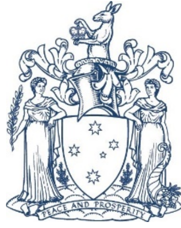

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005580

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the ***Coroners Act 2008***

Inquest into the Death of Ms AA

Delivered On:	7 April 2022
Delivered At:	Coroner's Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing Dates:	7 April 2022
Findings of:	Judge John Cain, State Coroner
Counsel Assisting the Coroner	Nicholas Ngai, Family Violence Senior Solicitor
Catchwords:	Family violence; intimate partner homicide; mandatory inquest; murder-suicide

HIS HONOUR:

BACKGROUND

1. Ms AA **(Ms AA)** was a 31-year-old woman who at the time of her death lived with housemates at Unit 83 of 8 Perth Street, Prahran.

2. Ms AA was born and grew up in Christchurch, New Zealand with her parents, Mr CC and Mrs DD and older sister, Ms EE. She was a bubbly, outgoing and friendly young woman who had a close relationship with her family.[1] She loved socialising and had a large group of friends, both male and female.

3. Ms AA was an independent young woman with an interest in travelling and seeing the world. She enjoyed multiple overseas trips on her own, visiting the USA, Singapore and travelling throughout the UK.[2]

4. In April 2017, Ms AA moved to Melbourne, Australia. Her friends in New Zealand had all settled down and she was looking for a fresh start and to continue her career as a personal assistant, the profession she had excelled in since she had left high school.[3]

5. Ms AA found a role with Deloitte within a year of moving to Melbourne. Ms AA reported to her parents that she felt she could relax as she had a great group of friends who she could socialise with. Ms AA moved to a flat with a group of young women around the same age.

6. Around May 2020, Ms AA commenced full time work as an executive assistant with a global cost consultant and quantity surveyor company. Her employer described her as '*positive person*', '*happy and always professional*'.[4]

7. In June 2020, Ms AA met Mr BB **(Mr BB)** on a mobile dating application.

8. Due to COVID-19 lockdowns, Ms AA and Mr BB's relationship progressed very quickly. The couple would go on regular dates and stay together at each others' residence after

[1] *Coronial Brief,* Statement of Mr CC dated 9 February 2021, 27
[2] *Coronial Brief,* Statement of Mr CC dated 9 February 2021, 28
[3] *Coronial Brief,* Statement of Mr CC dated 9 February 2021, 39
[4] *Coronial Brief,* Statement of Mr II dated 10 October 2020, 105

knowing each other for only two to four weeks. Ms AA described to a friend that she felt very spoilt but felt it was "*full on*" given the length of the relationship.[5]

9. Ms AA never reported any significant concerns about Mr BB to close family or friends, she felt it was easy to be in a relationship with him, that he treated her well and kept her grounded.

THE PURPOSE OF A CORONIAL INVESTIGATION

10. Ms AA's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Ms AA ordinarily resided in Victoria[6] and the death appears to have been unexpected and violent.[7]

11. 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.

12. 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 death occurred.[9]

13. 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.

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

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[5] *Coronial Brief*, Statement of Ms JJ dated 22 October 2020, 93
[6] Section 4 *Coroners Act 2008*
[7] Section 4(2)(a) *Coroners Act 2008*
[8] *Coroners Act 2008* (Vic) s 89(4),
[9] *Coroners Act 2008* (Vic) preamble and s 67.
[10] *Keown v Khan* (1999) 1 VR 69.
[11] *Coroners Act 2008* (Vic) s 69 (1).

15. 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.

16. 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.

17. 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.

18. 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.

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[12] *Coroners Act 2008* (Vic) s 67(1)(c).
[13] *Coroners Act 2008* (Vic) s 72(1).
[14] *Coroners Act 2008* (Vic) s 67(3).
[15] *Coroners Act 2008* (Vic) s 72(2).
[16] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[17] (1938) 60 CLR 336.

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

19. On the evening of 4 October 2020 Mr BB had a conversation with his housemates about his and Ms AA's relationship. He was questioning how meaningful their relationship was.[18] He felt he was putting a lot of effort into their relationship and it wasn't being reciprocated. He was extremely upset and frustrated about the situation and complained to his housemates about his circumstances.[19]

20. On 6 October 2020, Ms AA disclosed to her housemate that she had recently had an argument with Mr BB regarding her relationship history. Mr BB responded in a passive aggressive manner, crying and continuing to raise the topic of past relationships with her.[20] However, two days later, Mr BB spent the evening at Ms AA's home and appeared to be happy and content together.

21. On Friday 9 October 2020, Mr BB picked Ms AA up from her home in Prahran so that they could attend an 'American Football' themed birthday gathering at Mr BB's residence on 323 Church Street, Richmond, Victoria. Ms AA was in good spirits and had done her makeup for the occasion.[21] The group shared a meal and drinks while watching the AFL and continued the celebrations by drinking and dancing in the living room.

