IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 001071

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:	AA
Date of birth:	15 December 1961
Date of death:	27 February 2019
Cause of death:	1(a) Positional asphyxia
Place of death:	Victoria
Keywords:	Family violence; Homicide

INTRODUCTION

1. On 27 February 2019, AA was 57 years old when she was discovered deceased in her brother, BB's car. At the time of her death, AA was visiting relatives in Australia and was normally resident in China.

2. BB and AA were two of six siblings. BB, born on 3 October 1950,[1] was the eldest and only son.[2] AA, born on 15 December 1961,[3] was the youngest sibling. BB and AA's four other sisters were CC, DD, EE, and FF.[4] All the siblings were born in China to GG and HH.[5]

3. BB had a long history of regular verbal confrontations with his sisters regarding a range of issues, including property previously owned by their parents, financial interactions, and the challenges of financially and physically caring for their aging father. BB repeatedly expressed resentment towards AA and their other sisters in response to these issues and the financial support that BB had given to various family members upon their immigration to Australia.[6]

4. In 1989, BB moved to Australia to study and later became an Australian citizen.[7] Over time, three of BB's sisters, DD, EE and FF, and some of their children, also moved to Australia.[8] BB stated that over the years he assisted his siblings and their families, as well as other family members to immigrate to Australia.[9] In 2012, BB's father, GG, moved to Australia to be cared for by his children after being diagnosed with and initially treated for kidney cancer in China.[10] GG first lived with his daughter, FF, for a year before moving into his daughter EE's home.[11]

5. In November 2018, EE was diagnosed with cancer and could no longer care for GG.[12] After GG was hospitalised and discharged in December 2018, GG moved to BB's home.[13] EE's son, II, reported that BB would come to their house and verbally abuse his mother, telling her that she owed him and the entire family was indebted to him.[14]

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[1] Coronial Brief, Transcript of Record of Interview of BB, 248.
[2] Ibid 255.
[3] Coronial Brief, Statement of Identification of the Deceased, 204.
[4] Coronial Brief, Family Tree, 206.
[5] Ibid.
[6] Coronial Brief, Transcript of Record of Interview of BB, 296-301. Coronial Brief, Family History Document, 208-222.
[7] Coronial Brief, Statement of EE, 89. Coronial Brief, Family History Document, 209.
[8] Coronial Brief, Family Tree 206.
[9] Coronial Brief, Transcript of Record of Interview of BB, 299.
[10] Coronial Brief, Family History Document, 213.
[11] Coronial Brief, Statement of EE, 91-92.
[12] Coronial Brief, Family History Document, 215.
[13] Ibid 216
[14] Coronial Brief, Statement of II, 75-76.

6. AA, who lived in China, came to Melbourne with her husband in December 2018 to visit her son, father and other family members who lived in Melbourne.[15]

7. At the end of 2018, GG's health was declining and he required twenty-four-hour care. GG required assistance with all activities of daily living including eating, toileting, and bathing.[16] BB slept next to his father to provide him with care throughout the night.[17]

THE CORONIAL INVESTIGATION

8. AA'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.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into AA'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.

12. This finding draws on the totality of the coronial investigation into AA's death 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.[18]

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[15] Ibid.

[16] Eastern Health medical records relating to GG – Part 1, Discharge summary - 6 December 2018, 55. [17] Coronial Brief, Transcript of Record of Interview of BB, 323.

[18] 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

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

Circumstances in which the death occurred

13. GG was admitted to the hospital on 22 February 2019.[19] Upon his release on 26 February 2019, GG returned to BB's home with BB. AA accompanied her father and brother and intended to stay overnight to assist with their father's transition home.[20] That evening, BB's partner, LL, visited the home and found BB and AA arguing about money.[21] LL left shortly thereafter with the impression that things had settled down.[22]

14. BB later disclosed to investigating police that at around 7:00 am the next morning, he and AA argued again about money, the care of their father, and BB's inability to travel to their uncle's birthday party in Taiwan because other family members would not care for their father.[23] During the argument, BB physically assaulted AA, causing her significant injuries and likely rendering her unconscious.[24]

15. BB then wrote two notes asking for police members, or whomever read the notes, to contact his sisters DD or FF to take care of their father.[25] He stated that he had killed his sister AA '*to achieve justice'* and labelled himself '*justice maker'*.[26]

16. BB then put AA's body in the boot of his car and drove to his sister EE's house.[27] BB exited his car with a metal bar and approached his nephew, II, who was outside. BB hit II with the bar several times in two different incidents before II got control of the bar and restrained his uncle.[28] BB stated several times that he had killed AA and that her body was in the boot of his car.

