IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2015 000271

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Mayumi Spencer

Delivered On:	8 June 2023
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Date(s):	2 December 2022; 16 December 2022; 13 February 2023 and 14 March 2023
Findings of:	Judge John Cain, State Coroner
Counsel Assisting the Coroner	Nicholas Ngai
Keywords	Overdose; family violence; no person charged with an indictable offence in respect of a reportable death; mandatory inquest

Amended pursuant to section 76 of the Coroners Act 2008 (Vic) on 13 July 2023 by order of the State Coroner, Judge Cain. The cover page was amended to correct the delivery date and hearing dates.

INTRODUCTION

1. On 17 January 2015, Mayumi Spencer was located deceased at an apartment in Caravel Lane, Docklands, where she resided with her husband, Peter Spencer. Mrs Spencer was 29 years old at the time of her death.

2. Mrs Spencer was born in Sapporo City, Hokkaido Prefecture, Japan on 27 August 1985 to Masami and Kimiyo Yoneda. She had one older brother.

3. Mrs Spencer was raised in Japan and graduated from Seibudai High School in Niiza City, Saitama Prefecture. After high school she completed a two-year vocational course at Kanda Institute of Foreign Languages.

4. Mrs Spencer met Dr Spencer when he was visiting Japan in 2006. They commenced a relationship in 2010 and Mrs Spencer travelled to Australia in October 2010 to live with Dr Spencer.

5. Mrs Spencer and Dr Spencer initially stayed in New South Wales for a brief period before moving to Victoria. The couple were married in Australia in December 2011.

6. Dr Spencer is a respiratory and sleep physician. Prior to her death, Mrs Spencer worked for Dr Spencer as his business manager, managing his reports, billing and invoicing.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Mrs Spencer's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural, or violent, or result from accident or injury.[1]

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

[1] *Coroners Act 2008* (Vic) s 4.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mrs Spencer's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Mrs Spencer, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

12. Section 52(2) of the Act provides the circumstances under which it is mandatory for a coroner to hold an inquest into a death. One of those circumstances is where a coroner suspects the death was a homicide and no person or persons have been charged with an indictable offence in respect of the death.

13. In this instance, I am unable to rule out the possibility that Mrs Spencer's death may be due to homicide. I note the observations of the Victorian Court of Appeal in *Priest v West*[3], 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;*

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

[3] *Priest v West* [2012] VSCA 327

and the obligation to find, if possible, that cause, and those circumstances will not have been discharged."[4]

14. Consistent with the judgment in *Priest v West*, 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 and the circumstances that led to the death. I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.

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

15. On 19 January 2015 Mayumi Spencer, born 27 August 1985, was visually identified by her husband, Peter Spencer.

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

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

17. Forensic pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 17 January 2015 and provided a written report of her findings dated 5 June 2015.

18. The post-mortem examination revealed:

    a. A bruise on Mrs Spencer's left forehead and the nasal bridge, in keeping with recent blunt force trauma. There was no evidence of patterning to these injuries.

    b. Red-brown bruises on the antecubital fossae, consistent with sites of injection.

    c. An irregular transverse sharp force injury over the midline neck extending in a posteroinferior direction and terminating at the superior left upper thyroid lobe. The injury penetrated the sternothyroid and sternohyoid muscles and was associated with extensive soft tissue haemorrhage and some subcutaneous emphysema. The trachea

[4] Ibid, para 9

was intact. No damage to major neck vessels was identified. In particular, the carotid artery and internal and external jugular vein were intact.

d. There were two incised injuries, involving the epidermis and dermis, that were associated with the penetrating neck injury.

e. There was some diffuse strap muscle bruising but there was no evidence of neck compression. The laryngeal structures were intact. There were no petechiae.

f. There was evidence of aspiration of gastric contents with material within the lung bronchi. There was no evidence of obstruction of the trachea or main bronchi and there was no evidence of significant inflammatory reaction within histological sections.

g. There was a left pneumothorax with anterior rib fractures associated with some intercostal muscle haemorrhage. These changes are often seen in the setting of cardiopulmonary resuscitation.

h. There were superficial, punctate injuries to the left breast upper inner quadrant. The significance of these injuries is uncertain.

i. There was no evidence of significant injury sufficient to cause death.

j. There was no evidence of significant natural disease.

