IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1132

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**JOHN CAIN, STATE CORONER**
Deceased:	**CATHERINE LOUISE HALEY**
Date of birth:	26 August 1988
Date of death:	9 March 2018
Cause of death:	I(a) Blunt force injuries to the head
Place of death:	29 Fairfield Crescent, Diggers Rest, Victoria, 3427

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HIS HONOUR:

BACKGROUND

1. Catherine Louise Haley (**Ms Haley**) was a 29-year-old woman at the time of her death. Ms Haley was born in Essendon to Tania Haley-Unwin and Chris Shaw and was largely brought up by her mother and her stepfather, Boyd Unwin. She was the sister of Bianca Unwin and Dylan Unwin and was known as 'Katie' to her family.

2. Ms Haley had her first child, a son, with her previous partner in 2011. However, in 2014, Ms Haley separated from the father of her first child and commenced a relationship with Shane Robertson (**Mr Robertson**). Ms Haley and Mr Robertson moved in together in Diggers Rest, after Ms Haley fell pregnant in August 2016 and their daughter was born in April 2017.[1]

3. Ms Haley had shared care arrangements for her son with her former partner. Mr Roberts had two sons from a prior relationship who resided with Ms Haley and Mr Roberts every second weekend.[2]

4. After leaving school, Ms Haley became a qualified hairdresser and worked in the industry until June 2017 when she commenced work at Castello's Victorian Tavern (**Castello's**) in Gisbourne. Ms Haley remained working at Castello's until the fatal incident.[3]

5. Ms Haley's sister, Bianca Unwin, also worked at Castello's and noticed that Ms Haley had begun to have difficulties with Mr Robertson after she started at Castello's. Ms Unwin commented that Mr Robertson made frequent remarks about men gawking at Ms Haley whilst she worked at Castello's.[4]

6. Ms Haley's hours were dependent on the requirements of the bistro, she would sometimes finish early and work longer hours at other times. Ms Haley would sometimes not finish work until 11.30pm and reports indicate that on these occasions, Mr Robertson would accuse Ms Haley of cheating on him.[5]

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[1] *Coronial Brief*, Statement of Bradley Willoughby dated 15 March 2018, 262; Statement of Sacha Haack dated 16 March 2018, 269
[2] *Coronial Brief*, Statement of Tania Haley-Unwin dated 14 March 2018, 199
[3] *Coronial Brief*, Statement of Bianca Unwin dated 14 March 2018, 208
[4] Ibid
[5] *Coronial Brief*, Statement of Boyd Unwin dated 14 March 2018, 187

7. Mr Robertson became increasingly possessive and obsessively telephoned Ms Haley to the extent that she had to stay on the phone to Mr Robertson from the moment she left the house to the moment she walked into Castello's.[6]

8. On 14 December 2017, Ms Haley drove her co-worker, Nathan Cooney (**Mr Cooney**) home because his car had broken down. Ms Haley informed Mr Robertson of the trip, and he said that it was inappropriate, even though Ms Haley's two children were in the car.[7]

9. Afterwards, Mr Robertson was convinced that Mr Cooney and Ms Haley were having an affair and Mr Robertson contacted Mr Cooney warning him to "*stay away from his girl*".[8] On another occasion, Ms Unwin heard Mr Robertson say to Ms Haley on the telephone that he would attend the tavern's pool competition to confront Mr Cooney. She also heard Mr Robertson regularly ask Ms Haley who she was working with. Ms Haley was reportedly forbidden from working with Mr Cooney.[9]

10. According to Ms Haley's family and close friends, Mr Robertson set up an Instagram account to monitor Ms Haley.[10] He complained that Ms Haley's Instagram account did not contain enough photographs of him. To appease Mr Robertson, Ms Haley deleted several photographs from her account that depicted a work function that she and her sister had attended.[11]

11. The Castello's roster was posted in a Facebook Messenger 'group chat'.[12] Ms Unwin stated that if Ms Haley logged onto Facebook to view the roster, Mr Robertson would log on to Facebook and see that she was active.[13] Logging into Facebook alerted Mr Robertson that she had finished her shift. According to Ms Unwin, Mr Robertson would telephone her sister to abuse her for not telephoning him immediately.[14]

