IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 3182

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:	**TRACY ANNE CONNELLY**, born 25 February 1973
Delivered on:	16 July 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	10 July 2018
Counsel assisting the Coroner:	Rebecca Johnston-Ryan, State Coroner's Legal Officer
Catchwords:	Homicide, no person charged with an indictable offence in respect of a reportable death, mandatory inquest

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HER HONOUR:

BACKGROUND

1. Ms Tracy Anne Connelly (**Ms Connelly**) was a 40-year old woman who resided with her partner of 12 years, Mr Tony Melissovas, in their Ford Econovan which was parked outside of 25 Greeves Street, St Kilda at the time of her death.

2. Ms Connelly was the youngest of 4 children to Bryan and Sheila Connelly (**Mr and Mrs Connelly**). Ms Connelly's siblings were her brothers Leslie and Richard, and her sister Jean. Ms Connelly was not close to her family members, and at the time of her death she was estranged from her family at large.

3. In her early teenage years, Ms Connelly married Matthew Bryson (**Mr Bryson**), with whom she had a son, Billy Jack, in 1992. Ms Connelly and Mr Bryson's marriage failed, and Mr Bryson initially took custody of their son. When their son was aged 4 years old, Mr Bryson took his own life, and for a short period of time he resided with Ms Connelly. Mr and Mrs Connelly sought sole custody of Billy Jack. Mr and Mrs Connelly were successful in gaining custody of Billy Jack, and they took him to Queensland to reside with them. Following this, Ms Connelly broke all ties with her parents, and she had no known further contact with her son and family again.

4. Ms Connelly had worked as a sex worker from the age of 15, and had a number of criminal convictions for loitering for prostitution in a public place. At the time of her death, Ms Connelly worked as a street sex worker in the St Kilda area using the alias "Kelly".

5. Ms Connelly was inseparable from her long-term partner, Mr Melissovas, who supported Ms Connelly in her work by acting as her 'spotter'. This involved Mr Melissovas standing approximately 100 metres up the street from Ms Connelly, and noting the registration, make and model of Ms Connelly's client's cars, as well as the time Ms Connelly left with a client.

6. Ms Connelly would accommodate between 5 to 10 clients per day, and would either conduct her business at the client's premises, or would use her and Mr Melissovas' Ford Econovan. Ms Connelly would request payment upfront prior to providing her services. Ms Connelly would contact Mr Melissovas and provide details of her location to him via text message when she was with a client. When seeing clients in the Ford Econovan she would always lock the doors.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Ms Connelly's death constituted a *'reportable death'* under the *Coroners Act 1985* (Vic), as she ordinarily resided in Victoria at the time of her death and her death appears to have been violent.[1]

8. 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 the identity of the deceased person, the cause of death and the circumstances in which death occurred.

9. 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.

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

11. 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.

12. 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.

13. 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 3 *Coroners Act 1985 (Vic)*
[2] Section 89(4) *Coroners Act 2008*
[3] *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.

14. 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.

15. 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 was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death, or the deceased was immediately before the death, a person placed in custody or care, or the identity of the deceased is unknown.

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

16. An imprint of the deceased's right thumb was taken in order to identify the deceased. On 23 July 2013, Victoria Police produced a Deceased (Fingerprint) Identification Report matching the right thumb imprint taken to a known set of prints for Tracy Connelly, born 25 February 1973.

17. 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

18. On 22 July 2013, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy upon Ms Connelly's body. Dr Baber provided a written report, dated 30 October 2013, which concluded that Ms Connelly died from a stab wound to the eye.

19. Dr Baber also reported multiple sharp force injuries to the hands, trunk, and face, but noted that the wounds inflicted to the chest and abdomen were not of a degree that would have significantly contributed to Ms Connelly's death.

[4] (1938) 60 CLR 336

20. Dr Baber commented that the left eye injury caused disruption to the midbrain, the portion of the brain responsible for control of breathing and cardiovascular system control. Dr Baber reported that death would have occurred relatively rapidly as a result of this injury.

21. I accept the cause of death proposed by Dr Baber.

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

22. On 20 July 2013 at approximately 6.00am, Mr Melissovas was conveyed to the Alfred Hospital by ambulance. He was admitted for treatment of an infected hand.

23. At approximately 5.00pm, Ms Connelly attended the hospital to visit Mr Melissovas. She remained with him at the hospital until approximately 8.00pm, at which time she left to return to work.

24. At approximately 10.30pm, Mr Melissovas called Ms Connelly on her mobile phone and asked her how she was going. Ms Connelly told Mr Melissovas that it was quiet. This was the last time Mr Melissovas spoke with Ms Connelly.

