IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 6426

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the death of Catherine Claudia Thomas

Delivered on:	21 October 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	21 October 2021
Findings of:	Judge John Cain, State Coroner
Counsel assisting the Coroner:	Nicholas Ngai, Family Violence Senior Solicitor
Catchwords:	Family violence; Suspected homicide; no one charged with an indictable offence in respect of a reportable death; mandatory inquest.

HIS HONOUR:

BACKGROUND

1. Catherine Claudia Thomas (**Mrs Thomas**) was a 66-year-old woman who resided at 9 Pearce Street, California Gully, Victoria with her husband, Mr Maurice Thomas (**Mr Thomas**).

2. Mrs Thomas grew up in the Rosebery area and after completing her schooling, she worked as a secretary at a local solicitor's office until she met her husband, Mr Thomas and they were married in their twenties'. Mr Thomas worked on his family's farm in Patchewollock and the couple purchased a house in Hopetoun where they lived for a while.

3. Mr Thomas was born in Horsham and after completing his schooling, he worked on his father's farm with family. Mr Thomas eventually left farming to do bulldozing with a private company in Bendigo.

4. In the late 1980s, Mr and Mrs Thomas moved to Bendigo for work and resided in Epsom until they moved to their last address on Pearce Street in California Gully in the early 2000s. Whilst in Bendigo, the couple enjoyed 4WD driving and camping trips with local friends.

5. The available evidence suggests that in the years prior to the fatal incident, Mr and Mrs Thomas had struggled with health issues. Mrs Thomas was diagnosed with Lupus and Immune Neutropenia as an adult.[1] Her most recent prognosis in May 2020 was good and showed that she was stable and had no significant changes to her health.[2] Mrs Thomas also had a number of skin cancers removed throughout her adulthood and most recently a biopsy was taken on 14 October 2020. Mrs Thomas was still in the process of determining her treatment options in the lead up to the fatal incident but there was nothing interfering with her day-to-day life nor was the proposed treatment likely to affect her mobility.[3]

6. Mr Thomas was diagnosed with Type 2 Diabetes in 1997 and underwent surgery for a spinal tumour in early 2018.[4] Mr Thomas also suffered a shoulder injury in early 2018 during his work with a private bus company. He had a protracted Work Cover claim that resulted in him being deemed fit to return to work but due to concerns about his ability to continue usual duties, he retired in July 2020.[5]

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[1] *Coronial brief*, Statement of Dr Douglas Barrett dated 12 February 2021, 215-216
[2] Ibid, 217-218
[3] Ibid 218
[4] Medical records for Mr Thomas provided to the Court, 1
[5] 1-2

7. In August 2020, Mr Thomas' father passed away and this caused a significant amount of stress for Mr and Mrs Thomas in managing the estate of Mr Thomas' late father and assisting Mr Thomas' mother with Centrelink and support with Aged Care assistance.[6] Close family members noted that dealing with these issues after the death of Mr Thomas' father placed significant strain on Mr Thomas' mental health and wellbeing.[7]

8. Mr Thomas expressed concerns to his mother in mid-2020, that he believed Mrs Thomas' lupus was really bad and that she might be in a wheelchair before the years out and how he couldn't manage to support Mrs Thomas with his bad shoulder.[8] None of these concerns however were supported by the available medical evidence which indicated that Mrs Thomas had no anticipation of a wheelchair or becoming significantly unwell.[9]

THE PURPOSE OF A CORONIAL INVESTIGATION

9. Mrs Thomas's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Mrs Thomas ordinarily resided in Victoria[10] and the death appears to have been unexpected and violent.[11]

10. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the 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.

11. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[12] 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 death occurred.[13]

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[14] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[15] or to determine disciplinary matters.

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[6] *Coronial Brief,* Statement of Moya Poulton dated 18 December 2020, 63-64
[7] *Coronial brief*, Statement of Coral Dawn Thomas dated 13 January 2021, 73; Statement of Pollyana Thomas dated 19 May 2021, 93-94
[8] *Coronial brief*, Statement of Coral Dawn Thomas dated 13 January 2021, 73
[9] *Coronial brief*, Statement of Dr Douglas Barrett dated 12 February 2021, 215-216
[10] Section 4 *Coroners Act 2008*
[11] Section 4(2)(a) *Coroners Act 2008*
[12] *Coroners Act 2008* (Vic) s 89(4),
[13] *Coroners Act 2008* (Vic) preamble and s 67.
[14] *Keown v Khan* (1999) 1 VR 69.
[15] *Coroners Act 2008* (Vic) s 69 (1).