19. Neuropathological examination showed no significant neuropathological abnormality, and no epileptogenic focus. It was noted that the absence of an identifiable epileptogenic focus does not preclude the presence of clinical seizure disorder, although Mrs Spencer had no history of clinical seizure disorder. It was also noted that seizure-like activity can occur in the setting of acute cerebral hypoxia and can also be seen associated with drug use. Seizure is also a recognized potential side effect of cocaine use.

20. Toxicological analysis of post-mortem samples identified the presence of cocaine and numerous cocaine metabolites. One of the metabolites, coca ethylene, is formed as a metabolite of both alcohol and cocaine use and is considered to exacerbate the toxic effects of cocaine. No alcohol was detected. Paracetamol and propranolol were also detected at levels consistent with therapeutic use.

21. It was noted that the interpretation of post-mortem toxicology is complicated by multiple factors, including post-mortem redistribution, idiosyncratic drug reactions, drug metabolism, the time interval between ingestion of the drug and death, and the potential for developing drug tolerance. It is possible for a person to develop tolerance to cocaine use.

22. The levels of cocaine found in Mrs Spencer's post-mortem samples were high.

23. It was noted that the physiological effects of cocaine use are similar to those seen in methamphetamine users. These effects include hypertension, increased body temperature, psychological effects, and cardiac arrhythmias. Propranolol is a medication that is commonly used for the treatment of high blood pressure and cardiac arrhythmias. There is no record that the propranolol was administered by the attending ambulance officers.

24. There were no external stigmata of chronic injection drug use. There was no pathological evidence of chronic injection drug use.

25. Dr Francis provided an opinion that the medical cause of death was 1(a) Cocaine Toxicity.

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

26. On the evening of 16 January 2015, Mrs Spencer and Dr Spencer went out for dinner and then visited a bar in Melbourne with friends. They returned to their apartment at 1.10am the following morning.

27. In a statement provided to the coroner's investigator, Dr Spencer stated that in the early hours of the morning on 17 January 2015, at approximately 4.00am, Mrs Spencer had a fit and began vomiting.[5] He attempted to resuscitate her. Whilst doing so, Mr Spencer formed the belief that there was a blockage in her throat and consequently attempted to perform a cricothyroidotomy on her using a kitchen knife and pen. This procedure was unsuccessful.[6]

[5] *Coronial Brief,* Statement of Dr Peter Spencer dated 17 January 2015, 368
[6] Ibid

28. At 7.38am on 17 January 2015, Dr Spencer contacted emergency services and reported that Mrs Spencer was not breathing.[7]

29. Ambulance Victoria paramedics arrived at 7.49am and observed Mrs Spencer to be lying on the floor in the lounge area.[8] Dr Spencer appeared to be attempting cardiopulmonary resuscitation (**CPR**), although paramedics observed that compressions appeared to be "*pretty gentle*".[9]

30. Mrs Spencer was declared deceased at the scene by the attending paramedics. Her temperature was taken and noted to be 33.2 degrees, which suggested that she had been deceased *'for a considerable amount of time.'*[10]

31. Cocaine was located inside a blood-stained hand vacuum in the apartment, and a bloodstained towel, syringes and plastic bags containing cocaine were found under some clothes inside the washing machine.[11]

32. Dr Spencer was taken to the Melbourne West Police Station and was examined by a Forensic Physician employed by the Victorian Institute of Forensic Medicine.[12] The Forensic Physician noted bilateral bruised veins that had the appearance of needle track marks on the inner elbow crease of both elbows. The bruised veins on the inner aspect of both elbows were noted to be evidence of intravenous access with needles.[13]

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[7] Coronial brief, ESTA 000 emergency call transcript, 350

[8] Coronial brief, Statement of A Eade, 247

[9] Ibid, 248

[10] Ibid, 249.

[11] Coronial brief, VIFM toxicology report on pages 303-304 and Statement of Victoria Police Forensic Services, 301-302.

[12] Coronial brief, Statement of Dr Morris Odell, 315

[13] Ibid, 316

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

33. The relationship between Mrs Spencer and Dr Spencer met the definition of *'family member'*[14] as defined by the *Family Violence Protection Act 2008* (Vic) (**FVPA**). Evidence available to the court suggests that Dr Spencer's perpetrated *'family violence'*[15] towards Mrs Spencer during their relationship.

