IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 2518

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:	**SALLY BROOKS**
Date of birth:	2 March 1963
Date of death:	11 July 2011
Cause of death:	Head injuries
Place of death:	Royal Melbourne Hospital, Parkville, Victoria

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HER HONOUR:

BACKGROUND

1. Sally Brooks was a 48-year-old woman, who lived at Donvale, Victoria, at the time of her death.

2. Ms Brooks, who was born in the United Kingdom, migrated to Australia in 1995. On 9 January 1999, Ms Brooks married Robert Meade.

3. Ms Brooks was a much-loved and loving mother of three young children, Elizabeth, Archie and Charlotte. She enjoyed a close and loving relationship with her twin sister, Alison, brother, David, and parents, Audrey and Charles (who reside in the UK).

4. Ms Brooks was estranged from Mr Meade at the time of her death. Their relationship was, from at least 2003, characterised by family violence. Ms Brooks and Mr Meade separated in January 2009. In June 2009, they obtained final property and custody orders in the Family Court of Australia, with the children living with Ms Brooks and spending time with Mr Meade, on average, every three weeks. Ms Brooks and Mr Meade's divorce was finalised in late 2009. Mr Meade continued spending time with the children until February 2011, when he relocated to Adelaide with his third wife and her child, for a new job.

5. During their relationship and after separation, Ms Brooks told friends and family that Mr Meade was volatile, argumentative and unpleasant. He was reportedly verbally abusive, sexually coercive, manipulative and financially and personally controlling. Ms Brooks identified that she felt "*terrified*" of him at times.

6. Following their divorce, Mr Meade was inconsistent with or failed to pay Child Support to Ms Brooks. He falsely reported to Ms Brooks that he was unemployed. Due to financial constraints, Ms Brooks decided to return to live in the UK with the children.

7. In October 2010, Ms Brooks requested Mr Meade's approval to relocate the children to the UK. Mr Meade refused and, in January 2011, Ms Brooks and Mr Meade attended the Family Relationships Centre at Ringwood, Victoria, to try to resolve the issue. The mediation was unsuccessful.

8. In February 2011, Ms Brooks commenced proceedings in the Federal Magistrates Court to enable her to relocate the children to the UK. On 28 March 2011, Mr Meade consented via email to Ms Brooks relocating the children to the UK. On 5 April 2011, the Federal

Magistrates Court ordered that Ms Brooks could relocate the children to the UK "as soon as practicable". Ms Brooks made arrangements to leave Australia with the children on 11 July 2011.

9. During May 2011, Ms Brooks and Mr Meade communicated via email about financial matters, specifically Mr Meade's failure to pay Child Support to Ms Brooks. The tone of the emails was 'terse' and Ms Brooks eventually indicated that she would institute proceedings to require payment if necessary. Despite Mr Meade's claims that he was unemployed at the time, in June 2011, Ms Brooks discovered that Mr Meade was employed and receiving a salary from Uranium Equities Limited.

10. On 8 June 2011, Mr Meade failed to attend work. Instead, he travelled to Victoria. While in Victoria, Mr Meade sent Ms Brooks a text message, requesting further details about her relocation plans. Mr Meade told Ms Brooks that he was in Jamieson, New South Wales, however telephone records showed that he was in the Donvale area.

11. Between 10 and 16 June 2011, Mr Meade and Ms Brooks exchanged further emails about Child Support payments and the requirement for Mr Meade to provide a letter to the British High Commission, consenting to the children relocating there.

12. On 14 June 2011, Mr Meade had a conversation with a colleague about Ms Brooks' relocation with the children. Mr Meade indicated that he was upset about the relocation and was unable to do anything about it. Mr Meade asked his colleague to let him know if he '*had any contacts who could assist with the predicament*', stating in a '*half-joking*' manner that '*a couple of .22's and a baseball bat could solve the problem*'. The colleague considered Mr Meade's comments to be sinister in nature. He told Mr Meade that he knew a lawyer and a police officer and offered that there were alternative options available to him.

13. From 17-19 June 2011, Mr Meade spent time with his children at his mother's home in Vermont.

14. On 25 June 2011, Ms Brooks emailed Mr Meade, telling him that he could visit the children from 4-6 July 2011, before they relocated to the UK. Ms Brooks stated that their departure date was 8 July 2011, intentionally misleading him to their departure date because she was '*concerned about what he might do*'. Ms Brooks told her sister that she was concerned that Mr Meade may harm the children, referring to the death of Darcey Freeman and stating that she associated the father's actions as something that Mr Meade could be capable of.

