IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 2384

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:	**ZANE BRADBURY**
Date of birth:	15 June 2010
Date of death:	9 May 2014
Cause of death:	Head injury
Place of death:	135 Widford Street, Glenroy, Victoria
Catchwords:	Child homicide; death resulted directly from injury; was unexpected, violent, and not from natural causes; family violence

TABLE OF CONTENTS

HER HONOUR:

BACKGROUND

1. Zane Bradbury (**Zane**), born 15 June 2010, was three years and eleven months old at the time of his death. He was the eldest child of Charo Cunning (**Ms Cunning**)[1] and Coen Bradbury (**Mr Bradbury**).[2] Zane had two younger siblings, A [redacted] and B [redacted]

2. Zane did not have any significant past medical history. He was described as a very bright boy who made friends easily.[3]

3. Ms Cunning and Mr Bradbury met in 2010. By 14 February 2012, Ms Cunning and Mr Bradbury had ended their relationship and thereafter Mr Bradbury had minimal contact with his children.[4]

4. In November 2013, Ms Cunning commenced a relationship with Brok Hughes (**Mr Hughes**). In early 2014, Mr Hughes moved into Charito Cunning's home where Ms Cunning was residing with her three children. Charito Cunning is Ms Cunning's mother.

5. Charito Cunning reports that she never observed any injuries or marks on the children's bodies when she would assist with caring for them.[5] However, one evening in late-March 2014, Charito Cunning saw Mr Hughes smacking A [redacted] after he came out of his room asking for a bottle of milk. When challenged about this, Mr Hughes said, "*I can discipline the children; Charo told me I could.*"[6] Charito Cunning confronted her daughter about this incident, and about leaving the children unattended. Ms Cunning defended Mr Hughes, after which Charito Cunning told them to leave the house. As a result of this request, in April 2014, Ms Cunning and Mr Hughes moved to 135 Widford Street, Glenroy, Victoria with the children.[7]

---

[1] Born 20 April 1990.
[2] Coronial Brief, p.57.
[3] *R v Hughes* [2015] VSC 312, Sentencing Remarks, p.12.
[4] Coronial Brief, p.57.
[5] Coronial Brief, p.102.
[6] Coronial brief, p. 101.
[7] *R v Hughes* [2015] VSC 312, Sentencing Remarks, p.12.

6. Ms Cunning reports that she has used illicit drugs since the age of 15 years, (typically cannabis and ecstasy) and that she smokes marijuana daily.[8]

7. Mr Hughes[9] educated to Year 10, originally from Western Australia moved to Melbourne approximately seven years prior to the Zane's death and worked as a baker. He had also worked as a welder despite not holding any formal trade qualification. At the time of Zane's death, Mr Bradbury had been unemployed for one year and was receiving Centrelink benefits.

8. Mr Hughes has a biological son, born in June 2009, with whom he had no contact after his relationship with the child's mother ended. Mr Hughes admitted to being a regular cannabis user, having most recently used that drug the day prior to Zane's death.

9. Ms Cunning claimed that Mr Hughes was good with her children in that he would play outside with them and helped toilet train Zane. Both Ms Cunning and Mr Hughes disciplined the children in the same way, namely by smacking them on the bottom and sending them to bed or making them sit in the naughty corner.

THE PURPOSE OF A CORONIAL INVESTIGATION

10. Zane's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria, resulted directly from injury and was unexpected, violent, and not from natural causes.[10]

11. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[11] 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.

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

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

---

[8] Coronial Brief, p. 11.
[9] Born 28 September 1988.
[10] Section 4 *Coroners Act 2008.*
[11] Section 89(4) *Coroners Act 2008.*
[12] *Keown v Khan* (1999) 1 VR 69.

14. 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 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 the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

16. 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.

17. 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*.[13] 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 writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all of the witness statements in the coronial brief.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased, pursuant to section 67(1)(a) of the *Coroners Act 2008*

19. On 9 May 2014, the Deceased was visually identified by his mother, Charo Cunning, to be Zane Bradbury, born 15 June 2010.

[13] (1938) 60 CLR 336.

20. Identity is not disputed and required no further investigation.

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

21. On 10 May 2014, Dr Michael Burke (**Dr Burke**), a Senior Forensic Pathologist, practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Zane's body.

22. Dr Burke provided a written report, dated 26 June 2014, which concluded that a reasonable cause of death was '*head injury*' resulting from blunt force injury.

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

23. After Zane's death on 9 May 2014, in his home at 135 Widford Street, Glenroy, Mr Hughes provided a number of versions of events to police officers as to how the death occurred.

24. During a formal record of interview with police officers, Mr Hughes stated that in the hours leading up to Zane's death, Zane had been "*a terror*",[14] ripping down a curtain rod and the curtains in the lounge room. Both he and Ms Cunning yelled at Zane for his actions. Mr Hughes then took Zane to his bedroom for 'time out' as punishment. Mr Hughes also smacked Zane on the bottom, which made him cry.[15]

25. Mr Hughes, in a fit of anger, then grabbed Zane on the back of the neck and threw him towards his bed. As he landed, Zane's head struck the corner of the bed frame and the wall, and possibly the window sill. Either way, the force was such that Zane suffered a catastrophic shearing injury to his brain from which he later died.[16]

26. According to Mr Hughes, while Zane did not make much noise after this he was audibly moaning. Mr Hughes, knowing that Zane had been hurt as a result of his actions, straightened him up, laying him in the middle of the bed. At this point he called out to Ms Cunning. At this stage, Mr Hughes did not tell Ms Cunning the truth about how Zane had been hurt and suggested that he had fallen off the bed when jumping.

