IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 3624

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:	John Reed
Date of birth:	15 March 1952
Date of death:	20 July 2015
Cause of death:	1(a) Head injury
Place of death:	Alfred Hospital, Victoria
Catchwords:	Family violence, intimate partner homicide

INTRODUCTION

1. On 20 July 2015, Mr John Reed, was 63 years old when he was declared deceased at the Alfred Hospital. At the time of his death, Mr Reed was living with his partner, Ms Gayle Dunlop.

2. Mr Reed was originally born John William Caban in Newmarket, United Kingdom on 15 March 1952 to Peter and Evelyn Caban. Mr Reed's family migrated to Australia when he was very young and initially were based in Adelaide, South Australia.

3. Mr Reed fought in the Vietnam War in his youth. After serving in the Army, he returned to Australia and lived in New South Wales before moving to Western Australia where he met Ms Gayle Dunlop through his elder brother.

4. Mr Reed worked in several occupations as a painter, decorator, and a sign writer.

5. Mr Reed and Ms Dunlop's relationship bore a daughter, Meeka Dunlop, who was born in October 1990. The couple moved around often after commencing their relationship and lived in Victoria, New South Wales and South Australia before settling in Scarborough, Western Australia in 1992.

6. Mr Reed eventually settled in with Ms Dunlop in a public housing unit in Seaford, Victoria in early 2013 where they resided together until the fatal incident.

THE CORONIAL INVESTIGATION

7. Mr Reed'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. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Reed'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 Mr Reed, including evidence contained in the coronial brief and further evidence obtained under my direction. 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. On the evening of the 18 July 2015, Mr Reed and Ms Dunlop were at their Seaford residence when an altercation broke out between the couple shortly after approximately 7.30pm. A neighbour heard shouting and banging from their residence which lasted approximately 20 minutes.[2]

13. Ms Dunlop reported that she and Mr Reed had engaged in a verbal argument, during which she struck Mr Reed to the back of the head with a small foot stool.[3] This incident appears to have been overheard by a neighbour who reported hearing a scuffle and a loud thud.[4]

14. At approximately 9.15pm Ms Dunlop called 000 requesting an ambulance attend the Seaford residence. During this call Ms Dunlop was overheard by emergency services requesting that Mr Reed not '*dob [her] in*.'[5] She also was overheard saying *'I hope you die*'.[6] Paramedics

[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*, Statement of Joy Kirwan dated 1 August 2015, 156-157
[3] Director of Public Prosecutions Reference No.1 of 2017 [2018] VSCA 69, 39
[4] *Coronial Brief*, Statement of Penny Bowe dated 8 August 2015, 148-149
[5] *Coronial Brief*, Appendix A -Transcript of the 000 call on 18 July 2015, 681
[6] Ibid, 682

attended at the Seaford residence shortly afterwards and conveyed Mr Reed to hospital for treatment.[7]

15. Mr Reed died at the Alfred Hospital on 20 July 2015 as a result of the injuries he sustained on 18 July 2018. Ms Dunlop was initially charged with the murder of Mr Reed, however at the conclusion of a jury criminal trial in the Supreme Court of Victoria, Ms Dunlop was found not guilty of the murder of Mr Reed and was released into the community.[8]

Identity of the deceased

16. On 20 July 2015, Meeka Dunlop, visually identified the deceased to be her father, John Reed born 15 March 1952.

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

Medical cause of death

18. Forensic Pathologist Dr David Ranson from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 22 July 2015 and provided a written report of his findings dated 5 November 2015.

19. Dr Ranson noted the following:

    (a) There was evidence of a mild degree of natural disease with a small amount of coronary artery atherosclerosis that was not associated with any damage to the heart. An early bronchopneumonia was also present, this is a feature which is commonly seen in individuals who have survived for a period of time in a decreased conscious state following a serious head injury.

    (b) There was significant recent bruising to the body present in the back of the head. Adjacent to this area of bruising were substantive lacerations. There was an extensive fracture that passed through the vault of the skull and into the right middle cranial fossa and base of the left posterior fossa.

    (c) An accelerated fall with a head strike or a single forceful blow to the back of the head could have caused this degree of fracturing and lead to the lacerations found at the back of the head.

[7] *Coronial Brief*, Statement of Sarah Simpson dated 24 July 2015, 164-166
[8] Director of Public Prosecutions Reference No.1 of 2017 [2018] VSCA 69.

20. Toxicological analysis of pre-mortem samples identified the presence of alcohol at a concentration level of 0.16 g/100mL. Similar analysis of post-mortem samples detected the presence of therapeutic drugs related to Mr Reed's terminal medical management.

