IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002885

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:	Shirley Annette Kidd
Date of birth:	20 December 1954
Date of death:	28 May 2022
Cause of death:	1(a) Head injuries
Place of death:	5 Egan Court, Darley, Victoria, 3340
Keywords:	Family violence; history of trauma; parricide; substance use

INTRODUCTION

1. On 28 May 2022, Shirley Annette Kidd was 67 years old when she died as a result of head injuries inflicted by her grandson, Hayden Kidd, during a drug-induced psychosis.

2. Shirley lived with her husband of 43 years, Robin Kidd, with whom she shared three children, Rebecca, Matthew and Amelia, and ten grandchildren, including Hayden. Hayden was born in March 2002 and was 20 years old at the time of the fatal incident. Hayden is the son of Rebecca Kidd and her former partner, Daniel Shannon.

THE CORONIAL INVESTIGATION

3. Shirley'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.

4. 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.

5. 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.

6. Victoria Police assigned Detective Senior Constable Vin Schalken to be the Coronial Investigator for the investigation of Shirley's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, neighbours and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Shirley Annette Kidd 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

Identity of the deceased

8. On 29 May 2022, Shirley Annette Kidd, born 20 December 1954, was visually identified by her son, Matthew Kidd.

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

Medical cause of death

10. Forensic Pathologist Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 30 May 2022 and provided a written report of his findings dated 30 August 2022.

11. The post-mortem examination revealed injuries to the head which were a combination of blunt force, chop and penetrating injuries, with direct impact to the back left side of the head causing scalp laceration, skull fractures and brain injury.

12. There were blunt force injuries to the torso seen externally on the back and were associated with internal injuries to the liver, right lung and right lower ribs.

13. Dr Young reviewed four photos of a mattock recovered from the scene and opined that this implement was capable of causing any of the injuries seen on the deceased.

14. There were no obvious so-called 'defence' type injuries. There was no post-mortem evidence of any significant natural disease which may have caused or contributed to the death.

15. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

16. Dr Young provided an opinion that the medical cause of death was *1(a) head injuries.*

[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.

17. I accept Dr Young's opinion as to the medical cause of death.

Circumstances in which the death occurred

18. On 28 May 2022 at 2.29pm, Hayden was observed on CCTV smoking a cigarette on the rear veranda of his grandparents' Darley home. Between 2.30pm and 3.00pm, Shirley's son, Matthew, and daughter-in-law, attended Shirley's home and spoke about Hayden. Shirley noted her frustration that Hayden was not contributing financially to the household, had stopped paying 'board' and was always gaming in his room. Shirley indicated her desire to ask Hayden to leave, noting she had served him with an eviction notice earlier that year.

19. At 5.44pm, Hayden left his grandparents' home and at 6.05pm, he caught an Uber to the local IGA supermarket. He told the Uber driver that he was going to meet a friend. The Uber driver had previously driven Hayden in an Uber and observed that he appeared subdued on this occasion. She dropped him off in the carpark behind the IGA. Hayden returned to his grandparents' house at 7.48pm and was observed smoking on the rear veranda on CCTV at 9.03pm.

20. Robin retired to bed at about 7.30pm. At that time, Shirley was still awake, accompanied by Hayden's young cousin, AB.[2]

21. At about 10.15pm, the kitchen lights were switched on. At this time, Shirley was asleep in her bed, with AB sleeping beside her. While there was some conjecture about the precise sequence of events at Hayden's trial, the following was accepted by AB under cross-examination. Hayden came into Shirley's bedroom, lifted AB out of bed and held him around the waist. Hayden ran down to the garage with AB, chased by Shirley who instructed Hayden to put AB down. Once in the garage, AB wriggled out of Hayden's arms and ran away.

22. Robin recalled being awoken by the sound of scuffle. AB knocked on his bedroom door and told him that Shirley was lying on the ground in the garage and that Hayden had "*hurt*" her. AB led Robin to the garage where he observed Shirley lying face down on the ground in a pool of blood. He described a "*pickaxe…jammed in*" the back of her head. Robin instinctively removed the mattock (pickaxe) from Shirley's head.

[2] AB was the pseudonym applied by Justice Croucher in his sentencing remarks. For consistency, I have adopted the same pseudonym.

23. When walking to the garage earlier, Robin encountered Hayden returning inside who said, "*I'm going to sleep well tonight*". Hayden appeared pale and was unable to keep his eyelids open. When Robin entered Shirley's room, he observed Hayden lying down on her bed.

