
Comments pursuant to section 67(3) of the Act	**4**
Findings and conclusion	**10**

HER HONOUR:

BACKGROUND

1. James Peter Berias (**Mr Berias**) was a 34-year-old man, who lived with his parents at Werribee South at the time of his death.

2. In early 2014, Mr Berias had commenced a relationship with Brittney Johnston (**Ms Johnston**). During their relationship, Mr Berias remained living primarily at his parents' home in Werribee South, but regularly spent nights at Ms Johnston's home, where she lived with her two young daughters.

3. Mr Berias died on 6 April 2014, after Ms Johnston stabbed him in the chest.

4. In the months prior to Mr Berias' death, his relationship with Ms Johnston was described as turbulent and there were a number of family violence incidents. Mr Berias and Ms Johnston were reportedly both using methylamphetamine in the months prior to Mr Berias' death.

5. In March 2014, the difficulties in Mr Berias and Ms Johnston's relationship escalated. On 6 March 2014, Ms Johnston reportedly punched Mr Berias in the face. Mr Berias suffered a split lip and lost a tooth as a result of the punch. Ms Johnston cut her hand, requiring medical treatment.

6. Between 6 and 16 March 2014, Mr Berias' friend observed a laceration injury to Mr Berias' left arm. Mr Berias told his friend that he and Ms Johnston had argued and that Ms Johnston had swung a knife at him, cutting him on the arm when he raised it in self defence.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Mr Berias' 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 is inquisitorial.[2] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible,

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

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;

    (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

[3] See Preamble and s 67, *Coroners Act 2008*.
[4] *Keown v Khan* (1999) 1 VR 69.
[5] (1938) 60 CLR 336.

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 8 April 2014, Mr Berias was identified through fingerprint analysis. Also on 8 April 2014, Alex Berias identified Mr Berias' body as being that of his son, James Peter Berias, born 2 August 1980.

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 7 April 2014, Dr Noel Woodford, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Mr Berias' body and provided a written report, dated 7 July 2014. In that report, Dr Woodford concluded that a reasonable cause of death was '*stab wounds to the chest*'.

19. Dr Woodford commented that:

    (a) "*the mechanism of death is likely to have been one of significant blood loss into the pericardium, left chest cavity and the peritoneal cavity*";

    (b) "*the stab wound entered the left side of the chest and involved the left lung, diaphragm, pericardial sac and heart ...*" ;

    (c) "*the degree of force (required to inflict the stab wound) is estimated to be at least moderate on a four-point scale of mild, moderate, severe and extreme*"; and

    (d) "*there was no natural disease identified of a type likely to have caused or contributed to death*".

20. Toxicological analysis of the post mortem samples taken from Mr Berias identified the presence of methylamphetamine and amphetamine.

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

21. At some point in the afternoon or early evening of 6 April 2014, Mr Berias and Ms Johnston reportedly purchased a quantity of methylamphetamine (also known as 'ice').

22. That night, neighbours heard yelling at Ms Johnston's address.

23. At approximately 10.40pm, in the course of an argument in her home at Yarraville, Ms Johnston stabbed Mr Berias in the chest with a kitchen knife.

24. After she stabbed Mr Berias, Ms Johnston used Mr Berias' mobile telephone to call a friend, telling her friend that she had just stabbed Mr Berias and thought he was dead.

25. At approximately 10.44pm, Ms Johnston telephoned emergency services and requested an ambulance, saying that a male at her address had just stabbed himself.

26. Ambulance officers and police arrived at Ms Johnston's address at 10.58pm, where they found Ms Johnston and another woman attempting CPR on Mr Berias. Ambulance officers immediately took over resuscitation attempts, which proved unsuccessful and Mr Berias was confirmed dead at 11.45pm after resuscitation was ceased.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Criminal proceedings

27. Ms Johnston was arrested at the scene and later charged with manslaughter in relation to Mr Berias' death.

28. Ms Johnston pleaded guilty to manslaughter and, on 29 January 2015, was sentenced to eight years' imprisonment, with a non-parole period of six years.