21. Dr Ranson provided an opinion that the medical cause of death was '1(a) Head injury'.

22. I accept Dr Ranson's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

23. As Mr Reed's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**)[9] examine the circumstances of Mr Reed's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[10]

24. Mr Reed's relationship with Ms Dunlop met the definition of 'domestic partner' under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).[11] The fatal incident involved an assault by Ms Dunlop towards Mr Reed which meets the definition of 'family violence' in the FVPA, specifically the act of fatally assaulting Mr Reed to the head and causing his death.

25. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with Mr Reed and Ms Dunlop prior to Mr Reed's death.

History of unreported family violence

26. The available evidence suggests that family violence was present throughout Mr Reed and Ms Dunlop's relationship. The couple's daughter recounted witnessing numerous instances of family violence as a child, often after Ms Dunlop and Mr Reed had consumed alcohol. She described witnessing incidents of Mr Reed assaulting Ms Dunlop and instances where Ms

[9] 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.

[10] 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.

[11] Section 8(1)(c) of the *Family Violence Protection Act 2008*

Dunlop initiated physical violence against Mr Reed.[12] Meeka recalled two incidents where Ms Dunlop was hospitalised as a result of family violence. On the first occasion, Ms Dunlop required stitches after Mr Reed cut her with a glass. On the second occasion, Mr Reed was attempting to leave the property after an incident of verbal and physical violence and Ms Dunlop injured herself when she smashed the driver's side mirror on the car he was driving.[13] The last incident Meeka recalled witnessing occurred when she was 17 years old. On this occasion, Meeka purportedly tried to pull Mr Reed off Ms Dunlop during a physical assault and, when she was unsuccessful, Meeka '*picked up a knife and threw it at him but it missed*.'[14]

27. The Western Australia Police were called to two family violence incidents between Mr Reed and Ms Dunlop in 2007.[15] At the first incident police were called after Mr Reed smashed a window. When they attended Mr Reed was no longer at the property and Ms Dunlop indicated she did not wish police to take any action against Mr Reed.[16] At the second incident Ms Dunlop asked police to remove Mr Reed from their residence after he became agitated and started yelling at her. On this occasion Mr Reed became aggressive with police and had to be restrained by them before being removed from the property.[17]

28. Ms Dunlop and Meeka moved to Victoria in 2008, and Mr Reed moved to Victoria to reside with Ms Dunlop in 2012. Approximately six months after Mr Reed moved in with Ms Dunlop they recommenced having regular verbal arguments.[18]

29. Lynette Phillips lived next door to Ms Dunlop from 2011 until mid-2014. Ms Phillips reported overhearing numerous incidents of family violence during this time, commencing approximately six months after Mr Reed moved in. She described overhearing family violence which escalated from verbal abuse to physical abuse, including incidents where she heard Ms Dunlop pleading with Mr Reed to stop hitting her.[19] During this time Ms Phillips observed injuries to Ms Dunlop on numerous occasions,[20] including bruising to Ms Dunlop's face, arms and legs, and severe bruising over her torso and hips.[21]

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[12] *Coronial Brief*, Statement of Meeka Dunlop dated 8 September 2015, 89
[13] Ibid
[14] Ibid, 90
[15] *Coronial Brief*, Statement of Detective Senior Constable Richard Conti dated 19 October 2015, 104; Statement of Peter Arena dated 18 December 2015, 108
[16] *Coronial Brief*, Statement of Detective Senior Constable Richard Conti dated 19 October 2015, 104
[17] *Coronial Brief*, Statement of Peter Arena dated 18 December 2015, 109-111
[18] *Coronial Brief*, Statement of Meeka Dunlop dated 8 September 2015, 92
[19] *Coronial Brief*, Statement of Lauren Phillips dated 11 August 2015, 114-118
[20] Ibid
[21] *Coronial Brief*, Appendix B, Transcript of Interview with Lauren Phillips, 693

30. On 28 November 2014, Ms Dunlop called 000 to report a family violence incident and requested police attend at the Seaford residence. On this occasion Mr Reed had left the property before police arrived and Ms Dunlop stated that a verbal argument had occurred but did not disclose any physical violence. She informed police that she was not fearful of Mr Reed and that she had called the police because she was not sure what to do with their relationship. The attending officers submitted a formal referral to a support service for Ms Dunlop but did not take any further action.[22]