17. II's wife called triple zero for assistance and, when police arrived, BB allegedly told them that he had killed his sister AA and that her body was in the boot of his car.[29] Attending police members and paramedics confirmed that AA was deceased.[30]

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[19] Eastern Health medical records relating to GG – Part 1, Discharge Summary - 6 December 2018, 55.
[20] Coronial Brief, Family History Document, 218.
[21] Coronial Brief, Statement of LL, 64-65.
[22] Ibid 66.
[23] Coronial Brief, Transcript of Record of Interview of BB, 301.
[24] Coronial Brief, Transcript of Accused Phone Call, 240.
[25] Coronial Brief, Transcript of Record of Interview of BB, 288.
[26] Coronial Brief, Notes Left by Accused, 235-236.
[27] Coronial Brief, Transcript of Record of Interview of BB, 325.
[28] Coronial Brief, Statement of II, 68-69.
[29] Coronial Brief, Statement of Senior Constable Christopher Cooper, 134.
[30] [2020] VSC 701, 16

18. BB was charged with the murder of his sister and criminal proceedings were commenced against him.

19. At the conclusion of BB's criminal trial in the Supreme Court of Victoria, the trial judge noted that BB was experiencing fatigue and exhaustion in the days before the incident and the morning of the incident.[31] The trial judge also found that there was '*animosity and tension between the accused and the deceased in the weeks prior to the incident*.'[32]

20. On 23 December 2020, BB was sentenced to 10 years' imprisonment for the offence of manslaughter by unlawful and dangerous act. For the attack on his nephew, BB was also sentenced to 12 months imprisonment with nine months consecutively served with the manslaughter sentence for the offence of intentionally causing injury. The total effective sentence was 10 years and three month's imprisonment with a fixed non-parole period of six years and four months.[33]

Identity of the deceased

21. On 4 March 2019, AA, born 15 December 1961, was visually identified by her son, JJ.

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

Medical cause of death

23. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 27 February 2019 and provided a written report of her findings dated 14 June 2019.

24. The post-mortem examination revealed the following:

    a) There was evidence of blunt force trauma in a pattern strongly indicative of a recent assault. Bruising was evident to the left and right scalp, jaw, cheeks, upper back, chest and limbs. There was also evidence of orbital fractures around the right eye socket;

    b) There was further evidence of bilateral rib fractures involving the front and side of the chest on both sides;

[31] Ibid, 75.
[32] Ibid.
[33] [2020] VSC 884, 10.

c) Neuropathology examination showed some minor acute subarachnoid haemorrhage in a distribution that is consistent with blunt force trauma. Loss of consciousness from blunt force trauma is a possibility indicating possible positional asphyxia. This form of asphyxia involves positioning of the body in a way that compromises breathing, and it can cause or contribute to death; and

d) There was no evidence of any other significant natural disease that caused or contributed to death.

25. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

26. Dr Archer provided an opinion that the cause of death was 1 (a) Unascertained.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

27. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by a family member is particularly shocking, given that all persons have a right to safety, respect and trust in their familial relationships.

28. For the purposes of the *Family Violence Protection Act 2008*, the relationship between BB and AA was one that fell within the definition of '*family member*[34] under that Act. Moreover, BB's actions in fatally assaulting AA constitutes '*family violence'*.[35]

29. In light of AA's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[36] examine the circumstances of AA's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[37]

[34] Family Violence Protection Act 2008, section 8(1)(c)
[35] Family Violence Protection Act 2008, section 5
[36] 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
[37] 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

COMMENTS

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

Caring for an aged relative

30. The available evidence indicates that at the time of the fatal incident, BB was experiencing significant pressure and fatigue in caring for his father, GG. GG was in Australia on a medical treatment visa and was ineligible for many supports available only to Australian Citizens and Permanent Residents.