12. As Ms Haley's friendships with her workmates developed, Mr Robertson's surveillance increased. To appease Mr Robertson, Ms Haley deleted all her social media accounts but later reinstalled Facebook intermittently on the basis that she was not doing anything wrong. Mr

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[6] *Coronial Brief*, Statement of Bianca Unwin dated 14 March 2018, 208
[7] Ibid, 209
[8] Ibid
[9] Ibid, 210
[10] Ibid; Statement of Lana Ryan dated 28 April 2018, 309
[11] *Coronial Brief*, Statement of Bianca Unwin dated 14 March 2018, 210
[12] Ibid, 209
[13] Ibid
[14] Ibid

Robertson had access to Ms Haley's Facebook and Facebook Messenger accounts and could view who she spoke to.[15]

13. As Mr Robertson was convinced that Ms Haley was having a clandestine relationship with Mr Cooney, he created a false Facebook account to elicit information from Mr Cooney.[16] Ms Haley confronted Mr Robertson about the account and he eventually admitted to having created the fake profile on social media platforms. Ms Haley confided in her friends about the confrontation and the obsessive behaviour, Ms Haley said she was thinking of leaving the relationship.[17]

14. Ms Unwin urged her sister to leave Mr Robertson because of his jealous behaviour, however Ms Haley defended him because she did not want to break up the family unit.[18] Ms Haley told her sister of one argument when Mr Robertson accused her of cheating and said that he had decided to leave. Ms Haley told Mr Robertson to leave. She told her sister that Mr Robertson then grabbed some belongings and began smashing walls, hitting things and slamming doors in the family home before going out to his work vehicle and returning with a photograph of the couple, which he tore apart. On this occasion, Mr Robertson left and, due to the noise, Ms Haley's son came out because he thought there was an intruder.[19]

15. On 24 February 2018, Mr Robertson came into Castello's to see Ms Haley with their daughter.[20] Ms Unwin observed him sit down in the middle of the bistro to watch Ms Haley as she worked. Each time a male customer approached Ms Haley for service, Mr Robertson would glare at the customer and Ms Haley.

16. On 2 March 2018, Mr Robertson attended Castello's again, this time in the company of his sister, while Ms Haley worked the evening shift.[21] Ms Haley told Ms Unwin that Mr Robertson had originally attended Castello's to give her a rose but that he confronted her and said he had watched Ms Haley from his car and accused her of flirting with a male colleague.[22]

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[15] *Coronial Brief*, Statement of Nathan Cooney dated 14 March 2018, 348.
[16] *Coronial Brief*, Statement of Eloise Long dated 19 April 2018, 303; Statement of Bianca Unwin dated 14 March 2018, 210-212
[17] *Coronial Brief*, Statement of Lana Ryan dated 28 April 2018, 310
[18] *Coronial Brief*, Statement of Bianca Unwin dated 14 March 2018, 212
[19] Ibid, 213
[20] Ibid, 214
[21] *Coronial Brief*, Statement of Daniel Edmonds dated 15 March 2018, 342-343
[22] *Coronial Brief*, Statement of Bianca Unwin dated 14 March 2018, 214-215

THE PURPOSE OF A CORONIAL INVESTIGATION

17. Ms Haley'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.[23]

18. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[24] 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.[25]

19. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[26] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[27] or to determine disciplinary matters.

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

21. For coronial purposes, the phrase "*circumstances in which death occurred,*"[28] 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.

22. 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.

23. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[29]

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[23] Section 4 Coroners Act 2008
[24] Section 89(4) Coroners Act 2008
[25] See Preamble and s 67, *Coroners Act 2008*
[26] *Keown v Khan* (1999) 1 VR 69
[27] Section 69 (1)
[28] Section 67(1)(c)
[29] Section 72(1)

(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;[30] 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.[31] These powers are the vehicles by which the prevention role may be advanced.

24. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[32] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[33] 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.