27. Ms Cunning took Zane into her arms and shortly thereafter he vomited. Mr Hughes carried Zane to the bathroom and gave him a shower. During this time Mr Hughes had to physically support Zane as he could not support himself. Mr Hughes used the shower to both clean Zane and help him to regain consciousness. After the shower, Zane was placed

[14] Record of interview, page 51 (question and answer 388).
[15] Coronial brief, p. 1155.
[16] *R v Hughes* [2015] VSC 312, Sentencing Remarks, p.1.

back on his bed and left on his own for 10 to 15 minutes. Upon Ms Cunning and Mr Hughes' return, Zane was still in the same position and "*still wasn't getting any better.*"[17] His "*eyes were drooping and he was moaning.*"[18] There was a little bit of blood in the corner of his mouth.[19] They used a torch to shine into his eyes, but there was no response.[20] They talked to Zane for about half an hour in an attempt to get a response from him,[21] however his breathing had slowed down.

28. At 1.28pm Ms Cunning called an ambulance.[22] Ms Cunning told the 000 call taker that Zane was unresponsive, had fallen from a bed and sustained a head injury. During that call, Zane stopped breathing and Mr Hughes administered CPR under the direction of the 000 call taker.

29. At 1.35pm, Ambulance Victoria paramedic officers attended the home and located Zane unconscious, not breathing and without a palpable pulse. The paramedic officers commenced CPR and other resuscitative efforts.

30. Paramedic officers observed Zane to have a white frothy substance coming from his nose. The paramedic officers observed multiple bruises on Zane's face, torso and arms that appeared inconsistent with the report that he had sustained his injuries as a result of falling off the bed and hitting his head. Due to concerns that Zane had been assaulted, the paramedic officers requested police officers attend the house.

31. At 2.18 pm Zane was transferred to the Royal Children's Hospital. At 2:41 pm, Zane arrived at the hospital in a state of cardio-respiratory arrest. Efforts to revive Zane continued at the hospital, but he died at 3:50 pm.

COMMENTS PURSUANT TO SECTION 67(3) OF THE *CORONERS ACT 2008*

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

[17] Coronial brief, p. 1165 and 1166.
[18] Coronial brief, p. 1178.
[19] Coronial brief, p. 1178.
[20] Coronial brief, p. 1165.
[21] Coronial brief, p. 1178.
[22] Coronial brief, p. 989.

33. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr Hughes and Zane was one that fell within the definition of 'family member'. Moreover, the actions of Mr Hughes causing Zane's death constituted 'family violence'.

34. As a result, I requested that the Coroners Prevention Unit (**CPU**)[23] examine the circumstances surrounding Zane's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[24]

35. The CPU identified the presence of known risk factors for family violence including: parental substance use, mental health issues, unemployment and isolation. Available evidence indicates that Ms Cunning and Mr Hughes were struggling with raising three young children and utilised physical violence as a form of discipline. Mr Hughes evidenced poor emotional regulation and was quick to anger. All of these factors appear to have contributed to Zane's death.

36. Despite this the CPU identified that at a time leading up to Zane's death, none of the family members were engaged with any services that may have been able to provide support and act protectively in Zane's best interests.

37. On 4 March 2015, Mr Hughes pleaded guilty in the Supreme Court of Victoria to one count of child homicide and one count of intentionally causing injury to Zane. He also pleaded guilty to one count of intentionally causing injury to Zane's younger brother, A [redacted]

38. On 26 June 2015, Mr Hughes was convicted and sentenced to nine years and six months imprisonment, with a non-parole period of six years and three months.

39. I note, and adopt, the sentencing remarks of Justice Croucher as follows:

> *The gravity of the incident is increased substantially when regard is had to the fact that Mr Hughes was a 25-year-old man entrusted with the care of Zane, who was just a little boy about to turn four years of age. Zane's sin was to have angered Mr Hughes by ripping a curtain rod from the lounge curtains. Mr Hughes overreacted grossly and criminally. And now Zane is dead.*[25]

---

[23] 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.

[24] 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.

[25] *R v Hughes* [2015] VSC 312, Sentencing Remarks, p.1.

> *As I have explained, child homicide is a new statutory offence the maximum penalty for which is 20 years' imprisonment. The offence is serious, by definition. The life of a three-year-old boy has been lost as a result of behaviour that otherwise would amount to manslaughter. When a child pre-deceases his parents, and his grandparents, it reverses the natural order of things. Such a death must be all the more unbearable when the child is so young, as Zane Bradbury was, and is taken as a result of criminal behaviour by a person entrusted with his care.*[26]

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

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

FINDINGS AND CONCLUSION

42. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) *Coroners Act 2008*:

    (a) that the identity of the deceased was Zane Bradbury, born 15 June 2010;

    (b) that Mr Hughes caused Zane's death;

    (c) that Zane died on 9 May 2014, at 135 Widford Street, Glenroy, Victoria, from a head injury; and that the death occurred in the circumstances set out above.

43. I convey my sincere condolences to Zane's family and friends at his tragic and untimely death.

44. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

    (a) Ms Charo Cunning, senior next of kin.

    (b) Sergeant Anthony (Tony) Hupfeld, Coroner's Investigator.

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

[26] *R v Hughes* [2015] VSC 312, Sentencing Remarks, p.25.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 28 October 2016