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*,"[16] 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 Court's "*prevention*" role.

16. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[17]

    (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;[18] 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.[19] 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.[20] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[21] 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.

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16 *Coroners Act 2008* (Vic) s 67(1)(c).
17 *Coroners Act 2008* (Vic) s 72(1).
18 *Coroners Act 2008* (Vic) s 67(3).
19 *Coroners Act 2008* (Vic) s 72(2).
20 *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
21 (1938) 60 CLR 336.

IDENTITY OF THE DECEASED PURSUANT TO S.67(1)(a) OF THE ACT

18. On 7 December 2020, Coroner Jamieson completed a Form 8 determination of identity of the deceased who was confirmed to be Catherine Claudia Thomas, born 18 January 1954.

19. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH PURSUANT TO S.67(1)(b) OF THE ACT

20. Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Mrs Thomas and provided a written report of his findings dated 5 March 2021.

21. Dr Burke commented on the following:

    (a) there was a single shotgun injury to the posterior aspect of the neck and the severity of the injury indicated that death was inevitable and rapid onset; and

    (b) the characteristics of the shotgun discharged showed blackish material to the lower edge of the injury indicating a close range discharge. There was a partial exit to the front of the neck. The discharge was directed from back to front and left to right and roughly horizontal.

22. Dr Burke concluded that a reasonable cause of death was:

    I(a) Shotgun injury to the neck

23. Toxicological analysis of post-mortem specimens revealed the presence of therapeutic concentrations of the antidepressant Amitriptyline, hydroxychloroquine (treatment of rheumatoid arthritis) and paracetamol and alcohol at a concentration of 0.02 g/100mL.

24. I accept the cause of death proposed by Dr Burke.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO S.67(1)(c) OF THE ACT

25. The last time Mr and Mrs Thomas were seen alive was in the afternoon of 23 November 2020, when a neighbour spotted the couple doing their usual daily walk.[22] Police investigators

[22] *Coronial Brief*, Statement of Bill Kinders dated 12 May 2021, 49

believe that in the evening of the 23 November 2020 or early morning of 24 November 2020, Mr Thomas killed Mrs Thomas by shooting her from behind with a shotgun.

26. The available evidence suggests that the couple were in bed, and Mrs Thomas was asleep but Mr Thomas was still awake. Mr Thomas got out of bed and walked to the music room where the gun safe was located. He opened the safe, took his shotgun, loading it with two shells and returning to his bedroom and aimed the shotgun to Mrs Thomas back between her shoulder blades and fired, killing Mrs Thomas.

27. Mr Thomas remained in the house for some time and made an outgoing call from the house phone to a disconnected telephone number.[23] Mr Thomas then moved to the loungeroom where he stood facing the couch closest to the hallway entrance and shot himself.

28. Several friends and family members attempted to contact Mr and Mrs Thomas from 23 November 2020 onwards without success.[24] On the 26 November 2020, the couple's niece, Amy Arthur and their neighbour, Rhonda Kinder, expressed concerns about the lack of contact and arranged to attend the residence to check on them.[25]

29. Ms Arthur and her husband attended the address around 1:30pm and used a spare key to gain access to the residence.[26] Ms Arthur's husband discovered Mr Thomas's body and asked Ms Arthur to contact emergency services.

