IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 2614

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**IAIN WEST, ACTING STATE CORONER**
Deceased:	**WAYNE BROWN**
Date of birth:	11 April 1978
Date of death:	10 June 2016
Cause of death:	Stab wound to the chest
Place of death:	155 Camms Road, Cranbourne, Victoria

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HIS HONOUR:

BACKGROUND

1. Wayne Brown (**Wayne**) was a 38-year-old man, born on 11 April 1978 in Dandenong, Victoria. Wayne, of Aboriginal descent, was the eldest child of Colin and Iolanda Brown (**Colin** and **Iolanda**). Wayne had two younger siblings, a sister, Kelly Brown (**Kelly**), and a brother, Shane Brown (**Shane**).

2. In his early years, Wayne resided in Noble Park with his family. He attended Wallaroo Primary School until the family moved to Cranbourne. He then started at Cranbourne Primary School before going on to secondary education at Lyndhurst Technical College, where he completed Year 9.

3. At the time of his death, Wayne was unemployed and had an itinerant lifestyle living with friends and at times in the garage of his parents' home.

4. Shane, also of Aboriginal descent, was born on 25 August 1983 in Dandenong, Victoria. Shane initially resided in Noble Park with his family. He attended Cranbourne Primary School before attending Cranbourne High School, where he completed Year 10. At the time of Wayne's death, Shane was unemployed and residing at his parents' home.

5. In early 2005 Colin applied for a Family Violence Intervention Order (**FVIO**) against Wayne. In his application, Colin stated that whilst in prison Wayne had made '*threats against the family*', and had '*threatened to physically assault [Colin] once he [got] out of prison for giving him up [to] the police.*'[1] Colin also stated that he was concerned for his safety and the safety of his family when Wayne left prison.[2] A FVIO was granted to Colin on 30 March 2005. The FVIO was an indefinite order with no expiry date which prohibited Wayne from committing family violence against Colin and from going within 200 metres of Colin's home, amongst other conditions. This order was still in place on the day that Wayne died at Colin's home.

6. Over the next 11 years, Wayne was charged with breaching this FVIO on 21 separate occasions.[3] It is likely, however, that the number of breaches of the FVIO was actually higher

[1] Coronial Brief, Appendix H, 294
[2] *ibid*
[3] Coronial Brief, Appendix J, 304-326

than this as Colin only reported Wayne's breaches of the Order to the police when he felt that Wayne 'had done wrong by him.'[4]

7. There are a number of documented incidents of family violence between Wayne and Shane. These occurred on 3 August 2008, 8 March 2009 and 25 May 2012 and resulted in Colin calling the Police for assistance. Although Colin could not recall the details of these specific incidents, he stated that disputes between Wayne and Shane usually began with Wayne being abusive towards both his parents, and Shane intervening to defend them.[5]

8. On 22 October 2015 Wayne broke into his parents' home when they were not there. When they returned home he was verbally abusive towards them, smashed the house phone, and allegedly threatened to stab his father with a kitchen knife.[6]

9. On 12 November 2015 Wayne attended his ex-partner, Julie Hopkins' home, in contravention of a FVIO she had against him, and demanded to be let in. When she refused, Wayne sat on her front step for approximately three hours, only leaving after she called the police.[7]

10. In November 2015 Wayne met his 14 year old daughter, Madison Jagger (**Madison**), for the first time. Wayne had met Madison's mother, Michelle Dawson (**Michelle**), in 1999 and the two commenced a relationship shortly afterwards.[8] Michelle fell pregnant in 2000 and Madison was born on 26 February 2001 when Wayne was still in prison.[9] Michelle and Wayne's relationship ended prior to Madison's birth.

11. Madison had recently told Michelle that she wanted to meet her father and Michelle had agreed.[10] After this initial meeting in November 2015, Michelle and Madison began to see Wayne regularly.

12. On 7 December 2015 Wayne was arrested in relation to the family violence incidents on 22 October 2015 and 12 November 2015. He admitted to breaching the FVIO by being at Colin's property, damaging his phone and verbally abusing him, but denied the knife threat.[11]

13. On 18 January 2016 Wayne was at Michelle and Madison's home when he became verbally abusive and aggressive. He refused to leave when Michelle asked him to and allegedly