31. On 1 July 2015, an ambulance was called to the Seaford residence after Ms Dunlop reported that she had injured herself by falling over whilst taking the dog outside. When paramedics arrived they observed that Ms Dunlop's version of how she had sustained her injuries '*didn't make any sense as she was describing it*.'[23] They also noted that she '*changed her story a few times and [Mr Reed] kept butting in*.'[24] The paramedics separated Mr Reed and Ms Dunlop from each other for further questioning at which point Ms Dunlop disclosed that Mr Reed had pushed her over and she had hit her head on the coffee table and the door frame.[25] Ms Dunlop reported that similar incidents had happened before, that she was afraid of Mr Reed, and that she feared for her life.[26]

32. Ms Dunlop was conveyed to Frankston Hospital for medical treatment on 1 July 2015. Although she requested that the paramedics not pass information about the family violence incident on to the hospital, this information was conveyed to treating staff to ensure they could provide appropriate medical treatment.[27] No report was made to Victoria Police in relation to this incident and Ms Dunlop returned home following her medical treatment.

33. On 7 July 2015, Ms Dunlop called Victoria Police seeking their assistance to remove Mr Reed from the Seaford residence. Police attended and spoke with Ms Dunlop and Mr Reed separately. Ms Dunlop was adamant that Mr Reed be removed and Mr Reed agreed to leave, stating he would return to Western Australia.[28] The attending members offered to make a referral to housing support services to assist Mr Reed to find somewhere to stay before he returned to Western Australia but he declined this offer. The attending members conveyed Mr Reed to the

[22] *Coronial Brief*, Statement of Constable Rebecca Hough dated 4 August 2015, 128
[23] *Coronial Brief*, Statement of Melanie Nolan dated 15 September 2015, 135
[24] Ibid
[25] Ibid
[26] Court Transcript of *The Queen v Dunlop [2016] VSC 676* 9 November 2016, testimony of M Nolan, 259
[27] *Coronial Brief*, Statement of Melanie Nolan dated 15 September 2015, 135; VACiS – Electronic Patient Care Report, 612
[28] *Coronial Brief*, Statement of Gary Singh dated 20 October 2016, 145-146

Seaford train station and asked the Personal Security Officer's stationed there to ensure that Mr Reed left on the train.[29]

34. On 17 July 2015, at approximately 10.00pm, a neighbour overheard an argument from the Seaford residence which was loud enough to wake her. She reported hearing both a male and female yelling.[30]

COMMENTS

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

Proximate healthcare provided by Peninsula Health

35. Ms Dunlop attended Frankston Hospital on 1 July 2015 for the treatment of injuries resulting from an assault perpetrated by Mr Reed. Medical records from this admission state:

> *Pt initially stated that she fell down 5 x stairs whilst letting her dog out however, once Pt was outside with crew and away from her partner she stated that she was assaulted by her partner at approx. 22:30. Pt's story was somewhat ambiguous as she as reluctant to reveal details. She did say that her partner pushed her, she fell backwards and struck the back of her head on a table. Nic LOC. Pt claimed that her partner finally allowed her to call AV after bleeding from the head ceased.*[31]

36. Based on the medical records provided, it does not appear that Ms Dunlop was linked in with any support services in relation to her disclosure of family violence. This could have been achieved by an internal referral to the hospital's social work department or by providing Ms Dunlop with information for external family violence support services. This was a missed opportunity for intervention as Ms Dunlop could have benefited from the support of specialist family violence services if appropriate referrals had been made.

37. Since Mr Reed's death, Peninsula Health has developed a Clinical Guideline *Family Violence Response and Referral* in accordance with their *Integrated Approach to Family Violence Across the Life Span Strategy 2018-2021*.[32] This is an organisation wide guideline which would have covered Ms Dunlop's admission to Frankston Hospital and her disclosures of family violence

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[29] *Coronial Brief*, Statement of Constable Peter Hamilton dated 11 August 2015, 139-143
[30] *Coronial Brief*, Statement of Penny Bowe dated 8 August 2015, 148
[31] *Coronial Brief*, VACiS – Electronic Patient Care Report, 612
[32] Peninsula Health, Clinical Practice Guideline, *Family Violence Response and Referral* (2017) and Peninsula Health's Integrated Approach to Family Violence Across the Life Span Strategy 2018—2021, available online at: https://www.peninsulahealth.org.au/wp-content/uploads/SHRFV-Booklet-2018.pdf

had they occurred after the guideline was put in place. This guideline provides that hospital staff should make sensitive enquiries about family violence and ensure that the patient is made aware of services that are available to assist them. Treating clinicians should refer persons affected by family violence to the hospital's social work department or a specialist family violence service for additional support. Staff are also encouraged to contact Victoria Police to report family violence if the patient consents.[33]