30. Ms Arthur and her husband exited the house and called emergency services to attend.[27] Police members were first to arrive at around 1:47pm and found the deceased bodies of Mr and Mrs Thomas and commenced an investigation. Ambulance paramedics arrived shortly after and pronounced the couple deceased on site.[28]

31. The Police did not identify any signs of struggle, forced entry or of apparent third-party involvement.[29]

[23] *Coronial Brief*, Exhibit 51 Call charge records for Mr Thomas's home phone
[24] *Coronial Brief*, Statement of Amy Arthur dated 26 November 2020, 27-28
[25] Ibid
[26] *Coronial Brief,* Statement of Nicholas Arthur dated 26 November 2020, 41-43
[27] Ibid
[28] *Coronial Brief,* Statement of Ambulance Paramedic dated 6 December 2020, 208-209; Statement of Senior Constable Damien McIntosh dated 8 December 2020, 305
[29] *Coronial Brief,* Statement of Detective Senior Constable Joel Peters dated 24 June 2021, 324-327

COMMENTS

32. 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.

33. On the basis of the physical evidence as well as Dr Burke's opinion, I am satisfied to the coronial standard that Mr Thomas was capable of the actions necessary to cause Mrs Thomas's death and that she did not end her own life.

34. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr and Mrs Thomas was one that fell within the definition of 'spouse'[30] under that Act. Moreover, Mr Thomas's actions in fatally shooting Mrs Thomas constitutes 'family violence'.[31]

35. In light of Mrs Thomas's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)[32] examine the circumstances of Mrs Thomas's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[33]

36. The available evidence suggests that Mr Thomas exhibited behaviours that aligned with more traditional gender roles and beliefs of their generation. There was no evidence however to suggest that there were concerns of family violence between Mr and Mrs Thomas in the lead up to the fatal incident.

37. At the time of Mrs Thomas's death, the services that were involved with the couple were primarily focused on their health needs and there were no prevention opportunities identified in the provision of these services.

Homicide-suicides in advanced age couples

38. The available evidence in this case suggests that in the lead up to the fatal incident, Mr and Mrs Thomas experienced several significant relationship stressors including finances and deceased estate disputes, their daily care needs with advanced age and the stress over isolation

[30] Family Violence Protection Act 2008, section 9
[31] Family Violence Protection Act 2008, section 8(1)(a)
[32] 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
[33] 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

from the COVID pandemic. Mr Thomas had concerns about his own deteriorating health and that of Mrs Thomas.

39. Research into intimate partner homicide-suicides has identified a unique set of characteristics regarding homicide-suicides amongst elderly couples. Findings indicate that individuals amongst this population have often been married for many decades, may have been suffering from a significant illness at the time of the fatal incident and may have been experiencing financial problems and/or social isolation.[34]

40. Mrs Thomas's murder, and the subsequent suicide of Mr Thomas, appear to have several characteristics consistent with the category of homicide-suicides. Mr and Mrs Thomas were an elderly couple who had been married for many years and both Mr and Mrs Thomas' health had also been declining in the years and months leading up to the fatal incident.

41. Both Mr and Mrs Thomas also suffered from social isolation due to the COVID pandemic lockdown restrictions in Victoria that prevented them from 4WD activities, seeing close friends and family members and Mr Thomas visiting his dying father in hospital prior to his passing in August 2020.

42. Research highlights that in cases such as these, the act of homicide and suicide may be consensually agreed upon, '*whereby there has been an agreement that this course of action is preferable to living with a debilitating illness or unfavourable living conditions*.'[35] Police investigations into the death of Mr and Mrs Thomas, however, found no indication that Mrs Thomas was aware or agreeable to Mr Thomas's actions.

43. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.

FINDINGS AND CONCLUSION:

44. Having held an inquest into the death of Mrs Thomas, I make the following findings, pursuant to section 67(1) of the Act:

    a) The identity of the deceased was Catherine Claudia Thomas, born on 18 January 1954;

[34] Australian Government-Australian Institute of Criminology, *Murder-suicide in Australia,* No. 176 2008 <https://aic.gov.au/publications/cfi/cfi176>
[35] Roger Byard, '*Murder- Suicide; An Overview',* Forensic Pathology Reviews (2005) Vol 3, 345.

b) That the death occurred between 23-24 November 2020 at 9 Pearce Street, California Gully, Victoria from a I(a) Shotgun injury to the neck; and

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

45. I convey my sincerest sympathy to Mrs Thomas's family.

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

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

Ms Moya Poulton, Senior Next of Kin

Detective Senior Constable Joel Peters, Coroner's Investigator

Signature:

JUDGE JOHN CAIN
STATE CORONER
Date: 21 October 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.