THE PURPOSE OF A CORONIAL INVESTIGATION

15. Ms Brooks' death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**The Act**), as the death occurred in Victoria, and was both unexpected and as a result of an injury.[1]

16. 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]

17. 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.

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

19. 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.

20. 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.

21. 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

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[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.

(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.

22. 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.

23. 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

24. On 11 July 2011, Ms Brooks was visually identified by her sister, Alison Brooks, as being Sally Brooks, born 2 March 1963.

25. Identity is not in dispute and requires no further investigation.

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

26. On 13 July 2011, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy on Ms Brooks' body and provided a written report, dated 13 December 2011. In that report, Dr Lynch concluded that a reasonable cause of death was '*Head injuries*'. Dr Lynch commented that no significant natural disease was noted at autopsy.

27. On 29 July 2011, Dr Linda Iles, a Forensic Pathologist with a specialisation in forensic neuropathology practising at the Victorian Institute of Forensic Medicine, examined Ms Brooks' brain. Dr Iles provided a report dated 27 September 2011, in which she confirmed that Ms Brooks suffered a blunt head injury and identified the extensive injuries, comprising cortical contusion and lacerations with contusional injury, subarachnoid haemorrhage, ischaemic brain injury and mixed traumatic and ischaemic axonal injury.

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[5] (1938) 60 CLR 336.

28. Toxicological analysis of the pre and post mortem samples taken from Ms Brooks were consistent with the hospital medical intervention and treatment.

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

29. On the morning of 1 July 2011, Ms Brooks dropped the children at school and then delivered her car to the Doncaster East Car Repairs to obtain a Roadworthy Certificate. Ms Brooks informed the mechanic that she needed the car to be ready before 2.30pm that day so that she could collect her children from school. She then left the garage, at 8.50am, and was seen walking toward her home at Limassol Court.

30. Ms Brooks is believed to have arrived home and entered the house via the laundry at approximately 9.00am.

31. At 12.34 and 1.48pm, Doncaster East Car Repairs unsuccessfully attempted to contact Ms Brooks by telephone. Ms Brooks did not collect her car by 2.00pm, as arranged.

32. At 2.30pm, Ms Brooks failed to collect the children from school. Between 2.55pm and 4.00pm, the children's school unsuccessfully attempted to contact Ms Brooks by telephone.

33. At approximately 4.00pm, the children's school contacted the children's emergency contact, their neighbour, Alan Smith. Mr Smith, considering the situation to be unusual, drove to Ms Brooks' home before attending the school.

34. Mr Smith entered the house via a rear door and located Ms Brooks, unconscious, on the laundry floor. Ms Brooks had an obvious head injury and there was significant blood splatter in the laundry. Mr Smith telephoned for an ambulance and remained with Ms Brooks until the ambulance arrived.

35. Ms Brooks was transported to the Royal Melbourne Hospital, where she was placed on life support and underwent neurosurgical intervention. Despite the intervention, Ms Brooks' condition failed to improve and she died after life support was removed on 11 July 2011.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Criminal proceedings

36. Following several months of covert surveillance, on 13 September 2011, Mr Meade was arrested and charged with murder in relation to Ms Brooks' death. On 11 December 2013,

Mr Meade was convicted and sentenced to 23 years' imprisonment, with a 19-year non-parole period.

37. The Director of Public Prosecutions appealed the sentence on the grounds of manifest inadequacy. Mr Meade also appealed the conviction, on the basis that it was unsafe and unsatisfactory. On 26 June 2015, both appeals were dismissed.

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

Family violence

39. I requested that the Coroners Prevention Unit (**CPU**)[6] examine the circumstances of Ms Brooks' death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[7]

40. The CPU identified the presence of risk factors known to increase the likelihood and severity of family violence, including a history of controlling behaviour and current Family Law proceedings. Child custody disputes can be a trigger for family violence and women report experiencing violence in the context of implementing parenting arrangements or decision-making regarding children.[8]

41. In addition, the CPU identified service contact with a Family Relationship Centre and private psychologist proximate to the death.

42. In her mediation attempts through the Family Relationship Centre at Ringwood, Ms Brooks was asked whether she was experiencing family violence. Ms Brooks responded that she was not, but had suffered '*verbal abuse (and) the kids are scared at times*'. Ms Brooks did not self-identify her experience as one of family violence.

43. The mediator noted that Ms Brooks appeared intimidated by Mr Meade throughout the mediation session and upset at the end of the session. The counsellor spoke with Ms Brooks

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[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] Bagshaw, D., et al (2011) '*The effects of family violence on post-separation parenting arrangements: The experiences and views of children and adults from families who separated post-1995 and post-2006*', Family Matters, 86, 49-61.

to ensure she had support in place. Having failed to identify a family violence setting, no referrals were made in relation to family violence support.

