IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 2490

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**LEIGH JOSEPH RILEY**
Delivered on:	31 August 2016
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing date:	31 August 2016
Counsel assisting the Coroner:	Jodie Burns, Senior Legal Counsel, Coroners Court of Victoria
Representation:	Nil
Catchwords:	Homicide; no person charged with indictable offence; mandatory inquest

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HER HONOUR:

BACKGROUND

1. Leigh Joseph Riley was a 30-year-old man who lived in a boarding/rooming house at Glenroy, Victoria, at the time of his death.

2. Mr Riley was the father of two boys. Mr Riley did not have an ongoing relationship with his sons, who live in Sydney in the care of the Department of Human Services due to child protection concerns.

3. Mr Riley had a low IQ and had been diagnosed with an intellectual disability when he was a teenager. He also had a history of illicit substance and alcohol abuse. Mr Riley was reportedly verbally and occasionally physically abusive, when intoxicated.

4. Mr Riley had lived in Sydney for almost ten years, until a year or so prior to his death. On returning to live in Melbourne in 2014, Mr Riley re-commenced using illicit substances. Some months later, he moved into boarding/rooming house accommodation in Glenroy, which had been arranged for him by the Salvation Army.

5. Mr Riley was reportedly unhappy about some of the men who were sharing the house, although the reasons for his feelings about the men are unclear. He was actively seeking alternative accommodation at the time of his death.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Mr Riley's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria, and was unexpected, violent and as a result of an injury.[1]

7. 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, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

[1] Section 4 *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*
[3] See Preamble and s 67, *Coroners Act 2008*.

8. 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.

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

10. 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 to be considered relevant to the death.

11. 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.

12. 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.

13. 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.

14. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death

[4] *Keown v Khan* (1999) 1 VR 69.
[5] (1938) 60 CLR 336.

was as a result of homicide, or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

15. While Mr Riley's identity was not in dispute and he was not a person placed in "*custody or care*" as defined by section 3 of the Act, his death is considered to be a homicide. The Act provides that an inquest must be conducted into the circumstances of all deaths suspected to be a homicide, if no person has been charged with an indictable offence in respect of the death.

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 21 May 2015, Mr Riley was visually identified by his mother, Karen Riley, as being Leigh Joseph Riley, born 31 August 1984.

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 25 May 2015, Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy on Mr Riley's body and provided a written report, dated 3 August 2015. In that report, Dr Burke concluded that a reasonable cause of death was '*Head injury*'. Dr Burke commented:

> *"The post-mortem examination confirmed a severe brain injury. There was a fracture to the occiput (back of head) which would be consistent with a fall onto the back of the head. Mr Riley had a sutured injury to his nose in keeping with the history of the physical altercation.*
>
> *The biochemistry result from the Royal Melbourne Hospital showed a blood-alcohol level of 0.25g/dL."*

19. On 2 June 2015, Dr Linda Iles, a Forensic Neuropathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination on Mr Riley's brain and provided a written report, dated 17 July 2015. In that report, Dr Iles made the following neuropathological findings:

    (a) *Global cerebral ischaemic injury.*

    (b) *Left cerebellar haemorrhagic cavity and adjacent subarachnoid haemorrhage.*

(c) *Posterior fossa duroplasty.*

(d) *Diffuse brainstem swelling and compression.*

(e) *Bilateral inferior frontal and lateral left temporal burst lobes.*

(f) *Anterior temporal contusions.*

(g) *Frontal parasagittal white matter gliding contusions.*

20. Toxicological analysis of the post mortem samples taken from Mr Riley was consistent with the medical intervention.

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

21. Shortly before 11.40pm on Saturday, 16 May 2015, Mr Riley got into an altercation with an associate, Ronald Macrae, at their shared address at 23 Glen Street, Glenroy. Mr Macrae and Mr Riley had been friends for approximately 20 years. Mr Riley had arranged for Mr Macrae to move into the bungalow behind the boarding house.

22. Mr Riley and Mr Macrae had been drinking in the backyard of the boarding house since approximately 3.00 or 4.00pm on 16 May 2015. During the night, Mr Riley and Mr Macrae got into an argument about Mr Riley's friend. Mr Macrae reportedly attempted to calm Mr Riley down and encouraged him to go to bed. However, sometime after 11.00pm, the argument escalated and became physical.

23. Sharron Moore, a friend of Mr Macrae's who was staying with him in the bungalow, overheard the physical altercation over a period of approximately 10-15 minutes.

24. During the altercation, both Mr Riley and Mr Macrae hit, punched and pushed each other before Mr Macrae punched Mr Riley in the face. The force of the blow caused Mr Riley to fall backwards and hit his head on the concrete path. Mr Riley immediately lost consciousness.

25. Ms Moore, who had overheard the altercation, heard Mr Macrae say "*stop it*" twice and then heard a 'pop' sound, followed by silence. She went outside the bungalow and saw Mr Riley lying on the ground. Ms Moore told Mr Macrae to telephone for an ambulance, but did so herself after he refused to.

26. Ambulance Victoria paramedics attended and transported Mr Riley to the Royal Melbourne Hospital, where he was diagnosed with an un-survivable head injury. Mr Riley also developed hospital acquired pneumonia.

27. Mr Riley died on 23 May 2015 after his life support was removed. Mr Riley's family agreed to donate Mr Riley's organs after his death and this was facilitated.

28. Victoria Police investigated Mr Macrae's role in the circumstances surrounding Mr Riley's death. In the result, Mr Macrae was not charged with an offence in relation to Mr Riley's death because police were unable to establish to the requisite standard whether Mr Macrae was acting in self-defence when he struck Mr Riley.

FINDINGS AND CONCLUSION

29. Having investigated the death of Mr Riley and having held an inquest in relation to his death on 31 August 2016 at Melbourne, I make the following findings pursuant to section 67(1) *Coroners Act 2008*:

    (a) the identity of the deceased was Leigh Joseph Riley, born 31 August 1984; and

    (b) the death occurred on 23 May 2015, at the Royal Melbourne Hospital from head injuries,

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

30. I convey my sincerest sympathy to Mr Riley's family and friends.

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

    (a) Detective Senior Constable Shaun Roberts, Victoria Police, Coroner's Investigator.

    (b) Inspector Michael Hughes, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 31 August 2016