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* (Vic), the intimate personal relationship between Mr Berias and Ms Johnston 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 Mr Berias was considered to have occurred in the context of family violence.

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

32. The CPU identified the presence of known risk factors for family violence, including substance abuse, financial difficulties and a recent separation. The available evidence suggests that Mr Berias and Ms Johnston were having difficulties in their relationship, characterised by frequent arguments and physical violence, with both parties being the perpetrator of physical violence. Much of the tension was reportedly in relation to methylamphetamine use and monetary concerns regarding a car that Mr Berias had purchased with or for Ms Johnston shortly before they separated.

33. On 30 March 2014, Mr Berias and Ms Johnston separated following a family violence incident, which police officers attended. Police issued a Family Violence Safety Notice on 31 March 2014 and an interim Family Violence Intervention Order (**FVIO**) was served on Mr Berias on 1 April 2014, five days before his death.

34. At the time of his death, Mr Berias was in breach of the interim FVIO, with Ms Johnston's consent. Friends reported that Mr Berias and Ms Johnston had spent time together in person each day from 1 to 6 April 2014. Ms Johnston reported to a friend on 5 April 2014 that Mr Berias had sent her threatening text messages in the preceding days.

Ms Johnston's mental health treatment

35. In addition, the CPU identified service contact with a General Practitioner (**GP**) in the period proximate to Mr Berias' death.

36. In February 2014, Ms Johnston, who had a long history of mental ill health, mental health treatment and polysubstance abuse, began seeking treatment for her escalating mental ill health from her GP, Dr Ciaran Laughlin (**Dr Laughlin**). She presented with paranoia and

---

[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.

panic attacks and was treated with anti-psychotic, mood stabilising medication and anxiolytics.

37. On 18 February 2014, Ms Johnston presented to Dr Laughlin following a motor vehicle collision and physical assault. Ms Johnston reported that a man at a petrol station had head-butted her in the nose. Dr Laughlin noted that Ms Johnston appeared to be in a manic state, suffering increased anxiety and agitation. Ms Johnston stated that she felt like she was going to attack someone, but denied having any issues with family or friends and did not identify an individual that she considered to be at risk of attack.

38. On 27 February 2014, Ms Johnston presented to Orygen Youth Health (**Orygen**) as paranoid. She was not considered to be under the influence of illicit substances.

39. On 4 March 2014, Dr Laughlin completed a mental health care plan for Ms Johnston, including a referral to Headspace. Dr Laughlin provided Ms Johnston with contact numbers for a crisis line and discussed her mood and the support persons and agencies available to her.

40. On 8 March 2014, Ms Johnston presented to Dr Laughlin with a large laceration to her hand, which she stated was the result of an assault. Ms Johnston did not identify that the injury was obtained in a family violence incident.

41. Dr Laughlin stated that, while she was his patient, Ms Johnston often appeared anxious and agitated, beyond a level of "*routine simple anxiety*" and that both he and Ms Johnston were motivated to engage her with a psychiatrist. However, Registered Psychologists from Headspace at Sunshine attempted to contact Ms Johnston on 12, 13 and 14 March 2014 and she failed to answer their calls or make an appointment.

42. On 17 March 2014, Ms Johnston contacted Headspace Registered Psychologist, Lara Taylor (**Ms Taylor**), and engaged in a brief telephone-based assessment. As a result of this assessment, Ms Johnston was referred to the Youth Access Team (**YAT**) through Orygen and Melbourne Health, for immediate psychiatric evaluation and follow-up. Headspace deemed Ms Johnston as inappropriate for intake, citing a lack of capacity to provide specialist mental health services, outreach or a crisis response.

43. Also on 17 March 2014, Dr Laughlin referred Ms Johnston to Orygen as he considered that she was not a good candidate for psychology, but instead required psychiatric review as soon as possible. The evidence suggests that Ms Johnston was paranoid and entertaining

thoughts of self-harm and harming others at the time. Ms Johnston was also using two-to-three grams of cannabis daily and abusing alcohol. Evidence from friends of Ms Johnston and Mr Berias indicate that Ms Johnston was also regularly using methylamphetamine at this time.

