IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 005020

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Dannyll Ann Goodsell
Date of birth:	30 January 1985
Date of death:	05 October 2018
Cause of death:	1(a) INCISED INJURIES TO THE NECK
Place of death:	1 Kenworthy Place, Mount Pleasant, Victoria, 3350
Keywords:	Family violence; intimate partner homicide

INTRODUCTION

1. On 5 October 2018, Dannyll Ann Goodsell was 33 years old when she was murdered by her partner, Scott Cameron. At the time of her death, Ms Goodsell lived in a public housing residence in Ballarat.

2. Ms Goodsell was born on 30 January 1985 at Sutherland Hospital. She was the firstborn child of Donna Goodsell and Nigel Goodsell and had two younger siblings.

3. Ms Goodsell was raised in Mount Druitt in New South Wales and completed her Year 10 Certificate at Wyong TAFE.

4. Ms Goodsell had two children, a daughter and son, aged 14 and 10 respectively at the time of her death. Both of these children resided with Ms Goodell's mother.

5. Ms Goodsell moved to Victoria from New South Wales in 2014.

6. Ms Goodsell commenced a relationship with Mr Cameron in August 2018 and Mr Cameron moved into Ms Goodsell's residence shortly afterwards.

THE CORONIAL INVESTIGATION

7. Ms Goodsell'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.

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.

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 Ms Goodsell'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 Dannyll Ann Goodsell 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.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

12. In the days preceding her death Ms Goodsell told several friends that she was scared of Mr Cameron and wanted to end her relationship with him, but she was worried about what he would do to her.

13. At approximately 10.30pm on 4 October 2018 Ms Goodsell visited the home of a friend and indicated that she had been fighting with Mr Cameron and needed to get away to have some time on her own. Approximately one hour later Mr Cameron attended the residence and asked Ms Goodsell to leave with him, but Ms Goodsell refused and said she would come home soon. Mr Cameron reportedly took Ms Goodsell's bag and told her she could have it back when she came home.

14. Ms Goodsell told her friend that she was hoping Mr Cameron would leave and not be at her residence when she returned. Ms Goodsell's friend noted that Ms Goodsell seemed scared to go home.

15. Mr Cameron returned to Ms Goodsell's residence and packed some of his personal belongings. He then left and attended the residence of a friend who lived in Ballarat Central. During this visit, Mr Cameron's friend observed that Mr Cameron had incised injuries to his right forearm, which Mr Cameron stated were self-inflicted. Mr Cameron showed his friend a knife and hatchet that he had in his possession at this time.

[1] 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.

16. Ms Goodsell returned to her home later that evening. At 11.42pm a friend of Ms Goodsell called her and spoke to her for about five minutes. During this conversation Ms Goodsell sounded distressed and out of breath. She told her friend that Mr Cameron had put his hands around her throat a week prior and she was worried about what he would do to her. Ms Goodsell's friend offered for Ms Goodsell to stay with her, but Ms Goodsell was unable to leave as she had no car and was unable to get a lift.

17. Ms Goodsell later messaged her friend at 1.45am indicating that she thought she would be okay.

18. In the early hours of the morning on 5 October 2018 Mr Cameron sent a text message to Ms Goodsell telling her he had self-harmed and wanted to come back to her residence. Mr Cameron said everything was okay, to which Ms Goodsell responded '*It's not all OK'*. Mr Cameron stated that he loved her and Ms Goodsell responded *'if you love someone you would not harm them or control them'*.

19. At 1.41am Mr Cameron left his friend's home in Ballarat Central and returned to Ms Goodsell's residence.

20. Ms Goodsell continued to send messages to her friends during the early hours of the morning. In a text message exchange between 3.25am and 3.30am, a friend of Ms Goodsell asked her to come and see them and she replied that she could not, writing *'you will get me shot'*.

21. During a text message exchange between Ms Goodsell and another friend between 3.45am and 4.56am, Ms Goodsell sent a message at 4.56am stating *'I'm scared of Scott'*.

22. At some point after Ms Goodsell sent this message, Mr Cameron stabbed her over 50 times with a sharp implement, causing her death.

23. Mr Cameron attempted to clean the scene with bleach and placed Ms Goodsell's body under her bed. He then set fire to some items in a cabinet beside the bed and left the residence.

24. At 7.50am two of Ms Goodsell's friends and their mother attended her residence. They noticed the smell of smoke and could hear a smoke alarm. They attempted to gain entry to the residence and noticed blood in the living room through the window. They contacted emergency services. Members of the fire brigade attended and extinguished a small fire in the bedside cabinet. They then located Ms Goodsell's body.