25. At around this time Ms Connelly got onto the Open Family Australia Chatterbox Bus parked in Greeves Street, St Kilda. The Chatterbox Bus is part of an Open Family Australia outreach program engaging young people who are street frequenting, homeless, at risk of homelessness and/or engaging in risk-taking behaviour. While on the bus, Ms Connelly was given some food, and she spoke to a number of people.

26. At approximately 11.10pm at the corner of Mitchell and Carlisle Streets, St Kilda, sex worker Ms Davina Shutie spoke with Ms Connelly for approximately 5 to 10 minutes. While talking to Ms Connelly, Ms Shutie became aware of a client waiting for Ms Connelly. Ms Connelly told Ms Shutie that she had an hour booking, and Ms Shutie assumed it was with the man who seemed to be waiting for Ms Connelly. Ms Shutie stated that Ms Connelly did not appear to be in any hurry.

27. At approximately 12.00am on 21 July 2013, sex worker Ms Monique Ramsey observed Ms Connelly approximately 100 metres away crossing Carlisle Street, from the south side and continuing on walking north down Greeves Street. At the time Ms Ramsey observed Ms Connelly she was alone. This was the last confirmed sighting of Ms Connelly alive.

28. At approximately 1.15am, Ms Shutie made her way to Ms Connelly's van parked on Greeves Street. The curtains of the van were closed and Ms Shutie assumed that Ms Connelly was

inside. She banged on the van doors and attempted to look inside the van without success due to the curtains and poor light obscuring her view. Ms Shutie remained outside the van for approximately 20 minutes before she walked away.

29. At approximately 9.45am, Mr Melissovas attempted to call Ms Connelly on her mobile phone. Her phone was switched off. Mr Melissovas continued to attempt to call every 10 minutes for approximately 1 hour.

30. Some time between 1.00pm and 1.30pm, after Ms Connelly did not arrive at the hospital and was uncontactble via mobile phone, Mr Melissovas discharged himself from hospital. At approximately 2.40pm Mr Melissovas arrived at Greeves Street and approached the Ford Econovan. Mr Melissovas forced entry into the van via the front passenger side door. He discovered Ms Connelly inside the van covered in blood, not breathing and with no signs of life.

31. Emergency services were called to attend. At 2.56pm, Ambulance Victoria paramedics attended. Ms Connelly was pronounced deceased at the scene.

VICTORIA POLICE INVESTIGATION

32. Ms Connelly's death was the subject of a comprehensive investigation by Victoria Police Homicide Squad. Despite this investigation, no person or persons have been charged with indictable offences in connection with Ms Connelly's death.

33. 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."*

34. 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

[5] (2012) VSCA 327

I am required to make findings of fact and not express any judgement or evaluation of the legal effect of those findings.[6]

35. 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.

36. In the case of the death of Ms Connelly, I acknowledge that the Victoria Police Homicide Squad has conducted an extremely thorough investigation.

37. The Coroner's Investigator, Detective Sergeant Rodney Stormonth, has provided a statement to the Court in relation to this matter. Detective Sergeant Stormonth's statement establishes that despite the extensive homicide investigations undertaken, the person or persons responsible for Ms Connelly's death have, to date, not been identified. Further, Detective Sergeant Stormonth opines that there is no investigation he could undertake on my behalf at this time that would be likely to reveal additional evidence to identify the person or persons who killed Ms Connelly.

FINDINGS AND CONCLUSION

38. Having investigated the death of Ms Connelly and having held an Inquest in relation to her death on 10 July 2018, at Melbourne, I am satisfied of the following matters to the required standard:

    (a) that the identity of the deceased was Tracy Anne Connelly, born 25 February 1973;

    (b) that Tracy Anne Connelly died on 21 July 2013 at a location outside 25 Greeves Street, St Kilda, Victoria from a stab wound to the eye; and

    (c) that, despite extensive criminal investigation conducted by Victoria Police to date, no person or persons have been identified as being responsible for causing Ms Connelly's death. On that basis, I am also satisfied that no investigation which I am empowered by the Act to undertake, would result in the identification of the person or persons who caused Ms Connelly's death.

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[6] *Perre v Chivell* (2000) 77 SASR 282

39. I make the findings set out above pursuant to section 67(1) of the Act.

40. I note that in the future, if new facts and circumstances become available, section 77 of the Act allows any person to apply to the Court for a determination that some or all of these findings be set aside. Any such application would be assessed on its merits at the time of application.

41. I convey my sincerest sympathy to Ms Connelly's family and friends.

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

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

    (a) Anthony Melissovas; Senior Next of Kin;

    (b) Detective Sergeant Rodney Stormonth, Coroner's Investigator, Victoria Police; and

    (c) Detective Inspector Tim Day, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 16 July 2018