31. During an interview with police after the fatal incident, BB spoke of his belief that he had financially supported his family in numerous ways and that he had supported their emigration to Australia. In return, BB advised that he felt his sisters had cheated him out of money from their parents' property, took advantage when he gave them money, and had failed to assist him when he needed their financial and physical support with caring for their father.[38]

32. BB particularly noted that he had planned to attend a birthday party for their uncle in Taiwan, traveling on 28 February 2019, but that AA had refused to look after their father so that he could go.[39] BB also reported that he had had additional conflict with AA about care of their father when BB hurt his back in early February and wanted assistance with that care.[40] BB also believed his sister refused to provide financial assistance to pay for their father's grave and believed that she was financially able to assist.[41]

33. In Australia, family, friends and community are a crucial part of the aged care system. They are considered integral to the wellbeing of older people, and to ensuring safe and high-quality care.

34. The value of informal carers to the sustainability of the aged care system is difficult to overstate, but their work is largely invisible. From the number of informal carers, the economic value they contribute, and the important care and support that they provide, there is no doubt that the aged care system depends on the invaluable contribution of informal carers. The issue of informal carer fatigue and supports was examined as a significant concern by the recent Royal Commission into Aged Care Quality and Safety (**Royal Commission**).[42]

[38] Coronial Brief, Transcript of Record of Interview of BB, 296-301.
[39] Ibid 258.
[40] Coronial Brief, Family History Document, 217-218. Coronial Brief, Statement of II, 76.
[41] Coronial Brief, Transcript of Record of Interview of BB, 298.
[42] *Royal Commission into Aged Care Quality and Safety* (2021) Final report, Volume 2, Chapter 5.

35. The Royal Commission noted that a caring role can have detrimental effects on the health, wellbeing and financial security of the carer. Over time, this can affect the quality of care an older person receives and the sustainability of the caring relationship. Evidence provided to the Royal Commission further highlighted issues that the current aged care system provides reactive, inadequate support to informal carers. Supports are often not provided until the strain on a caring relationship has already reached crisis point.

36. The Royal Commission confirmed that informal carers face many challenges with accessing services, notably:

    a) there is no formal mechanism to link carers to services. Rather, the system relies on a carer self-identifying as a '*carer'* and knowing where to go for support. Many people providing care to friends, partners or parents do not identify with the term '*carer'*;

    b) carers are required to undertake separate intake and assessment processes if they are seeking supports for themselves as well as for the person they care for. This is an administrative burden for carers who have to provide information to different services and government agencies; and

    c) carers are required to navigate complex and fragmented systems. There are currently two distinct systems in place that provide information for informal carers of older people—Carer Gateway and My Aged Care, which operate in different departments.[43] There is no interoperability between the two systems. They are accessed through separate online portals and helplines and do not share information or data. It is left to carers to try to match availability of respite via My Aged Care with the availability of other support services via the Carer Gateway.[44]

37. Aged care is provided in people's homes, in the community and in residential aged care settings. Whilst there is a common perception that aged care only relates to nursing homes or residential care, more than two-thirds of people using aged care services do so from their own home.[45] High quality respite is an important and highly valued support service for informal carers. It improves the emotional wellbeing and physical health of carers, as well as presenting an opportunity to benefit the person receiving care. Had this service been available to GG, this

[43] Ibid, Volume 1, Executive Summary, 104.
[44] Ibid.
[45] Ibid, Volume 1, 62

would have undoubtably had a significant impact on the stress experienced the family members caring for him.

38. In the circumstances of this case, GG arrived in Australia on a medical treatment visa and many of the supports available to Australian Citizens and Permanent Residents are not available for temporary visa holders. The challenges and difficulties affecting Australian carers, as observed by the Royal Commission, are exemplified in circumstances where the aged relative being cared for is a temporary visa holder. The extent of this issue in Australia is unexplored and further research should be conducted by relevant government agencies to improve upon existing services available to temporary visa holders who require aged care 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 AA, born on 15 December 1961;

    b) the death occurred on 27 February 2019 at Victoria, from 1(a) Positional asphyxia; and

    c) the death occurred in the circumstances described above.

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

41. 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.

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

KK, Senior Next of Kin

The Honourable Colin Brooks, MP, Victorian Minister for Disability, Ageing and Carers

Judith Abbott, CEO, Carers Victoria

Steve Sant, CEO, Carers Australia

Detective Sergeant Brendan Devenish, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 21 November 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.