IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 006390

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:	Mrs A
Date of birth:	14 November 1941
Date of death:	Between 20-21 November 2019
Cause of death:	1(a) Stab wounds to the chest
Place of death:	VICTORIA
Keywords:	Intimate partner homicide; family violence; elderly couple

INTRODUCTION

1. On 21 November 2019, Mrs A was 78 years old when she was fatally stabbed in her residence in Hadfield, Victoria. At the time of her death, Mrs A lived her husband, Mr B.

2. Mr and Mrs A were both born in Austria and had been married for 60 years. Mrs A worked as a dress maker whilst Mr B worked as a tool maker. The couple had previously lived in New South Wales and moved to Melbourne in mid-November 2019.

3. In the 18 to 24 months before her death, Mrs A had discussed with her son, Mr C, the apparent deterioration of Mr B's mental functioning. They had observed that his memory was declining and that day-to-day tasks were becoming challenging for him.

4. Approximately 12 months before the fatal incident, Mrs A and Mr C approached Mr B suggesting relocating to Melbourne to be closer to Mr C. Mr B initially resisted the proposed relocation and he was also opposed seeking treatment for his deteriorating mental state.

5. In 2017, Mr B underwent a mini mental state examination (**MMSE**) with his general practitioner. His test results indicated that he had mild cognitive impairment. He took the same test in 2018, the results of which again indicated a mild cognitive impairment. Approximately three months prior to her death, Mrs A contacted Mr C and said that Mr B had agreed to relocate to Melbourne.

6. On 12 November 2019, Mr and Mrs A flew down to Melbourne to complete their relocation. The couple stayed with their son until settlement of the purchase of the Hadfield property was effected on 15 November 2019.

THE CORONIAL INVESTIGATION

7. Mrs A'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 Mrs A'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 A 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. CCTV footage of Mrs A's property depicts Mr and Mrs A together in the rear yard on 20 November 2019. The last footage depicting Mrs A is at 7.21pm on the same day.[2] The available evidence confirms that no other person entered or left the property after Mrs A's last CCTV footage sighting and until she was discovered by Mr C on 21 November 2019.[3]

13. On 21 November 2021, Mr C attempted to call Mrs A at around 9:15am with no success. Mr C attempted to unsuccessfully call Mrs A again at 4:31pm and then 7:59pm.[4] Mr C then drove to Mrs A's property and, upon arrival, entered through the garage using his remote entry key. Upon entering the house, Mr C saw Mrs A lying on the lounge room floor wrapped in a blue and brown rug.[5] Mr C called out to Mr B and contacted emergency services at 8:31pm to request police and ambulance attendance.

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[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.
[2] *Coronial Brief*, Exhibit 32
[3] *Coronial Brief,* Exhibit 33
[4] *Coronial Brief,* Statement of Mr C dated 22 November 2019, 52
[5] Ibid, 53

14. Whilst on the phone to the police, Mr C saw Mr B walk down the stairs and peek down at him. Mr C remained on the phone to emergency services until police members arrived at the residence at 8:41pm.[6]

15. Ambulance paramedics arrived at the residence at 8:46pm and examined Mrs A.[7] They observed dark blood surrounding her head and a box cutter lying next to her with blood on it. Mrs A had a large haematoma to the left side of her head. She also had multiple lacerations on her left forearm.[8] Paramedics confirmed that she had passed in light of observations of her body being pale and rigid and post-mortem lividity and rigor mortis.[9]

16. Mr B was not arrested at this time and was permitted to go to Mr C's house. Mr B was charged with the murder of Mrs A on 22 November 2019. On 24 March 2021, in the Supreme Court of Victoria, Mr B was found unfit to stand trial.[10]

Identity of the deceased

17. On 21 November 2019, Mrs A, born 14 November 1941, was visually identified by her son, Mr C.

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

Medical cause of death

19. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 22 November 2019 and provided a written report of her findings dated 30 March 2020.

20. The post-mortem examination revealed the following:

    a) there was evidence of defence-type wounds to the left forearm;

    b) there was some natural disease identified, none of which has caused or contributed to death;

    c) at least a moderate force would be required to inflict the stab wound to the deceased that bisected the rib; the two that entered the pulmonary artery would be at least mild force.

[6] *Coronial Brief*, Statement of Leading Senior Constable Peter Gray dated 21 November 2019, 63
[7] *Coronial Brief,* Statement of Rachel Adams dated 18 December 2019, 93
[8] Ibid
[9] Ibid
[10] Supreme Court Case [2021] VSC 301

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

22. Dr Baber provided an opinion that the medical cause of death was 1 (a) Stab wounds to the chest.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

23. 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.

24. On the basis of the physical evidence as well as Dr Baber's opinion, I am satisfied to the coronial standard that Mr B was capable of the actions necessary to cause Mrs A's death and that she did not end her own life.

25. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr and Mrs A was one that fell within the definition of 'spouse'[11] under that Act. Moreover, Mr B's actions in fatally stabbing Mrs A constitutes '*family violence'*.[12]

26. In light of Mrs A's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)[13] examine the circumstances of Mrs A's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[14]

27. The available evidence indicates that there were no concerns of family violence between Mr B and Mrs A in the lead up to the fatal incident.

28. At the time of Mrs A's death, the services that were involved with the couple were primarily focused on their health needs and there were no prevention opportunities identified in the provision of these services.

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

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[11] Family Violence Protection Act 2008, section 9
[12] Family Violence Protection Act 2008, section 8(1)(a)
[13] 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
[14] 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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mrs A, born 14 November 1941;

    b) the death occurred between 20-21 November 2019 at Victoria, from STAB WOUNDS TO THE CHEST; and

    c) the death occurred in the circumstances described above.

31. I convey my sincere condolences to Mrs A's family for their loss.

32. 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.

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

Mr C, Senior Next of Kin

Detective Senior Constable Kevin Morgan, Coroner's Investigator

Signature:

Judge John Cain
STATE CORONER
Date: 21 July 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.