38. It is also noted that as of 19 April 2021, Frankston Hospital will be a prescribed agency under Phase Two of the Family Violence Multi-Agency Risk Assessment and Management Framework (**MARAM**), as it is a public health service. This means hospital staff will be required to comply with the MARAM Framework in identifying family violence and responding to disclosures, and to refer patients to appropriate support services.[34]

Third party reporting of family violence

39. Statements of neighbours, friends and family describe Mr Reed and Ms Dunlop's relationship as one characterised by a long-standing history of family violence. Despite the long history of family violence, Ms Dunlop and Mr Reed appear to have had limited service involvement with respect to the family violence.

40. During the criminal trial for the murder of Mr Reed, Ms Dunlop gave evidence that she grew up in a household where family violence was commonplace and stated that her father perpetrated family violence against her mother and sister when he was intoxicated. Ms Dunlop stated that '*the violence was everyday, it was shocking. There was not one day there wouldn't be broken glass everywhere, you couldn't even tiptoe, smashed window, food all over everything. Mum smashed to pieces*.'[35] Ms Dunlop indicated that her mother never reported the violence to anyone, and when asked why she did not seek further police assistance in relation to the violence perpetrated by Mr Reed, Ms Dunlop stated '*I just didn't want to dob [sic], it's just something you don't do, and I didn't want him getting into trouble. My mum never told anyone, so*.'[36]

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[33] Peninsula Health, Clinical Practice Guideline, *Family Violence Response and Referral* (2017) 8.
[34] <https://www.vic.gov.au/about-information-sharing-schemes-and-risk-management-framework>; <https://www.vic.gov.au/report-on-implementation-of-the-family-violence-risk-assessment-and-management-framework-2018-19/appendix-2-organisations-prescribed-in-phase-two> and Statement of Dr Helen Hewitt provided to the Court dated 12 May 202
[35] Court Transcript, Testimony of Gayle Dunlop, 736
[36] Ibid, 744

41. Mr Reed's death, and deaths similar to his, highlight the difficult and often dangerous predicament that family violence presents to family, friends and others who either become aware of it, or suspect it is occurring. Coupled with this is the reoccurring indication within the relevant research, that female victims of family violence are more likely to disclose the violence to family or friends, rather than to authorities or specialist services. Many times, third parties feel, understandably, ill-equipped to assist or are concerned that any intervention may increase the danger for the victim or themselves.

42. In an effort to address the barriers that third parties face in obtaining access to information about family violence and providing information and assistance to victims of family violence, the Royal Commission into Family Violence (**the Royal Commission**)[37] reviewed the available resources for third parties.

43. At its conclusion, predominantly by way of recommendations 10 and 37, the Royal Commission encouraged the adoption of a model whereby third parties (as well as victims and perpetrators of family violence) can access information via a website to assist in recognising family violence and how to seek help, both in the crisis period and during longer term recovery.[38]

44. This Court is advised that the Victorian Government has selected the Orange Door[39] website as the most suitable existing site with the capacity to develop into a space for the delivery of accessible information for those experiencing, witnessing and being affected by family violence. The Court is also informed that, in line with the Royal Commission's recommendation, the website is now currently in operation.[40]

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

45. I reiterate my previous recommendation in the coronial findings in the cases of the deaths of Ms ZT[41], Mrs FS[42] and Mrs K.[43] I recommend that the **Victoria 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

[37] Victoria, Royal Commission into Family Violence, Final Report, March 2016
[38] Victoria, Royal Commission into Family Violence, Recommendation 10
[39] http://orangedoor.vic.gov.au
[40] http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=12>; *The Lookout* website can be found at http://www.thelookout.org.au
[41] COR 2016 2733
[42] COR 2017 2423
[43] COR 2017 1889

informal supporters assisting persons affected by family violence.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was John Reed, born 15 March 1952;

    (b) the death occurred on 20 July 2015 at the Alfred Hospital, Victoria from 1(a) Head injury; and

    (c) the death occurred in the circumstances described above.

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

48. I convey my sincere condolences to Mr Reed's family for their loss.

49. 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.

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

Ms Meeka Dunlop, Senior Next of Kin

Department of Premier and Cabinet Family Violence and Service Delivery Reform Unit

Ms Eleri Butler, Chief Executive Officer, Family Safety Victoria

Ms Amber Salter, Legal Counsel, Peninsula Health

Detective Acting Sergeant Kyle Simpson, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 3 June 2021

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.