34. As Mrs Spencer's death occurred in circumstances where there was an apparent history of family violence, I requested that the Coroners Prevention Unit (**CPU**)[16] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[17]

35. Statements from friends and family of the Spencers, and service records from GenWest[18] and the Consulate-General of Japan suggest that Dr Spencer perpetrated family violence towards Mrs Spencer during their relationship in the form of physical abuse, emotional and psychological abuse, and coercive and controlling behaviour. Mrs Spencer stated to friends that Dr Spencer had kicked her out of their house on several occasions late at night, punched her in the jaw, slapped her, pushed her over and hit her, sent her abusive messages calling her a *'piece of shit'* and a *'whore'*,[19] and on one occasion, had allegedly injected her with cocaine against her wishes.[20]

36. It was also alleged that Dr Spencer made threats to kill Mrs Spencer and himself, exhibited jealous behaviour, monitored Mrs Spencer's email and Facebook and only permitted her to

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

[15] Family Violence Protection Act 2008, section 5

[16] 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

[17] 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

[18] A specialist family violence service then known as Women's Health West.

[19] Coronial brief, Statement of D Cone 207.

[20] Coronial brief, Statement of S James, 199; Statement of D Cone, 207.

meet with her friends when he was present. On at least one occasion, Mrs Spencer advised a friend that she was scared of Dr Spencer.

37. In July 2012, following a family violence incident, Mrs Spencer moved out of the marital home and told Dr Spencer that she wanted a divorce. Friends and family of Mrs Spencer encouraged her to return home to Japan, but Mrs Spencer stated she was unable to as Mr Spencer had her passport, and she had no money.

38. Mrs Spencer contacted the Consulate-General of Japan for assistance in obtaining emergency travel documentation and reported to consulate staff that she wanted a divorce from her husband, and that she was scared of him because he had been violent towards her. The consulate commenced her application, referred Mrs Spencer to Victoria Police and provided her with the contact details of family violence support services. However, Mrs Spencer subsequently advised the consulate she had resolved matters with her husband and no longer needed to return to Japan.[21]

39. During this time, Dr Spencer sent a series of abusive text messages to Mrs Spencer. When Mrs Spencer refused to contact him, he attended the workplace of one of Mrs Spencer's friends, allegedly telling her that he *'could not live without'*[22] Mrs Spencer and *'would kill [Mrs Spencer] and then himself.'*[23]

40. On 15 August 2012, Mrs Spencer applied for and obtained an interim Family Violence Intervention Order (FVIO) against Dr Spencer which included conditions that prohibited him from contacting or communicating with her. Mrs Spencer was supported through the court process by a family violence support service, GenWest.[24] Mrs Spencer reported to GenWest that Dr Spencer was verbally, emotionally and psychologically abusive and had also physically abused her in the past although she had not reported this to the police. Mrs Spencer also indicated that she was scared of Dr Spencer.

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[21] Coronial brief, Statement of Y Nemoto, 219

[22] Coronial brief, Statement of S James, 200.

[23] Ibid.

[24] At the time this service was known as Women's Health West.

41. The FVIO was served on Dr Spencer on 20 August 2012. Later that same day, Dr Spencer reportedly advised Mrs Spencer that he was going to suicide and had taken several medications with an intent to overdose. Mrs Spencer contacted police and Dr Spencer was transported to the Royal Melbourne Hospital for medical treatment and a mental health assessment.

42. After this incident Mrs Spencer resumed her relationship with Dr Spencer, telling a friend that *she was scared to leave [Dr Spencer] in case he tried to kill himself again and that it was her fault [that] he had tried to commit suicide, and it was her fault that he has ruined his career.'*[25]

43. On 29 September 2012 at the Melbourne Magistrates' Court, Mrs Spencer's FVIO application was withdrawn on the basis that Dr Spencer had provided an undertaking to the court.

44. On 2 February 2013, a family violence report was made to Victoria Police by Dr Spencer. Dr Spencer reported that Mrs Spencer had taken his keys and credit card after he reportedly refused to discuss their marital issues. Police recorded the incident as a verbal dispute, with no threats or violence, and noted that neither party was in fear for their safety. Mr Spencer was recorded by police as the Affected Family Member (AFM) and Mrs Spencer as the Respondent. Formal referrals were provided to both parties, and Mrs Spencer was referred to GenWest.

45. GenWest contacted Mrs Spencer via telephone on 11 February 2013. Mrs Spencer advised them that she had withdrawn her FVIO against her husband and that she felt safe with him. Mrs Spencer indicated that she did not require further assistance from their service and knew the contact phone numbers for family violence support services and emergency services and would call them if needed. This was the last family violence service contact identified prior to Mrs Spencer's death.

