IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2003 2370

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:	**WILLIAM AUBREY THOMPSON**
Delivered on:	29 June 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	29 June 2017
Counsel assisting the Coroner:	Leading Senior Constable, Kelly Ramsey, Police Coronial Support Unit
Representation:	Nil
Catchwords:	Homicide, no person charged with indictable offence in respect of a reportable death, mandatory inquest

TABLE OF CONTENTS

HER HONOUR:

BACKGROUND

1. William Aubrey Thompson (**Mr Thompson**) was a 39-year-old man who resided at Port Melbourne with a friend at the time of his death.

2. Mr Thompson was in an eight-year relationship with Mary Dimitriou and they had planned to marry.

3. Mr Thompson was trained in martial arts. At the time of his death, he was training in Brazilian Jiu-Jitsu, at a gym called '*Extreme Jiu Jitsu and Grappling*' (**Extreme Jiu Jitsu**) at Suite 3, 660 Warrigal Road, Chadstone. He was a regular at Extreme Jiu Jitsu, usually attending on Mondays, Wednesdays and Fridays.

4. Mr Thompson did not appear to have full-time employment, but was registered as the owner of a business called '*A2Z Amusements Pty Ltd*', which was a vending business with machines in nightclubs. Mr Thompson had previously worked in the nightclub industry as a bouncer, but was not a licensed crowd controller.

5. At the time of his death, Mr Thompson was being investigated in relation to drug offences by police in another jurisdiction.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Mr Thompson's 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.[1]

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

---

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

8. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] 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 phrase "*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 and causally 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 Court's "*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*.[4] 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.

---

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

VICTORIA POLICE HOMICIDE INVESTIGATION

14. Immediately after Mr Thompson's death, Victoria Police commenced a criminal investigation because the death was considered to be a homicide.

15. Mr Thompson's death was initially investigated by the Homicide Squad and then transferred to the Purana Task Force. Despite this investigation, no person or persons have been charged with indictable offences in connection with Mr Thompson's death.

16. I note the observations of the Victorian Court of Appeal in *Priest v West*,[5] where it was stated:

> *"If, in the course of the investigation of a death it appears that a person may have caused the death, then the Coroner must undertake such investigations as may lead to the identification of that person. Otherwise, the required investigation into the cause of the death and the circumstances in which it occurred will be incomplete; and the obligation to find, if possible, that cause and those circumstances will not have been discharged."*

17. Consistent with this judgment, and mindful that the Act mandates that I must conduct an inquest, one of the purposes of the inquest is to investigate any evidence that may lead to the identification of the person (or persons) who may have caused the death, bearing in mind that I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.[6]

18. Section 7 of the Act specifically states that a coroner should avoid unnecessary duplication of inquiries and investigations, by liaising with other investigative authorities, official bodies or statutory officers. The rationale behind this provision is to allow for consideration of public interest principles that weigh against the potential benefits of any further investigation, such as further cost to the community. It also acknowledges that although a number of authorities or organisations may have the mandate to investigate, some are more appropriately placed than others to do so in any given circumstance.

19. In this case, I acknowledge that the Victoria Police through the Purana Task Force, has conducted an extremely thorough investigation in this matter.

20. In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Thompson's death is an unsolved and open homicide case.

---

[5] (2012) VSCA 327
[6] *Perre v Chivell* (2000) 77 SASR 282

21. The Coroner's Investigator, Detective Sergeant Sara Morse, has provided a statement to the Court in relation to this matter.