22. Guests on the evening described Ms AA as *'quite drunk'* and observed Mr BB to be *'a little more possessive'* and *'looking for attention from [Ms AA] more than usual'*.[22]

23. Ms AA and Mr BB proceeded to bed in Mr BB's room at around 11:30pm. At some time between 11:30pm on 9 October 2020 and 3:00am on 10 October 2020, Mr BB awoke, retrieved a 7.5kg weight plate from the rooftop of the apartment and returned to his bedroom.

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[18] *Coronial Brief,* Statement of Mr FF dated 10 October 2020, 78
[19] *Coronial Brief*, Statement of Mr GG dated 10 October 2020, 88
[20] *Coronial Brief*, Statement of Mr GG dated 22 October 2020, 98
[21] *Coronial Brief,* Statement of Mr FF dated 10 October 2020, 80
[22] *Coronial Brief,* Statement of Mr GG dated 10 October 2020, 89; Statement of Mr FF dated 10 October 2020, 80

He repeatedly struck a sleeping Ms AA to the head with the weight plate, causing serious injuries resulting in her death.[23]

24. Following the fatal assault, Mr BB fled on foot to 120 Spencer Street Melbourne, where he worked as the building manager. CCTV footage shows Mr BB using his swipe card to enter the building via the loading bay and proceed via the goods lift to the twenty-third level at 3:08 am, 10 October 2020.[24]

25. At 3:18am, Mr BB contacted '000' and requested police attendance at Unit 5 of 323 Church Street Richmond, telling the phone operator:

> *"I've just murdered my girlfriend ... Ms AA ... ... I grabbed a seven – like, a – like, a weight plate and I hit her. I struck her over the head probably about three to four times. I don't know if she's deceased but I presume so.'*[25]

26. The event was subsequently dispatched to Victoria Police units in the area. At approximately 3.20 am, Police members attended the 323 Church Street, Richmond address and began a search of the premises for Ms AA. Ambulance paramedics and police members located Ms AA's body and determined her to be deceased at 3.45 am.[26]

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

27. On 15 October 2020, Ms AA, born 14 September 1989 was identified through a comparison of dental records completed by a forensic odontologist.

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

[23] *Coronial Brief,* Exhibit 12 – 000 Phone Call transcript 10 October 2020, 231-233
[24] *Coronial Brief,* Exhibit 10 – CCTV footage 120 Spencer Street, Melbourne, 228
[25] *Coronial Brief,* Exhibit 12 – 000 Phone Call transcript 10 October 2020, 231-233
[26] *Coronial Brief*, Statement of Mr LL dated 1 January 2021, 118

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

29. Dr Sarah Parsons, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy on the body of Ms AA on 10 October 2020 and provided a written report of her findings dated 5 February 2021.

30. Dr Parsons commented on the following:

   (a) Ms AA had compressed multiple skull fractures, along with underlying intracerebral haemorrhage and a subdural haematoma.

   (b) Ms AA had injuries to multiple planes of her head, and it is likely that she was struck more than once. The injuries were consistent with having been inflicted by the weight plate located at the scene.

   (c) There is no natural disease that may have caused or contributed to Ms AA's death.

31. Dr Parsons concluded that a reasonable cause of death was:

    I(a) Blunt head trauma

32. Toxicological analysis of post-mortem specimens detected blood ethanol at a level of 0.04g/100ml.

33. I accept the cause of death proposed by Dr Parsons.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

34. 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.

35. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr BB and Ms AA was one that fell within the definition of '*de facto partner*'[27] under that Act. Moreover, Mr BB's actions in fatally assaulting Ms AA constitutes '*family violence*'.[28]

36. In light of Ms AA's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[29] examine the circumstances of Ms AA's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[30]

37. There was no evidence however to suggest that there were concerns of reported or unreported family violence between the couple in the lead up to the fatal incident. The main conflict reported by close friends of both parties was that they were at odds in relation to the long-term status of relationship. In the lead up to the fatal incident, Ms AA was questioning whether to remain in the relationship which was in stark contrast to Mr BB's serious commitment to Ms AA and the relationship.[31]

38. At the time of the couple'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.

FINDINGS AND CONCLUSION

39. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

    a) the identity of the deceased was Ms AA, born 14 September 1989;

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[27] Family Violence Protection Act 2008, section 9

[28] Family Violence Protection Act 2008, section 8(1)(a)

[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 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

[31] *Coronial Brief*, various statements of close associates of Mr BB and Ms AA detailing conflicting long term relationship aspirations of the couple.

b) the death occurred on 10 October 2020 at 5/323 Church Street, Richmond, Victoria, 3121, from blunt head trauma; and

c) the death occurred in the circumstances described above.

40. I convey my sincere condolences to Ms AA's family for their loss.

41. Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

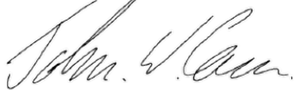
Mr CC and Mrs DD, Senior Next of Kin

Ms Kate Davey, Victorian Government Solicitor's Office

Unit Manager, Civil Litigation Unit, Victoria Police

Senior Constable Richard Smith, Coroner's Investigator

Signature:



Judge John Cain
STATE CORONER
Date: 7 April 2022

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.