25. 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

26. Upon reviewing the available evidence, Coroner John Olle completed a Form 8 *Determination by Coroner of Identity of Deceased* dated 13 March 2018, concluding that the identity of the deceased was Catherine Katie Hayley born 26 August 1988.

27. 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

28. On 10 March 2018, Dr Joanna Glengarry, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Glengarry provided a written report dated 24 May 2018 and concluded that Ms Haley died from blunt force injuries to the head.

29. Prior to the commencement of the autopsy, Dr Glengarry attended Ms Haley's residence in Digger's Rest at 4.10am on 10 March 2018 and observed Ms Haley lying in situ. Dr

[30] Section 67(3)
[31] Section 72(2)
[32] Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152
[33] (1938) 60 CLR 336

Glengarry observed calvarial fractures with extrusion of the brain contents and blood across the face, head and hair. Ms Haley had a deformed mid and upper face consistent with facial fractures. A left ring finger had been avulsed[34]. Dr Glengarry was shown the weapon purported to have used on Ms Haley, but she did not handle it or measure its dimensions.

30. Dr Glengarry commented on the following in her written report:

(a) The autopsy demonstrated severe blunt force injuries to the head and face. Injuries to the skin had patterning comprising parallel lines between 0.1 and 0.3cm wide, separated by 0.3 to 0.5cms and of variable lengths. Dr Glengarry considered that the patterning of the injuries was consistent with the appearance of the threaded screw ends of the bloodied weights bar that she had observed at the scene of death.

(b) There were multiple fractures to both sides of the face (greater on the left than the right side), with depression of the facial contour and loss of the structural integrity of the upper and middle parts of the face.

(c) There were multiple fractures to the left side of the calvarium[35] and both sides of the skull base. The skull fractures included dislocation of bone fragments inwards into the brain substance. In the regions of the skull fractures, the underlying brain had multiple lacerations of its brain surface and damage to the left-brain parenchyma.

(d) That estimating the precise number of blows required to inflict injuries is problematic, as multiple blows to one area may result in a single injury. Conversely, a single blow to one area may result in multiple injuries. With these caveats in mind, Dr Glengarry was of the opinion that the *minimum* number of blows necessary to cause the facial injuries was at least three, and the *minimum* number of blows to cause the injuries to the left side of the head was two.

(e) that the estimation of force needed to cause the observed injuries required consideration not only of the extent of the injury, but also the weight and relative kinetic energy of the weapon used to cause the injuries. In Dr Glengarry's opinion, the force required to result in the injuries identified in Ms Haley was *severe*.

(f) Dr Glengarry observed a bruise to the knuckles of the right hand, the right wrist and a bruise of the left wrist as well as small bruises to the leg. These were not able to be

[34] Torn away
[35] The top, rounded part of the skull

demonstrated histologically, therefore a comment on their age was problematic. Dr Glengarry commented that it was possible for the bruises to have arisen at or around the time of death, however she could not exclude that they may have developed at a time unrelated to the events prior to death.

31. Toxicological analysis of samples of postmortem blood did not detect the presence of alcohol or any common drugs or poisons.

32. I accept the cause of death proposed by Dr Glengarry.

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

33. On 9 March 2018, Ms Haley dropped her children off at her parent's house before commencing the lunchtime shift at Castello's.[36]

34. After the lunch shift, Ms Haley went to her family's home to catch up with her parents who had been watching over her children. Mr Robertson called Ms Haley during this time and they began to argue. Ms Haley's mother overheard Ms Haley arguing with Mr Robertson. Ms Haley was heard saying that she was "*really over it*" and "*I'll be home when I'm home*".[37] Once Ms Haley ended the call, she told her sister that Mr Robertson had called her earlier in the day, upset and said, "*I know you like Daniel*".[38]

35. Ms Haley departed for home with her daughter at around 5.30pm.[39] Shortly after 7:00pm, Ms Haley and Mr Robertson took their daughter to a local hotel for dinner and returned home at about 8:45pm to put their daughter to bed.[40]

36. Mr Robertson then started arguing with Ms Haley and she told him the relationship was over. She started packing a bag and left the house for a short period. Mr Robertson telephone his mother and told her Ms Haley was leaving him and that the relationship was over.[41]