22. The confidential nature of the Victoria Police's ongoing investigation prevents me from reciting each and every matter which has been established by the Purana Task Force. However, Detective Sergeant Sara Morse's statement indicates that the following important matters have been established and are able to be disclosed:

    (a) Victoria Police intelligence is that Mr Thompson was involved in the drug trafficking and manufacturing trade;

    (b) an examination of the scene revealed that a shotgun and a .45 calibre firearm were used;

    (c) the location of fired round cases at the scene, damage to the windows in Waverley Road, the position of Mr Thompson and his wounds are all consistent with one offender standing on the roadway and one offender standing on the footpath and both shooting at Mr Thompson, who was seated in his vehicle;

    (d) despite the extensive homicide investigation conducted by the Purana Task Force, the person or persons responsible for Mr Thompson's death have not been formally identified;

    (e) no person or persons has ever been charged with an indictable offence in relation to Mr Thompson's death; and

    (f) the homicide investigation into Mr Thompson's death is ongoing and the Purana Task Force file remains open.

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

23. On 23 July 2003, Mary Dimitriou identified the body of Mr Thompson, to be that of her partner, William Aubrey Thompson, born 16 December 1963.

24. Mr Thompson's identity was also confirmed through fingerprint comparison.

25. 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

26. On 22 July 2003, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Thompson's body. Dr Lynch provided a written report, dated 23 September 2003, which concluded that Mr Thompson died from gunshot injuries to the head and chest.

27. Dr Lynch commented that Mr Thompson:

    (a) had received seven gunshot injuries; and

    (b) had co-existent natural disease in the form of 60% occlusion to the left anterior descending coronary artery, which was unrelated to his death.

28. Toxicological analysis of post mortem specimens taken from Mr Thompson was negative for drugs and alcohol.

29. I accept the cause of death proposed by Dr Lynch.

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

30. On 21 July 2003, Mr Thompson arrived at Extreme Jiu Jitsu at approximately 6.00pm. He remained there until the end of the last class at approximately 8.30pm.

31. The only other people remaining at Extreme Jiu Jitsu at that time were the owner and head instructor and another student.

32. At approximately 9.15pm, the owner, other student and Mr Thompson all left Extreme Jiu Jitsu and began walking to their respective vehicles. Their vehicles were all parked on the southern side of Waverley Road, opposite the Red Rooster store.

33. Upon reaching his vehicle, Mr Thompson placed his gym gear in the boot of the vehicle and then got into the driver's seat.

34. As the other student unlocked the driver's door of his own vehicle, he saw a dark Ford sedan (**the Ford sedan**) pull up at a right angle to Mr Thompson's vehicle, across the west-bound traffic lanes of Waverley Road. The Ford sedan had travelled across Waverley Road from the Red Rooster car park.

35. Two males alighted from the Ford sedan and shot Mr Thompson. One of the offenders stood at the driver's side door of Mr Thompson's vehicle and shot him with a shotgun. The other offender stood on the footpath and fired a handgun into the passenger side of Mr Thompson's vehicle. Both offenders then got back into the Ford sedan and drove away along Waverley Road.

36. Emergency services were called to attend the scene and paramedics pronounced Mr Thompson deceased.

37. At approximately 10.25pm, the Metropolitan Fire Brigade was called to attend the scene of a car fire in Port Melbourne. The car was a stolen 1996 maroon coloured Ford sedan, which was believed to be the Ford sedan.

FINDINGS AND CONCLUSION

38. Having investigated the death of Mr Thompson and having held an Inquest in relation to his death on 29 June 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was William Aubrey Thompson, born 16 December 1963;

    (b) Mr Thompson died on 21 July 2003 outside 744 Waverley Road, Chadstone, Victoria, from gunshot injuries to the head and chest; and

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

39. Despite an extensive criminal investigation conducted by Victoria Police, no person or persons have been identified, to date, as being responsible for causing Mr Thompson's death. On that basis, I am satisfied that no investigation which I am empowered to undertake, would be likely to result in the identification of the person or persons who caused Mr Thompson's death.

40. I convey my sincerest sympathy to Mr Thompson's family and friends.

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

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

    (a) Mary Dimitriou, senior next of kin;

(b) Detective Senior Constable Vincent Schalken, Coroner's Investigator, Victoria Police;

(c) Detective Senior Sergeant Michael J Dwyer, Officer in Charge of the Purana Task Force, Victoria Police;

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

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 29 June 2017