24. Robin called his son, Matthew, and spoke to Matthew's wife to explain what had happened. Matthew's wife alerted Robin's friend, who attended the scene shortly thereafter. The friend called 000 at 10.27pm. At about this time, Hayden reportedly approached the friend and stroked him on the chin. This led the friend to believe that Hayden was substance affected.

25. Police arrived on scene at 10.36pm and arrested Hayden. He was compliant with police and advised that he injected himself with drugs three times. He was assessed by paramedics, who noted he was confused and appeared to be "*very drug affected*". He told paramedics he consumed alcohol and cannabis earlier that day. Hayden was conveyed to hospital where he underwent a blood test which showed trace amounts of cannabis and mirtazapine, but no alcohol or other commonly encountered drugs.

26. Hayden was originally charged with murder and pleaded not guilty. Forensic psychiatrists were engaged by both the prosecution and defence, and both gave evidence casting doubt on whether Hayden possessed murderous intent at the time of the killing, in the context of the psychosis that he was experiencing. It was later agreed by the parties that Hayden would plead guilty to manslaughter. Hayden was convicted and sentenced to a period of five years' imprisonment, with a non-parole period of two and a half years. In Justice Croucher's sentencing remarks, his Honour noted:

> *[Hayden] perceived his maternal grandmother Shirley Kidd to be his sadistic stepfather sleeping with his much younger self, who, in truth, was his seven-year-old cousin AB. Acting on this confused misidentification, [Hayden] wrested 'himself' from the clutches of his 'stepfather', and carried him to the garage. His grandmother awoke and chased after them, no doubt alarmed at his actions and out of concern for AB.*[3]

[3] *R v Kidd* [2024] VSC 458, 2.

FURTHER INVESTIGATIONS AND CPU REVIEW

27. As Shirley's death occurred in circumstances of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[4] examine the circumstances of Shirley's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[5].

28. I make observations concerning service engagement with Hayden and Shirley as they arise from the coronial investigation into her death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and Shirley's death.

29. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[6] I make observations about services that had contact with Hayden and Shirley to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Family violence history

30. There was no evidence of prior family violence between Hayden and Shirley. However, there was an extensive history of family violence allegedly perpetrated by Hayden's stepfather, CD[7], which is relevant to the circumstances of Shirley's death.

31. When Hayden was about two years old, his mother re-partnered with CD, who became his stepfather. Hayden lived with his mother, CD, and two younger half-siblings until 2013, when he was aged 13. Rebecca gave evidence at Hayden's trial that he was subjected to severe physical and emotional abuse by CD. This included smacking and humiliating Hayden in public if he soiled himself and using a cigarette lighter to burn the soles of his feet or the inside of his legs as punishment for failing to pack away his toys. When Hayden was aged about seven or eight, CD threatened to cut off his penis. Rebecca recalled an incident where she had

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[4] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[5] 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.

[6] *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

[7] CD was the pseudonym applied by Justice Croucher in his sentencing remarks. For consistency, I have adopted the same pseudonym.

to pull CD away from Hayden, when he was trying to drown him in the toilet. At times, Hayden refused to attend school or participate in activities for fear that other children might see the bruises or marks left on him from CD's assaults. CD was allegedly physically violent towards Hayden and Rebecca, but not to Hayden's stepsiblings.

32. In 2015, Hayden, Rebecca and her other children in 2015 moved in with Robin and Shirley to escape CD's violence. Hayden lived with his grandparents for short periods from 2015 onwards. Hayden reportedly got along with his grandfather, however intermittently had conflict with his grandmother. These frustrations stemmed from Hayden's lack of employment and constant gaming. Shirley also did not like that Hayden used cannabis, but both she and Robin wanted to support him to achieve his potential and goals.

Service contact - Uniting

33. After a suicide attempt in 2019 and suicidal ideation in 2020, Hayden experienced a mental health inpatient admission. Following his admission, Hayden was supported by Uniting in a youth residential unit for young people experiencing mental health issues (Barnagnen) from June 2020 to June 2021. After this time, he moved back to his grandparents' house.

34. Throughout Hayden's time at Barnagnen, records documented that:

    a) He found it hard to trust others due to past trauma.

    b) He experienced nightmares and was afraid to sleep.

    c) He frequently used cannabis both at Barnagnen and offsite, which he explained was to reduce traumatic flashbacks. When he stopped using cannabis, the flashbacks increased.

    d) He commenced an online university course in October 2020, however ceased in December 2020.

    e) He was offered multiple job interviews and opportunities, none of which he commenced.

    f) He often struggled to maintain his unit or personal hygiene.

    g) He wanted to address his trauma but had not found referrals made by Uniting to be helpful in that regard.