37. Ms Haley soon returned home and began banging on the front door, yelling at Mr Robertson to let her in. On entering the house, Ms Haley resumed packing her bag and Mr Robertson tried to plead with her not to leave.[42] Ms Haley eventually said that she would sleep in her

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[36] *Coronial Brief,* Statement of Tania Haley-Unwin dated 14 March 2018, 203
[37] Ibid, 204
[38] *Coronial Brief,* Statement of Bianca Unwin dated 14 March 2018, 216
[39] *Coronial Brief,* Statement of Tania Haley-Unwin dated 14 March 2018, 203
[40] *Coronial Brief,* Appendix C and D – CCTV footage screenshots from neighbouring unit, 512-526
[41] *Coronial Brief,* Statement of Lynne Robertson dated 10 March 2019, 114
[42] *Coronial Brief,* Appendix N – Transcript of police video recorded interview with Shane Robertson, 689

son's room but Mr Robertson continued to argue with her and left the house. Ms Haley locked Mr Robertson out for five to ten minutes before letting him back in.[43]

38. Ms Haley and Mr Robertson continued arguing until around 10:30pm. At one point during their argument Mr Robertson reportedly went into the lounge room and picked up a dumbbell bar made of heavy iron and entered the bedroom where Ms Haley was lying on her son's bed. Mr Robertson approached her and hit her multiple times with the bar to her face and head, killing her.[44]

39. Mr Robertson contacted his mother shortly after at 10:46pm, informing her that he had killed Ms Haley and that he wanted to drop off his daughter at her house.[45] At 10:55pm, Mr Robertson's mother called emergency services and requested an ambulance attend the residence at 29 Fairfield Crescent, Diggers Rest.[46]

40. Mr Robertson arrived at his mother's residence at around 11:00pm to drop off his daughter. Mr Robertson's brother in law attempted to block his car from leaving and Mr Robertson fled the scene on foot.[47] Mr Robertson was apprehended by police the next day on 10 March 2018 at around 12:30am.[48]

41. Victoria Police members arrived at the residence at around 11:11pm and found Ms Haley's body in her son's bedroom. Ambulance paramedics arrived at around 11:30pm and she was confirmed deceased at the scene.[49]

Criminal investigation

42. On 6 March 2019, Shane Robertson was convicted and sentenced to a term of imprisonment for 24 years, with a non-parole period of 19 years for the murder of Ms Haley.[50]

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[43] Ibid, 692
[44] Ibid, 701-731
[45] *Coronial Brief*, Appendix L – Call records for Shane Robertson, 551; Statement of Lynne Robertson dated 10 March 2019, 114
[46] *Coronial Brief*, Appendix H – Emergency services call records, 532
[47] *Coronial Brief*, Statement of Dylan Tame dated 10 March 2018, 131-132
[48] *Coronial Brief*, Statement of Senior Sergeant Timothy Cron dated 1 May 2018, 439
[49] *Coronial Brief*, Appendix Q – Paramedic records, 739-740
[50] *R v Robertson* [2019] VSC 145, 18

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

43. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.

44. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Ms Haley and Mr Robertson was one that fell within the definition of '*de facto partner*'[51] under that Act. Mr Robertson's stalking and emotional abuse of Ms Haley, his controlling behaviour and ultimately the act of fatally assaulting her constituted '*family violence*'.[52]

45. In light of Ms Haley's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[53] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[54] A review of the available evidence unfortunately did not identify any proximate service contact with either Ms Haley or Mr Robertson.

Third party reporting of family violence

46. Ms Haley's death, and deaths similar to hers, highlights the difficult and often dangerous predicament that family violence presents to family, friends and others who either become aware of it, or suspect it is occurring. Coupled with this is the reoccurring indication within the relevant research, that female victims of family violence are more likely to disclose the violence to family or friends, rather than to authorities or specialist services. Many times, third parties feel, understandably, ill-equipped to assist or are concerned that any intervention may increase the danger for the victim or themselves.