44. Orygen contacted Ms Johnston and arranged for her to attend an assessment on 20 March 2014. Ms Johnston failed to attend the assessment and a second appointment was made, for 24 March 2014. Ms Johnston also failed to attend the assessment on 24 March 2014, finally attending on 26 March 2014.

45. Ms Johnston was assessed by a YAT senior clinician, Lachlan Collins (**Mr Collins**). Ms Johnston also received continued support through the Royal Melbourne Hospital from 18 to 31 March 2014.

46. On 2 April 2014, Ms Johnston underwent further assessment at Orygen, by Senior Psychiatric Registrar, Dr Yang Yun (**Dr Yun**). Dr Yun determined, based on clinical evidence, that Ms Johnston was not suffering from a psychotic disorder, but considered her to have significant Cluster B personality traits, predominantly antisocial personality disorder and some borderline personality traits. Ms Johnston denied substance use. Ms Johnston reportedly requested a diagnosis of psychosis and became abusive when informed of referral options. She became angry and left the interview prematurely. Records indicate that Ms Johnston preferred treatment by a psychiatrist, rather than a psychologist.

47. Orygen conducted a detailed assessment, taking into account its previous assessments of Ms Johnston. No active signs of psychosis were identified, although a history of general paranoid ideas and non-specific auditory hallucinations (as reported by Headspace), which could be consistent with Ms Johnston's regular methylamphetamine use and a Cluster B personality disorder. Ms Johnston was considered to be functioning in the community, able to coordinate a move to safe accommodation (after her previous accommodation was destroyed in a fire), her mental state was in keeping with previous assessments and no specific risks to Ms Johnston or others were identified. Although Ms Johnston made comments to YAT workers over the telephone that she may 'snap' and hurt someone, at the in-person assessments she denied being a risk to others. There was no mention of Mr Berias in Orygen's file on Ms Johnston.

48. Ms Johnston's medical records indicated an intention to contact Ms Johnston after the YAT clinical review meeting on 4 April 2014. There was no evidence that this was done on Friday, 5 April 2014, and Mr Berias died the following day. Given Ms Johnston's dissatisfaction with Orygen's proposed treatment plan and her failure to immediately engage in telephone contact with the service on prior occasions and recent failures to show at in-person appointments, I am satisfied that Orygen's failure to contact Ms Johnston on 5 April 2014 did not cause or contribute to Mr Berias' death in any way.

49. Dr Laughlin reported that, following his last appointment with Ms Johnston on Friday, 5 April 2014, he intended to contact Orygen Psychiatry on the next Monday morning to discuss Ms Johnston's angry and anxious presentation to him on 5 April 2014 and her unhappiness at the treatment plan being for psychological, rather than psychiatric services.

Treatment for substance abuse

50. The CPU identified research that suggested that mental health and substance use disorders account for more than half of the burden of disease for 15 to 25 year olds.[9] Substance use is commonly recognised in borderline personality disorders (**BPD**), where it is associated with increased psychosocial impairment, psychopathology, self-harm and suicidal behaviour.

51. Ms Johnston, who had a history of substance abuse which began when she was 12 years old, denied substance abuse to her treating medical and mental health professionals, beyond minimal but regular marijuana and alcohol consumption. She stated that she had not used methylamphetamine since prior to her last pregnancy. However, Orygen clinicians identified that Ms Johnston exhibited symptoms that were possibly indicative of regular methylamphetamine use. Orygen records for Ms Johnston from April 2008 reflected that they were aware of polysubstance abuse and dependence at that time.

52. Ms Johnston's assessment with Headspace indicated that Dr Laughlin had reported that Ms Johnston "*looks like she is on ice*".

53. Despite this report and her long history of previous substance abuse, there were no current substance use issues identified in Ms Johnston's referrals to Headspace and Orygen and it appears that no substance use support and/or treatment was provided to her. The CPU identified that, although Ms Johnston's treating clinicians were appropriately suspicious about substance use, their primary focus was on her escalating mental health issues.