44. The CPU identified research indicating that child custody mediation practitioners should screen for coercive and controlling behaviour, as it may go undetected when practitioners simply enquire about family violence and there has, historically, been no physical abuse in the relationship.[9]

45. From 17 December 2010 until 4 March 2011, Ms Brooks saw a psychologist, Mr Constantino Economou, in relation to her difficulty negotiating custody arrangements with Mr Meade and her concerns for the children, who appeared fearful of their father. After their first session together, Mr Economou suggested that Ms Brooks take some precautions, such as changing the locks on the house and not meeting with Mr Meade alone.

46. In January 2011, Ms Brooks reported to Mr Economou that she was coping well and not having any issues with Mr Meade. However, in an email to her solicitor and Mr Economou on 9 January 2011, Ms Brooks sought reassurance from Mr Economou that Mr Meade would not hurt the children. Ms Brooks' primary safety concern was that Mr Meade may harm the children.

47. In February 2011, Ms Brooks reported to Mr Economou that she was considering counselling for the children due to Mr Meade's ongoing negative and derogatory remarks in front of them.

48. On 4 March 2011, Ms Brooks attended her last appointment with Mr Economou and reported feeling happier and coping well. Mr Economou discussed the option of Ms Brooks seeking a Family Violence Intervention Order if Mr Meade attended the family home. There is no evidence that Ms Brooks pursued this option and there was no further contact between Ms Brooks and Mr Economou.

49. While Ms Brooks' did not pursue a Family Violence Intervention Order, there is no evidence to suggest that doing so would have changed the outcome. Mr Meade lived interstate, they only communicated via email and text message and Ms Brooks appeared willing to commence court proceedings to enforce Mr Meade's compliance with Family Court orders and Child Support payments. Mr Meade appeared compliant with Ms Brooks'

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[9] Beck, C.J.A. and Raghaven, C. (2010) '*Intimate Partner Abuse Screening in Custody Mediation: The Importance of Assessing Coercive Control*', Family Court Review, Vol. 48(3), 555-556.

wishes that he not attend the home, spending time with the children at his mother's house when contact was arranged.

50. On the information available to professionals interacting with Ms Brooks prior to her death, there was arguably no way to predict the extreme threat that Mr Meade posed to her. Mr Meade did not have a history of physical violence, threatening or stalking behaviour toward Ms Brooks. He had no apparent substance use or mental health issues and had re-married and relocated interstate, appearing to have moved on with his life. However, the CPU identified that Ms Brooks' own perception that Mr Meade may be capable of harming their children to spite her can be, according to the Australian Psychological Society, "*the best indicator of the dangerousness of (a) violent partner, regardless of any informal or professional risk assessment*".[10]

51. This case is a clear example of how more subtle forms of family violence can be challenging to identify and respond to and may give no clear indication of the true level of risk to the victim. Since the death of Ms Brooks in 2011, reforms have occurred to the Family Law system and Victoria has conducted a Royal Commission into Family Violence. Greater awareness is developing of family violence characterised by subtle coercive and controlling behaviour rather than overt physical violence.

52. Improved awareness among service providers such as Family Relationship Centres, psychologists and family law professionals of the risk to victims of less overt family violence may go some way to identifying the risks to persons such as Ms Brooks and creating opportunities for safety planning.

53. Psychologists have an important role in identifying and responding to family violence and I am satisfied that Mr Economou turned his mind to this issue and advised Ms Brooks appropriately.

54. The need for psychologists to have appropriate knowledge and expertise in family violence was identified by the Royal Commission into Family Violence, where it was recommended that the Chief Psychiatrist, in consultation with psychologists' peak bodies, coordinate the development of a family violence learning agenda for all psychologists. I agree with this recommendation and encourage the learning agenda to include issues specific to child custody disputes.

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[10] Australian Psychological Society, Submission to the Victorian Royal Commission into Family Violence, p.7. Found at: http://www.psychology.org.au/Assets/Files/2015-APS-Submission-Victorian-Royal -Commission-Family-Violence-June.pdf

FINDINGS AND CONCLUSION

55. 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 Sally Brooks, born 2 March 1963; and

    (b) the death occurred on 11 July 2011, at the Royal Melbourne Hospital, Parkville, Victoria, from head injuries sustained on 1 July 2011; and

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

56. I convey my sincerest sympathy to Ms Brooks' family and friends.

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

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

    (a) Audrey Brooks, senior next of kin.

    (b) Detective Leading Senior Constable Kyle Simpson, Victoria Police, Coroner's Investigator.

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

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 13-SEPTEMBER-2016