IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 4738

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**IAIN WEST, ACTING STATE CORONER**
Deceased:	**BELLA JAYDE LAWRENCE**
Date of birth:	25 March 2012
Date of death:	17 September 2015
Cause of death:	I(a) Complications of blunt force trauma to the abdomen
Place of death:	Wimmera Base Hospital, 83 Baillie St, Horsham, VIC 3400

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HIS HONOUR:

BACKGROUND

1. Bella Jayde Lawrence (**Bella**) was three years old at the time of her death. Bella was the second of three children born to Angie Roberts (**Ms Roberts**). Her biological father was Jonathan Lawrence who also fathered Bella's older brother. Bella's younger, half-brother was born to Ms Roberts and Harley Woodford (**Mr Woodford**) in January 2015.

2. Mr Woodford was born in Geelong on 21 November 1994. Mr Woodford grew up in western Victoria having completed Year Nine and working in semi-skilled roles.

3. Ms Roberts and Mr Woodford had met through social media in approximately August 2013 and formed a relationship. A few months later, Mr Woodford moved in with Ms Roberts and her two children, Bella and Bella's older brother at their residence in Ararat.[1]

4. In approximately 2014, Ms Roberts and Mr Woodford moved to Horsham and Mr Woodford was employed with a disability aid equipment repair company in the Horsham area.

5. Mr Woodford was reported to be *"old fashioned"* in his thoughts about child rearing and believed that *"kids should be seen and not heard"*.[2] He responded aggressively if he perceived others to disobey his rules in the household and was a regular cannabis user, smoking cannabis during evenings in a shed behind the residence. Ms Roberts noted that Mr Woodford had a short temper if he had not used cannabis to relax.[3]

6. In the months prior to her death, Ms Roberts noticed that Bella had several bruises across her body and that family members noticed that her behaviour had changed.[4]

7. In July 2015, Mr Woodford had a car accident while Bella and her younger brother were in the car. Following this incident, Ms Roberts observed Bella complaining of a sore stomach and acting *"a bit different"*. Ms Roberts also noted that Bella's appetite had significantly declined in the two weeks prior to the fatal incident.

8. In a further incident a fortnight before Bella's death, Bella allegedly had an accident and landed on a coffee table in the family home. Ms Roberts reported that she had a large bruise

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[1] *Coronial Brief*, Statement of Ms Angie Roberts dated 22 September 2015, 50
[2] *Coronial Brief*, Statement of Ms Angie Roberts dated 5 April 2016, 59
[3] *Coronial Brief*, Statement of Ms Angie Roberts dated 5 April 2016, 59
[4] *Coronial Brief*, Statement of Ms Angie Roberts dated 22 September 2015, 52; *Coronial Brief*, Statement of Linda Pilgrim dated 29 September 2015, 97

on her back as a result of this injury and she wanted to take Bella to see a doctor but Mr Woodford advised against this.[5]

9. On approximately 6 September 2015, Bella was reported to have fallen from a chair and hit the back of her head and *"it formed an egg"* in the affected area. Ms Roberts noticed the injury on her head when brushing Bella's hair.[6]

THE PURPOSE OF A CORONIAL INVESTIGATION

10. Bella'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.[7]

11. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[8] 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 the death occurred.[9]

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[10] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[11] or to determine disciplinary matters.

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

14. For coronial purposes, the phrase "*circumstances in which death occurred,*"[12] 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.

15. 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

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[5] *Coronial Brief*, Statement of Ms Angie Roberts dated 22 September 2015, 53
[6] *Coronial Brief*, Statement of Ms Angie Roberts dated 22 September 2015, 52
[7] Section 4 *Coroners Act 2008*
[8] Section 89(4) *Coroners Act 2008*
[9] See Preamble and s 67, *Coroners Act 2008*
[10] *Keown v Khan* (1999) 1 VR 69
[11] Section 69 (1)
[12] Section 67(1)(c)

the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

16. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[13]

    (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;[14] 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.[15] These powers are the vehicles by which the prevention role may be advanced.

17. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[16] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[17] 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.

18. 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

19. On 17 September 2015, Ms Roberts visually identified the deceased to be her daughter, Bella Lawrence, born 25 March 2012.

20. 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

21. On 21 September 2015, Dr Matthew Lynch (**Dr Lynch**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Bella's body. Dr

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[13] Section 72(1)
[14] Section 67(3)
[15] Section 72(2)
[16] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[17] (1938) 60 CLR 336

Lynch provided a written report, dated 9 March 2016, which concluded that Bella died from complications of blunt force trauma to the abdomen.

22. Dr Lynch commented that he observed multiple bruises on Bella's body involving the head (left front, right parietal, both occipital regions and both cheeks), chest, abdomen, back and both upper and lower limbs. Dr Lynch noted that the bruises confirmed the presence of haemorrhage but no evidence of any inflammatory reaction which is suggestive of recent injury.