25. Mr Cameron was arrested on 6 October 2018. He initially pleaded not guilty to the murder of Ms Goodsell, however he later changed this to a plea of guilty. On 5 June 2020 in the Supreme Court of Victoria Mr Cameron was sentenced to a term of imprisonment of 29 years for the murder of Ms Goodsell.[2]

Identity of the deceased

26. On 8 October 2018, Dannyll Ann Goodsell, born 30 January 1985, was identified via fingerprint identification undertaken by the Victorian Institute of Forensic Medicine.

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

Medical cause of death

28. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 6 October 2018 and provided a written report of her findings on 6 December 2018.

29. The post-mortem examination revealed:

    a) There were in excess of 50 incised (sharp force) injuries to the face, scalp, neck and arms. These injuries were mainly clustered over the head, neck and shoulders.

    b) The mechanism of death was exsanguination (blood loss), which results in circulatory collapse.

    c) There were defence type injuries in multiple orientations on both hands and forearms.

    d) Some bruises were seen over the neck, left leg, arms and chest. These did not show obvious patterning and did not contribute to Ms Goodsell's death.

    e) There was no soot in the airways, and no detection of carboxyhaemoglobin or hydrogen cyanide in Ms Goodsell's blood. The presence of these compounds in significant quantities can indicate smoke inhalation.

    f) There was no significant natural disease that could have caused or contributed to Ms Goodsell's death.

[2] *R v Cameron* [2020] VSC 334

30. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine and amphetamine in Ms Goodsell's blood. There was also detection of paracetamol, cannabis metabolites and the benzodiazepines nordiazepam (a metabolite of diazepam), temazepam and oxazepam (both diazepam metabolites and medications in their own right).

31. Dr Archer provided an opinion that the medical cause of death was 1(a) Incised injuries to the neck.

FURTHER INVESTIGATIONS AND CORONERS PREVENTION UNIT REVIEW

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. The relationship between Ms Goodsell and Mr Cameron met the definition of *'family member'* as described by the *Family Violence Protection Act 2008* (Vic) (FVPA).[3] Moreover, Mr Cameron's actions towards Ms Goodsell during and after their relationship, including his fatal assault of Ms Goodsell, constituted *'family violence'*.[4]

34. In light of Ms Goodsell's death occurring in circumstances of family violence, I requested that the Coroners Prevention Unit (CPU)[5] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[6]

Family violence risk factors

35. Mr Cameron had an extensive criminal history prior to his relationship with Ms Goodsell, which included charges relating to his perpetration of family violence. Mr Cameron served a term of imprisonment from 20 December 2017 to 16 June 2018 and was released shortly before he commenced his relationship with Ms Goodsell.

36. Both Ms Goodsell and Mr Cameron were regular users of illicit substances, predominantly methylamphetamines.

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[3] *Family Violence Protection Act 2008* (Vic), s 8.
[4] *Family Violence Protection Act 2008* (Vic), s 5.
[5] The CPU 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.
[6] The VSRFVD provides assistance to 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.

37. Mr Cameron also had a history of mental ill health and suicidal ideation.

Family violence in the relationship

38. Mr Cameron appears to have perpetrated family violence towards Ms Goodsell throughout their relationship.

39. Friends of Ms Goodsell reported witnessing Mr Cameron acting *'aggravated'* and *'nasty'* towards Ms Goodsell. Ms Goodsell reported to her friends that Mr Cameron was controlling, psychologically and physically abusive, and had damaged her property including her phone. She reported that he restricted her movements, did not let her go anywhere alone, constantly checked on her and monitored her phone messages. She also reported that he had threatened to suicide if she ever left him or was unfaithful to him. Ms Goodsell also showed a friend text messages in which Mr Cameron threatened to suicide if Ms Goodsell did not reconcile with him.

40. In the week prior to the fatal incident Mr Cameron allegedly assaulted Ms Goodsell by placing his hands around her throat and choking her.

Proximate service contact

41. The family violence perpetrated by Mr Cameron against Ms Goodsell does not appear to have been reported to any services prior to the fatal incident. The most proximate contact that either party had with services was in early August 2018, and this related to Mr Cameron's mental health.

42. On 10 August 2018 Mr Cameron presented to Ballarat Health for a mental health assessment after expressing suicidal ideation and was admitted overnight. Records from this interaction indicate that Mr Cameron reported being in a relationship with Ms Goodsell at this time.

43. Ballarat Health discussed anger management strategies with Mr Cameron, and healthier ways for him to release his anger. However, there is no indication that these discussions related to him perpetrating family violence against Ms Goodsell.