35. During his stay at Barnagnen, Hayden received multiple referrals to assist in addressing his mental health, including to Headspace.

36. After Hayden left Barnagnen, he continued to engage with Uniting. He had multiple discussions with workers between December 2021 and the fatal incident. These discussions related to Hayden's living situation with his grandparents, amongst other issues. Hayden fluctuated between being unhappy with living with his grandparents and telling his support worker that the arrangement was good. Shirley also mentioned some challenges in relation to Hayden living at their home.

37. In January 2022, Hayden advised workers that he was unhappy living with his grandparents and wanted assistance to relocate. In February 2022, Shirley advised workers that Hayden could continue to stay with her but only until he found other permanent accommodation. In March 2022, Hayden discussed obtaining assistance for moving into a private rental once he was enrolled in a course, so that he could take the course location into consideration.

38. Hayden continued to engage with Uniting workers until the time of the fatal incident. A Uniting worker attended the home six days prior to the fatal incident and took Hayden to a local coffee shop. Case notes from this interaction recorded that Hayden appeared clean and spoke openly about his plans for the future, including working towards gaining employment. He advised that he recently attended his general practitioner (**GP**) for a mental health care plan so that he could see a psychologist.

39. I have not identified any deficiencies or prevention opportunities with respect to Hayden's engagement with Uniting. Uniting was persistent in their attempts to engage with Hayden, made numerous referrals for other support services and were flexible in response to his changing needs.

Service contact - general practitioner

40. Hayden visited his GP on 23 April 2022 to obtain a mental health care plan (**MHCP**). The MHCP noted concerns for depression, anxiety and post-traumatic stress disorder. His risk to others was noted to be 'nil' at that time. According to his Medicare records, Hayden did not see any other health professionals after this date. I have not identified any prevention opportunities with respect to this contact.

Relevant literature – the impact of trauma and family violence on young people

41. It would appear that there was some link between Hayden's experiences of family violence as a child and the fatal incident, notwithstanding the role of cannabis-induced psychosis.

42. The 2016 Royal Commission into Family Violence (**RCFV**) recognised the need to develop supports for children and young people who have been victims of violence and made several recommendations targeted at improving services for this cohort. Despite these recommendations, in 2022, the Family Violence Reform Implementation Monitor (**FVRIM**), '*Monitoring Victoria's family violence reforms: Crisis response to recovery model for victim survivors*' noted that:

> *Many stakeholders, ranging from victim survivors to legal services and peak bodies, despaired at the lack of targeted and easily accessible therapeutic services for children. … We are not aware of any monitoring of the services provided using the counselling and therapeutic interventions funding but suggest this may be an area for further investigation. The Royal Commission was clear about the need for child victim survivors to have access to such support and noted 'if we do not provide this support, the effects of family violence suffered by children may be carried on to the next generation.*[8]

43. In a recent national study, 89% of young people who had used violence in the home reported that they had experienced child abuse.[9] The study also found a high level of overlap between young people's experiences of violence and use of their violence being retaliatory (against people who had abused them).[10] This is relevant in the present case, given Hayden's experience of family violence for many years and his perception that Shirley was the perpetrator of that violence (whilst experiencing a cannabis-induced psychosis). Researchers concluded that:

> *this study reiterates the call made over six years ago by the Victorian RCFV (2016) that children must be seen and responded to as victim-survivors of family violence in their own right. Supporting the recovery needs of young people who have experienced and used DFV is an essential strategy to reduce the risk of intergenerational violence,*

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[8] Family Violence Reform Implementation Monitor, *Monitoring Victoria's family violence reforms: Crisis response to recovery model for victim survivors* (2022) 49.
[9] Kate Fitz-Gibbon, Silke Meyer, Hayley Boxall, Janemaree Maher and Steven Roberts 'Adolescent family violence in Australia: A national study of prevalence, history of childhood victimisation and impacts' (2022) 15, *ANROWS Research Report*, 16.
[10] Ibid.

to minimise the impacts of AFV on other family members, and to ensure the trauma experienced by young Australians as a result of DFV is addressed.[11]

44. While Hayden did receive referrals and engaged with various services to varying extents, it appears the available services may not have been effective in meeting his needs as a victim-survivor of family violence. This is not a criticism of Uniting or anyone else, rather is an observation about the availability of specialist services for victim-survivors of family violence, particularly those in similar situations to Hayden.