23. Dr Lynch also noted significant abdominal trauma, particularly evidence of rupture of the liver and 600ml of blood present within the abdominal cavity. The significant volume of blood within the abdomen represented approximately 60% of Bella's total blood volume.[18]

24. Toxicological analysis of post mortem specimens taken from Bella were negative for common drugs or poisons.

25. 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

26. On the evening of the 16 September 2015, Ms Roberts had gone out for a drive with her two sons, in order to settle the younger one after dinner. Mr Woodford remained at home, looking after Bella. He was cleaning up after dinner and as he took some dishes from the lounge to the kitchen, he somehow tripped over Bella, as she was playing on the floor. She was knocked on to her back.[19]

27. Mr Woodford then deliberately stepped on her abdomen with one foot and lifted the other off the ground. He thereby placed the entire weight of his body, approximately 100 kilograms, on to her stomach.[20]

28. Bella immediately displayed signs of distress from Mr Woodford's actions. Shortly afterwards, he told her not to tell her mother what he had done, other than to inform her if she had a belly ache. Mr Woodford observed Bella to be upset and he put her to bed, with a bottle of water.[21]

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[18] This is based on estimated blood volume of 1000 ml for a 14-kilogram child.
[19] *Coronial Brief,* Appendix D, transcript of interview of Harley Woodford on 1 April 2016, 180
[20] *Coronial Brief,* Appendix D, transcript of interview of Harley Woodford on 1 April 2016, 181
[21] *Coronial Brief,* Appendix D, transcript of interview of Harley Woodford on 1 April 2016, 182

29. When Ms Roberts returned home, Mr Woodford made no mention of what had taken place. He said nothing about Bella having been hurt and told Ms Roberts that he had put Bella to bed as she was not feeling well.[22]

30. The next morning on 17 September 2015, Mr Woodford left early for work. Later that same morning, Bella complained to her mother that she felt sick. She said that she had a sore stomach.[23] As Ms Roberts knew nothing of what had occurred the previous evening, she did not seek medical attention for her.

31. Ms Roberts took Bella with her to drop off her eldest son at kindergarten. Upon arriving at the kindergarten, Bella told her mother that she was going to be sick. Ms Roberts then drove home with Bella. Ms Roberts sat Bella down in front of the television and after a while, Bella appeared to be seriously ill and started to become unresponsive.[24]

32. At approximately 12.00pm, Ms Roberts telephoned Mr Woodford and told him that Bella was very sick.[25] He returned home quickly and attempted to get Bella off the couch, but she was unable to stand on her own, and simply collapsed.

33. Ms Roberts and Mr Woodford then drove Bella to Wimmera Hospital and arrived at approximately 12.35pm. Upon arrival at the hospital, Bella was unconscious and unresponsive. Treating emergency physicians were unable to resuscitate Bella and she was pronounced deceased at 1.14pm.[26]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

34. The unexpected, unnatural and violent death of a young child 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.

35. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Bella and Mr Woodford was one that fell within the definition of family member[27] under that Act.

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[22] *Coronial Brief*, Statement of Ms Angie Roberts dated 22 September 2015, 59
[23] *Coronial Brief*, Statement of Ms Angie Roberts dated 22 September 2015, 54
[24] *Coronial Brief*, Statement of Ms Angie Roberts dated 22 September 2015, 54
[25] *Coronial Brief*, Statement of Ms Angie Roberts dated 22 September 2015, 55
[26] *Coronial Brief*, Statement of Dr John Williams dated 28 September 2015, 68; *Coronial Brief*, Statement of Dr Garry Matthews dated 20 October 2015, 70
[27] *Family Violence Protection Act 2008*, section 8.

Moreover the actions of Mr Woodford stepping forcibly on Bella and causing her death constitutes family violence.[28]

36. In light of Bella's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[29] examine the circumstances of Bella's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**). 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.

37. Whilst the CPU did not identify any victim specific risk factors associate with Bella, they did identify the presence of a number of risk factors for family violence in relation to Mr Woodford.[30] In particular, Mr Woodford regularly used cannabis for emotional regulation purposes and was described as using it to help "*him to relax*".[31] The assessment undertaken by the forensic psychologist following the fatal incident, advised that Mr Woodford's cannabis use induced "*prominent paranoia which seeded ongoing interpersonal tensions which in turn led to increased anxiety and agitation*".[32]

38. Despite the presence of several known risk factors for family violence, the CPU identified limited opportunities for the legal system, health system and family violence service providers to intervene to reduce the risk of family violence. Both Bella and Mr Woodford lacked contact with service providers leading up to the fatal incident.

39. Family violence literature on filicide defines it to be the murder of a child older than 12 months of age by a parent or step-parent.[33] Available statistics indicate that filicides affect female and male children equally[34], whilst younger children were found to be at greater risk

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[28] *Family Violence Protection Act 2008*, section 5(1)(a)(i)

[29] 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

[30] The CPU utilised the *Family Violence Risk Assessment and Risk Management Framework*, also known as the *Common Risk Assessment Framework* (**CRAF**) to assess risk factors which have been found to impact on the likelihood of family violence occurring and the severity of family violence that is likely to occur. CRAF was designed to assist service providers from a wide range of fields understand and identify risk factors associated with family violence and respond consistently.