44. Mr Cameron was discharged from Ballarat Health on 11 August 2018 with a plan for him to receive community follow-up, however he did not attend his scheduled post-discharge review appointment. Staff from Ballarat Health made numerous attempts to contact Mr Cameron, including via telephone and post, and conducted an unscheduled home visit to Ms Goodsell's residence, however they were unable to contact him. As a result, Mr Cameron was discharged

from the service and a discharge summary was sent to Mr Cameron's General Practitioner advising him of Mr Cameron's recent admission and discharge.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

45. The available evidence suggests that several of Ms Goodsell's friends and associates were aware of or suspected that Mr Cameron was perpetrating violence against Ms Goodsell prior to her death, but it does not appear that any relevant support services were contacted in relation to this violence.

46. There have been many family violence homicides examined by this court where third parties were aware of or suspected that family violence was occurring in a relationship prior to a family violence related death but no services were contacted in relation to this family violence. This is consistent with research which indicates that victims of family violence are more likely to talk to family and friends about their experiences of violence than contact a family violence support services or the police.[7]

47. I note that Ms Goodsell and many of the friends she disclosed the family violence to were also users of illicit substances. This may have created an additional barrier to them interacting with services and contributed to their apparent reluctance to engage with, or make reports to, police. Research indicates that negative perceptions of previous interactions with police by people who use illicit substances may lead to long-term negative views about police, and this may impact on their cooperation with police.[21]

48. At the time of Ms Goodsell's death, there was limited information and resources available to third parties to assist them in accessing information about family violence and providing support to persons experiencing family violence. In the coronial findings into the deaths of

[7] Glennys Parker and Christina Lee, 'Violence and abuse: An assessment of mid-aged Australian women's experiences' (2002) 37(2) Australian Psychologist 142-148; Jenny Mouzos and Toni Makkai, 'Women's Experiences of Male Violence: Findings from the Australian Component of the International Violence Against Women Survey (IVAWS)' (Research and Policy Series No 56, Australian Institute of Criminology, 2004) 101; Janet Fanslow and Elizabeth Robinson, 'Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand.' (2010) 25(5) J Interpers Violence 929-951.

Mrs FS[8], Mrs ZT[9], Mrs K[10], Mrs VT[11], and John Reed[12] I noted this issue and recommended that the Victorian Government and Family Safety Victoria

> *develop a research based strategy, in consultation with victim survivors, informal supporters and priority communities, to provide targeted information and services to informal supporters assisting persons affected by family violence.*

49. This recommendation was accepted in full by Family Safety Victoria (FSV). Since that time FSV have undertaken work across several areas to improve the assistance available to third parties assisting persons affected by family violence. This included the release in March 2020 of a *'Family Violence Support During COVID-19 Practice Note'* which provided information for third parties on what they should do if they were concerned someone they knew needed help, as well as information regarding the services that could assist. The Orange Door website[13] also contains information and advice for persons who are worried that someone they know may be experiencing or perpetrating family violence.

50. The Victorian Government has released the *Victorian Family Violence Research Agenda 2021-2024* (the Research Agenda), which identifies the primary prevention of family violence as a research priority. The Research Agenda notes that research in this area should include critical elements of primary prevention work such as research into the role of bystanders. I endorse the inclusion of this issue in the Research Agenda and note the importance of further research being conducted in this space.

51. I also note that Safe and Equal[14] has undertaken extensive work to improve family violence awareness and resources for third parties. This work has included the launch of the inaugural *'Are you safe at home?'* day and a new website which provides information and resources for the community to assist them in helping someone who may be unsafe at home.[15]

[8] COR 2017 2423
[9] COR 2016 2733
[10] COR 2017 1889
[11] COR 2016 1879
[12] COR 2015 3624
[13] https://www.orangedoor.vic.gov.au/
[14] Safe and Equal is the peak body for specialist family violence services providing support to victim survivors in Victoria.
[15] https://areyousafeathome.org.au/

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Dannyll Ann Goodsell, born 30 January 1985;

    b) the death occurred on 05 October 2018 at 1 Kenworthy Place, Mount Pleasant, Victoria, 3350, from incised injuries to the neck; and

    c) the death occurred in the circumstances described above.

53. I convey my sincere condolences to Ms Goodsell's family for their loss.

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

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

Donna Goodsell, Senior Next of Kin

Sergeant Scott Riley, Coroner's Investigator

Signature:

Judge John Cain
STATE CORONER
Date: October 6, 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 investigation. 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.