45. In 2024, the *Pave the Way: Investing in the Safety and Futures of the Next Generation: Strong Foundations Submission* recommended that:

> *To meet the recovery needs of young people affected by family violence, tailored, age-appropriate responses need to be developed and resourced, alongside the mainstream therapeutic interventions delivered across each region in Victoria. These programs need to be accessible to young people, regardless of whether they are accompanied by an adult victim-survivor, fall under the child protection system or are navigating the service system on their own.*[12]

46. It is therefore important to continue the current work in responding to the trauma of young people who experience family violence and considering children and young people as victims in their own right. This is particularly important in the present case, as Hayden's young cousin was exposed to the fatal incident. I therefore intend to recommend that Family Safety Victoria work with the Department of Families, Fairness and Housing to review and adequately resource statewide programs for recovery from family violence.

Opportunities for prevention and intervention

Recovery from trauma

47. Hayden actively sought to manage his trauma by engaging in mental health services through Uniting, and proximate to the fatal incident, sought a MHCP to access a psychologist. While not necessarily preventative in this matter, this case highlights potential ongoing gaps in

[11] Kate Fitz-Gibbon, Silke Meyer, Hayley Boxall, Janemaree Maher and Steven Roberts, 'Adolescent family violence in Australia: A national study of service and support needs for young people who use family violence' (2022) *ANROWS Research Report*, 14.
[12] Melbourne City Mission, Berry Street Y-Change, Centre for Innovative Justice and Youth Affairs Council Victoria, Pave the Way: *Investing in the Safety and Futures of the Next Generation: Strong Foundations Submission*, Recommendation 12, 22

therapeutic and recovery resource, in particular (but not limited to), young people who experience family violence.

Prevention of family violence

48. The most significant prevention opportunity for the fatal incident appears to have been in the prevention of the family violence and subsequent trauma Hayden experienced as a child. Hayden regularly told others that his reliance upon cannabis was the result of the trauma and violence he experienced as a child.

49. It is not within the scope of this investigation to consider the specific instances of family violence experienced by Hayden as a child, however, this history emphasises the importance of primary prevention of family violence. In my finding into the death of Thi Minh Phuong Nguyen, I recommended:

> *The Victorian Government urgently increase the total quantum of primary prevention funding, and prioritise longer term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria.*
>
> *The Federal Government commit to long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch in Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia. These include:*
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> - *Our Watch (to provide independent national leadership on primary prevention)*
> - *Australia's National Research Organisation for Women's Safety (**ANROWS**) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)*
> - *Australian Bureau of Statistics (to deliver the Personal Safety Survey)*
> - *Workplace Gender Equality Agency.*[13]

[13] Finding into death without inquest – Thi Minh Phuong Nguyen (COR 2021 0964), 13-14.

50. In response to the above recommendations, the Victorian Government noted that it is "*committed to addressing family violence, with more than $4 billion invested to prevent and respond to family violence in Victoria since the Royal Commission into Family Violence in 2016. This includes over $450 million invested in primary prevention and gender equality initiatives.*"[14]

51. The Commonwealth Government stated in response to the above recommendation that it is "*committed to ending gender-based violence in one generation, and will continue to work together with the states and territories to prevent this violence by changing the underlying social drivers as well as addressing the attitudes and systems that drive violence against women and children*".[15]

52. I accept both the State and Commonwealth Governments are committed to improving primary prevention at a state and federal level, however I am of the view that more can and should be done. I intend to provide a copy of this finding to both the State and Commonwealth Governments, to consider as part of their ongoing work in this space.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Shirley Annette Kidd, born 20 December 1954;

    b) the death occurred on 28 May 2022 at 5 Egan Court, Darley, Victoria, 3340, from *1(a) head injuries*; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) The **Family Safety Victoria** work with the **Department of Families, Fairness and Housing** to review and adequately resource statewide programs for recovery from family violence, including ensuring accessible programs tailored to the specific needs of young people.

[14] Correspondence from the Secretary, Department of Families, Fairness and Housing to Coroners Cour of Victoria dated 21 March 2025 in response to the Finding into death without inquest – Thi Minh Phuong Nguyen, 1.
[15] Correspondence from the First Assistant Secretary, Government Division, Department of Prime Minister and Cabinet to Coroners Court of Victoria dated 13 March 2025 in response to the Finding into death without Inquest – Thi Minh Phuong Nguyen, 1.

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

Pursuant to section 73(1A) 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:

Robin Kidd, Senior Next of Kin

Department of Families, Fairness and Housing

Family Safety Victoria

Commonwealth Government

Uniting (Victoria & Tasmania) Ltd (C/- MinterEllison)

Victorian Government

Detective Senior Constable Vin Schalken, Coronial Investigator

Signature:

Judge John Cain
State Coroner
Date: 23 May 2025

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.