47. In an effort to address the barriers that third parties face in obtaining access to information about family violence, and providing information and assistance to victims of family violence, the Royal Commission into Family Violence (**the Royal Commission**)[55] reviewed the available resources for third parties.

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[51] Family Violence Protection Act 2008, section 9
[52] Family Violence Protection Act 2008, section 5(1)(a)(i)
[53] 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
[54] 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
[55] Victoria, Royal Commission into Family Violence, *Final Report* (2016) available at: http://www.rcfv.com.au/Report-Recommendations

48. At its conclusion, predominantly by way of recommendations 10 and 37, the Royal Commission encouraged the adoption of a model whereby third parties (as well as victims and perpetrators of family violence) can access information via a website to assist in recognising family violence and how to seek help, both in the crisis period and during longer term recovery.[56]

49. This Court is advised that the Victorian Government has selected "*The Lookout*"[57] website as the most suitable existing site with the capacity to develop into a space for the delivery of accessible information for those experiencing, witnessing and being affected by family violence. The Court is also informed that, in line with the Royal Commission's recommendation, the website is now currently in operation.[58]

The introduction of Support & Safety Hubs

50. A central feature of the State Government's response to the Royal Commission's recommendations is the introduction of the Orange Doors (also known as Support and Safety Hubs)[59] at locations across Victoria, a central point for the family violence response network which will:

a) receive police referrals, referrals from non-family violence services, including family and friends, as well as self-referrals;

b) provide a single, area-based entry point into local specialist family violence services, perpetrator programs and integrated family services and link people to other support services;

c) perform risk and needs assessments and safety planning using information provided by the recommended state-wide central information point;

d) provide prompt access to the local Risk Assessment and Management Panel;

e) provide direct assistance until the victim, perpetrator and any children are linked with services for longer term support;

f) book victims into emergency accommodation and facilitate their placement in crisis accommodation;

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[56] Victoria, Royal Commission into Family Violence, Recommendation 10
[57] http://www.thelookout.org.au
[58] http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=12>; *The Lookout* website can be found at http://www.thelookout.org.au
[59] Victoria, Royal Commission into Family Violence, Recommendation 37

g) provide secondary consultation services to universal or non-family violence services; and

h) offer a basis for co-location of other services likely to be required by victims and any children.[60]

51. This Court is informed that the Department of Premier and Cabinet, along with Family Safety Victoria, is currently collaborating with partner agencies to design and implement the Orange Doors State-wide. Orange Doors currently operate in five areas across Victoria.[61] These are forecast to be completed by 31 March 2021, by which time an additional three Orange Door sites will have been rolled out across Victoria.[62]

52. In light of the comprehensive nature of the Royal Commission's work in this regard, I support the recommendations put forward, specifically in this case as they relate to the issue of assisting third parties to educate and assist both perpetrators and victims of family violence.

53. In Ms Haley's case, education and information via a website, such as '*The Lookout*' may have provided an initial avenue for the family members and friends to assist her, while the Orange Doors may have provided an opportunity to report concerns and create more tangible opportunities for intervention and prevention.

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

FINDINGS AND CONCLUSION

55. 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 Catherine Louise Haley, born 26 August 1988;

b) the death occurred on 9 March 2018 at 29 Fairfield Crescent, Diggers Rest, Victoria, 3427, from blunt force injuries to the head; and

c) the death occurred in the circumstances described above.

56. I convey my sincerest sympathy to Ms Haley's family.

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[60] Victoria, Royal Commission into Family Violence, *Summary and Recommendations* (2016) 55
[61] Bayside Peninsula, North Eastern Melbourne, Inner Gippsland, Barwon and Mallee
[62] Loddon, Central Highlands and Goulburn. Further information can be found online at: <http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=220>

57. Pursuant to section 73(1) of the *Coroners Act 2008*, 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) Mrs Tania Haley-Unwin, senior next of kin;

    b) Detective Senior Constable Matthew Paul Noonan, Coroners Investigator, Victoria Police; and

    c) Chief Executive Officer of Family Safety Victoria.

Signature:

JOHN CAIN
STATE CORONER
Date: 9April 2020