IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 2851

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:	[redacted] MS
Delivered on:	29 June 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	29 June 2017
Counsel assisting the Coroner:	Leading Senior Constable, Kelly Ramsey, Police Coronial Support Unit
Representation:	Nil
Catchwords:	Homicide, no person charged with indictable offence in respect of a reportable death, mandatory inquest

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HER HONOUR:

BACKGROUND

1. [redacted] was a [redacted] man who resided at [redacted] with his sister, [redacted] and her family at the time of his death.

2. [redacted] was born in Lebanon and immigrated to Australia in 1988 to live with [redacted] after his mother died. [redacted] raised [redacted] as though he were her own child.

3. In 2006, at age [redacted], [redacted] married [redacted] and they had a daughter, [redacted]. [redacted] and [redacted] relationship was tumultuous and broke down when [redacted] was one year old. [redacted] returned to live with [redacted]

4. On 17 June 2010, [redacted] travelled to Lebanon for 13 days. On his return, [redacted] family noticed that he seemed unhappy and withdrawn. He told his family that he did not have any friends.

5. In the last ten years of his life, [redacted] was charged with and convicted of a variety of offences including serious assaults, assaults against police, driving offences, theft, robbery and criminal damage. At the time of his death, [redacted] was on bail for drug trafficking and possession charges.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. [redacted] 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.[1]

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] 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.

[1] Section 4 *Coroners Act 2008*
[2] Section 89(4) *Coroners Act 2008*

8. 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.

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

10. 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.

11. 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.

12. 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.

13. 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.

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[3] *Keown v Khan* (1999) 1 VR 69
[4] (1938) 60 CLR 336

VICTORIA POLICE HOMICIDE INVESTIGATION

14. Immediately after MS death, Victoria Police commenced a criminal investigation because the death was considered to be a homicide.

15. MS death was investigated by the Homicide Squad. Despite this investigation, no person or persons have been charged with indictable offences in connection with MS death.

16. 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."*

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

18. 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.

19. In this case, I acknowledge that the Victoria Police Homicide Squad has conducted an extremely thorough investigation in this matter.

20. In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that MS death is an unsolved and open homicide case.

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[5] (2012) VSCA 327
[6] *Perre v Chivell* (2000) 77 SASR 282

21. The Coroner's Investigator, Sergeant Sarah Woods, has provided a statement to the Court in relation to this matter.

22. The confidential nature of the Victoria Police's ongoing investigation prevents me from reciting each and every matter which has been established by the Homicide Squad. However, Sergeant Woods' statement indicates that the following important matters have been established and are able to be disclosed:

    (a) at the time of his death, [redacted] was on bail for drug trafficking and possession offences;

    (b) despite the extensive investigation conducted by the Homicide Squad, no person has been charged with an indictable offence in relation to [redacted] death; and

    (c) the homicide investigation into [redacted] death is ongoing and the file remains open.

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

23. On 26 July 2010, [redacted] identified the body of [redacted] to be that of her brother, [redacted] born [redacted]

24. 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

25. On 25 July 2010, Dr Paul Bedford, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon [redacted] body. Dr Bedford provided a written report, dated 26 October 2010, which concluded that [redacted] died from a gunshot injury to the pelvis.

26. Dr Bedford commented that [redacted] gunshot injury caused damage to the right iliac artery with extensive blood loss in the abdomen.

27. Toxicological analysis of post mortem specimens taken from [redacted] identified the presence of methylamphetamine and amphetamine.

28. I accept the cause of death proposed by Dr Bedford.

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

29. On [redacted], MS spent time at his home. He made and received a large number of telephone calls throughout the day, including approximately 50 calls in a three-hour period.

30. At approximately 6.20pm, MS left his home abruptly in his car, telling his sister that he would be home in 10 minutes.

31. Shortly after 7.00pm, an anonymous caller telephoned CrimeStoppers and stated that a group of about 10 males were standing on East Street at Hadfield. The caller said that:

    (a) two or three males from the group had rushed toward another male who was standing alone outside one of the shops;

    (b) as the males from the group reached the other male, he disappeared underneath a roller door belonging to one of the shops;

    (c) all of the males were dressed similarly; and

    (d) one of the three males who rushed toward the lone male had a shaved head and a stocky build.

32. At 7.16pm, two of MS acquaintances drove into the Northern Hospital and stopped in the emergency parking bay. The two men and a passer-by removed MS from the car and taken him into the hospital.

33. At 7.22pm hospital staff telephoned emergency services, advising police that a male had been admitted to the hospital with a gunshot wound.

34. Despite resuscitation in the Emergency Department and emergency surgery to repair his right iliac artery and other pelvic injuries, MS was unable to be saved and was pronounced deceased at 10.30pm.

FINDINGS AND CONCLUSION

35. Having investigated the death of MS and having held an Inquest in relation to his death on 29 June 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was MS born [redacted]

(b) [redacted] died on [redacted] at the Northern Hospital, 185 Cooper Street, Epping, Victoria, from a gunshot injury to the pelvis; and

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

36. Despite an extensive criminal investigation conducted by Victoria Police, no person or persons have been identified, to date, as being responsible for causing [redacted] death. On that basis, I am satisfied that no investigation which I am empowered to undertake, would be likely to result in the identification of the person or persons who caused [redacted] death.

37. I convey my sincerest sympathy to [redacted] family.

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

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

(a) [redacted] senior next of kin;

(b) Sergeant Sarah Woods, Coroner's Investigator, Victoria Police;

(c) Inspector Michael Hughes, Homicide Squad, Victoria Police;

(d) Northern Health.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 29 June 2017

Coroners Court of Victoria