[25] Coronial brief, Statement of M Yoneda, 87; Statement of S James, 200-202; Ambulance Victoria, patient care record relating to Peter Spencer dated 20 August 2012.

46. In a statement to police, made after Mrs Spencer's death, Dr Spencer admitted that he and Mrs Spencer *'fought a lot at the start'* of their relationship but said that, recently, the *'relationship had been really good'*.[26]

47. On 28 November 2022, Dr Spencer provided a number of statements and a response to the Court. The statements from close fiends and associates provided by Dr Spencer purport to indicate observations of the couple being happy in the 18 months leading up to the fatal incident and that Mrs Spencer reported a desire to have children.

Medical investigation

48. The available evidence indicates that there was a significant delay between when Dr Spencer reportedly noticed that Mrs Spencer required medical attention (approximately 4.00am) and when he contacted emergency services (7.38am).

49. In a statement made following Mrs Spencer's death, Dr Spencer indicated that after he discovered Mrs Spencer in medical distress, he spent some time attempting to resuscitate her and attempting to perform a cricothyroidotomy [27]upon her. It is unclear how long he performed these actions for.

50. The Australian and New Zealand Council on Resuscitation Guidelines[28] outline what to do when encountering an apparently critically unwell patient. One of the first actions outlined by the guidelines is to call for help.

51. In an expert opinion provided to the court, Dr Anthony Cross noted that even in a stressful situation, such as the one involved in this matter, which required a doctor to attempt resuscitation upon his own wife in a domestic setting, he;

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[26] Coronial brief, Appendix D - Statement of P Spencer.

[27] A cricothyrotomy is an incision made through the skin and cricothyroid membrane to establish a patent airway during certain life-threatening situations, such as airway obstruction by a foreign body, angioedema or massive facial trauma.

[28] ANZCOR Guideline 3 – Recognition and First Aid Management of the Unconscious Person and ANZCOR Guideline 8 – Cardiopulmonary Resuscitation (CPR) https://resus.org.au/guidelines.

'would expect a very early response (if not the first) to be the calling of an ambulance. More specifically, I would consider it reasonable, given Peter Spencer's medical training and concern for aspiration of vomitus to undertake the actions [Dr Spencer described] to attempt to clear the airway before calling an ambulance. However, these actions can be performed rapidly and should be abandoned quickly if not successful, leading to only a very short delay (less than a minute or two) before calling the ambulance.'[29]

52. Based on the available evidence, I am unable to determine whether Mrs Spencer would have survived if emergency services had been called sooner.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

53. Despite a thorough and comprehensive criminal investigation in relation to the circumstances of Mrs Spencer's death, no person or persons have been charged with an indictable offence in relation to Mrs Spencer's death.

54. It is important to note that it is not the purpose of a coronial investigation to investigate possible criminal conduct and compile a brief of evidence in preparation for a future criminal trial. Section 69 of the Act expressly prohibits a coroner from including in a finding or a comment, any statement that a person is or may be guilty of an offence.

55. After a careful review of the available evidence, I have formed the belief to the coronial standard that an indictable offence may have been committed in the circumstances of Mrs Spencer's death. The indictable offence I have formed the belief to the requisite standard is negligent manslaughter due to the delays in seeking urgent medical assistance and Dr Spencer's duty of care to Mrs Spencer upon discovering her in a state requiring urgent medical assistance.

56. Accordingly pursuant to section 49(1) of the Act, I direct that the Principal Registrar notify the Director of Public Prosecutions that I believe an indictable offence may have been committed in connection with Mrs Spencer's death.

[29] Coronial brief, Statement of A Cross.

FINDINGS AND CONCLUSION

57. Having held an inquest into the death of Mayumi Spencer, I make the following findings, pursuant to section 67(1) of the Act:

    a. the identity of the deceased was Mayumi Spencer, born 27 August 1985;

    b. the death occurred on 17 January 2015 at 514/5 Caravel Lane, Docklands, Victoria;

    c. the cause of death was (1)(a) Cocaine toxicity; and

    d. the death occurred in the circumstances described above.

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

59. I convey my sincere condolences to Mrs Spencer's family for their loss.

60. 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.

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

    Dr Peter Spencer, Senior Next of Kin

    Lily Hardman, Australian Health Practitioner Regulation Authority

    Detective Acting Sergeant Leigh Smyth, Coroner's Investigator

Signature:

Date: 13 July 2023

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.