[31] Psychological report prepared Patrick Newton for Harley Woodford dated 10 February 2017, 3

[32] Psychological report prepared Patrick Newton for Harley Woodford dated 10 February 2017, 3

[33] Dominique Bourget, Jennifer Grace and Laurie Whitehurst, 'A review of maternal and paternal filicide.' (2007) 35(1) *Journal-American Academy of Psychiatry and the Law* 74.

[34] A. S. C. Ciani and L. Fontanesi, 'Mothers who kill their offspring: testing evolutionary hypothesis in a 110-case Italian sample.' (2012) 36 (6) *Child abuse & neglect*, 519-527.

of fatal harm from their mothers and older children at greater fatal risk from their fathers.[35] In addition to this, the majority of victims of filicide are below six years of age.[36]

40. Whilst research into filicides is considerably underdeveloped, a study of 378 cases of filicide in Canada provides evidence that step-parents are more likely to cause fatal injury to a child than genetic parents. I note that this same study also evidences that step-parents kill younger children at a higher rate than genetic parents who kill their children.[37]

41. Research also suggests that step-parents are found to use more violent ways of killing their step-children compared to genetic parents who kill their children.[38] Step-parents were more likely to kill a child by beating or bludgeoning them and in another study were found to be "*more likely to kill after maltreating the child.*"[39]

42. Whilst there is limited Australian research on filicides, research surveying Canadian trends in filicide between 1961 and 2011 found that the proportion of step-fathers killing their step-children has increased from 11 per cent between 1974 and 1983, to 29 per cent from 2004 to 2011.[40] This research suggests that a rise in blended families has been a contributing factor to the increase in filicide deaths involving a step-parent.[41]

43. On 17 February 2017, in the Supreme Court of Victoria, Mr Woodford pleaded guilty to child homicide in relation to Bella's death. On 24 February 2017, he was sentenced to nine years and six months' imprisonment with a non-parole period of six years and six months.[42]

44. I am satisfied that the available evidence does not identify any obvious missed opportunities that could have prevented Bella's death.

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[35] A. Debowska, D. Boduszek and K. Dhingra, 'Victim, perpetrator, and offense characteristics in filicide and filicide–suicide' (2015) 21 *Aggression and violent behavior*, 113-124

[36] [36] A. Debowska, D. Boduszek and K. Dhingra, 'Victim, perpetrator, and offense characteristics in filicide and filicide–suicide' (2015) 21 *Aggression and violent behavior*, 113-124

[37] G. T. Harris, N. Z. Hilton, M. E. Rice and A. W. Eke, 'Children killed by genetic parents versus stepparents' (2007) 28 *Evolution and Human Behavior*, 85–95

[38] V. A. Weekes-Shackelford and T. K. Shackelford, 'Methods of filicide: Stepparents and genetic parents kill differently' (2004) 19(1) *Violence and Victims*, 75–81

[39] M. Liem and F. Koenraadt, F., 'Filicide: A comparative study of maternal versus paternal child homicide' (2008) 18 *Criminal Behaviour and Mental Health*, 166–176 in Agata Debowska, Daniel Boduszek, and Katie Dhingra, 'Victim, perpetrator, and offense characteristics in filicide and filicide–suicide' (2015) 21 *Aggression and violent behaviour,* 118.

[40] M. Dawson, 'Canadian trends in filicide by gender of the accused, 1961–2011' in Thea Brown, Danielle Tyson and Paula F. Arias (eds), *When Parents Kill Children: Understanding Filicide* (Springer International Publishing AG, 2018), 18.

[41] M. Dawson, 'Canadian trends in filicide by gender of the accused, 1961–2011' in Thea Brown, Danielle Tyson and Paula F. Arias (eds), *When Parents Kill Children: Understanding Filicide* (Springer International Publishing AG, 2018), 18-19.

[42] *DPP v Woodford* [2017] VSCA 312, 20.

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

FINDINGS AND CONCLUSION

46. 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 Bella Jayde Lawrence, born 25 March 2012;

    (b) the death occurred on 17 September 2015 at Wimmera Base Hospital, 83 Baillie St, Horsham, VIC 3400, from complications of blunt force trauma to the abdomen; and

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

47. I convey my sincerest sympathy to Bella's family.

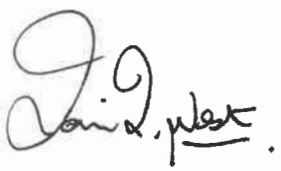
48. Pursuant to section 73(1A) of the Act, I direct that a copy of this finding be published on the Coroners Court website.

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

    (a) Jonathan Lawrence and Angie Louana Roberts, senior next of kin; and

    (b) Detective Acting Inspector Stuart Bailey, Victoria Police, Coroner's Investigator.

Signature:



IAIN WEST

ACTING STATE CORONER

Date: 24 January 2019