---

[9] McGorry, P. and Goldstone, S. (2011) "Is this normal? Accessing mental health in young people" *Australian Family Physician* 40(3), 94.

54. The CPU advised that:

(a) many individuals who are willing to engage in treatment for mental health concerns are unwilling to disclose substance use;

(b) unwillingness to disclose substance use can be attributed to a variety of factors including shame, concern regarding potential criminal charges or child protection issues, concern that disclosure may influence prescribing decisions (i.e. anxiolytics or opioids) or a general disinclination to address substance use;

(c) community-based health professionals have to rely on client self-report and clinical observation to identify substance use issues. If client self-report and clinical observation are inconsistent, clinicians can try to address that throughout the treatment episode;

(d) clinical observation is not necessarily a reliable indicator of substance use because symptoms of substance use can mimic other mental health symptoms or be caused by physical health issues; and

(e) Ms Johnston was aware that her substance use was problematic, contributed to violent behaviour and posed a risk to others. However, it appears that she was not yet ready to disclose it or engage in treatment.

55. Although the treatment providers adequately screened for substance use issues by asking about current substance use, Ms Johnston's consistent denial meant that they were unable to engage her in a relevant treatment or support plan.

56. The CPU further advised that the relevant clinicians work within the Victorian Department of Health and Human Services-funded 'Victorian Dual Diagnosis Initiative' (**VDDI**). The VDDI is a cross-sector (alcohol and drug, mental health community support and clinical mental health) initiative which contributes to the further development of mental health and drug and alcohol clinicians', agencies' and the sector's capacity to recognise and respond effectively to people with co-occurring mental health and substance use concerns (dual diagnosis).

Public health and safety

57. The CPU identified that there was a current family violence context, specifically emotional and physical abuse, with both parties being the perpetrator at various times. Ms Johnston

also had a significant family violence history, as both victim and perpetrator. The available evidence indicates that Mr Berias and Ms Johnston were experiencing problems in their relationship that were, in some cases, made evident in front of friends.

58. The VSRFVD noted that Mr Berias' death occurred in circumstances whereby friends and family identified having witnessed or been aware of family violence. Previously, Coroners have made comments and recommendations in relation to the under-reporting of family violence out of a perception that outside involvement may exacerbate a situation which the victim appears to be managing. In this case, friends and family may not have perceived Ms Johnston to pose a real risk to Mr Berias' safety, due to his physical size.

59. In the Finding into the death of Nicole Joy Millar,[10] the then State Coroner, Judge Ian Gray,[11] recommended that Victoria Police, together with Crime Stoppers, conduct a trial extending the '*Say Something*' campaign to family violence. I have noted in recent findings into deaths that occurred as a result of family violence,[12] that in its response to Judge Gray's recommendation, Crime Stoppers, which is a not-for-profit that relies substantially on government crime prevention grants for project and campaign delivery costs, highlighted budgetary constraints as a barrier to implementing this action. Crime Stoppers recently advised the Court that it has been unsuccessful in securing the required funding.

60. 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 Mr Berias' death.

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

FINDINGS AND CONCLUSION

62. 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 James Peter Berias, born 2 August 1980;

    (b) the death occurred on 6 April 2014, at 52 Blackwood Street, Yarraville, Victoria, from a stab wound to the chest; and

[10] COR 2010 2064.
[11] Judge Ian Gray retired as the State Coroner in December 2015.
[12] Investigations into the deaths of Stuart Rattle (COR 2013 5647) and Drew Dax (COR 2015 0188).

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

63. I convey my sincerest sympathy to Mr Berias' family and friends.

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

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

(a) Alec and Kathleen Berias, senior next of kin.

(b) Detective Leading Senior Constable Leigh Smyth, Victoria Police, Coroner's Investigator.

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

(d) Orygen Youth Health

(e) Headspace

(f) Dr Ciaran Laughlin, Westgate Medical Centre

Signature:

JUDGE SARA HINCHEY
STATE CORONER

DATE: 17 FEBRUARY 2017