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[4] Coronial Brief, Statement of Colin Brown, dated 10 June 2016, 97; See also Coronial Brief, Appendix H, 294
[5] *ibid*, 98.
[6] Victoria Police Preliminary Prosecution Brief, dated 21 January 2016
[7] *ibid.*
[8] Coronial Brief, Statement of Michelle Dawson, dated 12 June 2016, 69
[9] *ibid.*
[10] *ibid*, 71-72.
[11] Above n 6

assaulted Madison by shoving her and slapping her to the face.[12] Madison called the police and Wayne left before they arrived. When the police attended they issued a Complaint and Warrant for a FVIO to protect Madison and Michelle.[13]

14. On 24 January 2016 Wayne again attended Julie Hopkins' home. He entered the house via an unlocked door but was pushed outside by Julie and her daughter. The police were called and Wayne continued to cause commotion outside of the property for some time but left before the police arrived.[14]

15. On 22 February 2016 Wayne was convicted of a number of the FVIO breaches as well as with assaulting Colin and Madison. He was sentenced to four months imprisonment and a 12 month Community Corrections Order upon release from his sentence, as well as 200 hours of community work.[15] A FVIO was also issued which prohibited Wayne from committing family violence against Madison and Michelle and from attending Michelle's home whilst he was under the influence of alcohol.

16. Prior to Wayne's incarceration on 22 February 2016, in early February 2016, he rekindled his relationship with Michelle. [16]

17. Michelle and Madison picked Wayne up when he was released on 23 May 2016. Wayne wanted to purchase alcohol and this led to an argument between himself and Michelle. Wayne walked away after this argument and he called Michelle later requesting that she assist him with transport. When Michelle and Madison arrived to pick him up Wayne was reportedly intoxicated, made threatening comments towards Michelle and attempted to lunge at Madison through the car window. As a result, Michelle drove away.[17]

18. On 5 June 2016 Michelle and Wayne were at Colin and Iolanda's house when Wayne became aggressive and accused Michelle of sleeping with Shane. Wayne forced Michelle to leave with him and a physical altercation took place in the car where he hit her in the face.[18]

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[12] Coronial Brief, Statement of Timothy Howell dated 10 August 2016, 174.
[13] Above n 6, 72
[14] Above n 9, 174
[15] *ibid*, 176
[16] Above n 8, 72
[17] *Ibid*, 73
[18] *ibid*, 74

THE PURPOSE OF A CORONIAL INVESTIGATION

19. Wayne's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[19]

20. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[20] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[21]

21. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[22] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[23] or to determine disciplinary matters.

22. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

23. For coronial purposes, the phrase "*circumstances in which death occurred,*"[24] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

24. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

25. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[25]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[26] and

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[19] Section 4 *Coroners Act 2008*
[20] Section 89(4) *Coroners Act 2008*
[21] See Preamble and s 67, *Coroners Act 2008*
[22] *Keown v Khan* (1999) 1 VR 69
[23] Section 69 (1)
[24] Section 67(1)(c)
[25] Section 72(1)

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[27] These powers are the vehicles by which the prevention role may be advanced.

26. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[28] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[29] 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 that they caused or contributed to the death.

27. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

28. On 10 June 2016, the deceased was visually identified by Iolanda Brown, to be Wayne Brown, born 11 April 1978.

29. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

30. On 11 June 2016, Dr David Ranson (**Dr Ranson**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Wayne's body. Dr Ranson provided a written report, dated 29 September 2016, which concluded that Wayne died from a 'stab wound to the chest'.

31. Dr Ranson commented that several mechanisms of death could apply in relation to the stab wound to Wayne's left side chest. However extensive blood haemorrhage due to the incision of the left lung tissue most likely resulted in Wayne's death.

32. Toxicological analysis of the post mortem samples taken from Wayne identified the presence of a significant level of alcohol and traces of methyl amphetamine, cannabis and methadone.

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[26] Section 67(3)
[27] Section 72(2)
[28] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[29] (1938) 60 CLR 336

33. I accept the cause of death proposed by Dr Ranson.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

34. On Friday, 10 June 2016, sometime between 5.00pm and 5.45pm, Wayne contacted Michelle, asking her to meet him. Michelle did not want Wayne to come to her home as she did not feel safe meeting him on her own.[30] She spoke to Wayne's parents and obtained their permission to bring Wayne to their home. She agreed to collect Wayne from a TAB venue located on High Street in Cranbourne and suggested that they talk at his parents' house.

35. Between 6.30pm and 7.00pm, Michelle and Madison drove to the TAB venue located on High Street and picked up Wayne. Wayne had cans of alcohol and some marijuana on him at the time and also appeared inebriated.[31]

36. Shortly after being picked up, Wayne, Michelle and Madison arrived at Wayne's parent's house. Both of Wayne's parents were home and so was his brother Shane.[32] Wayne went to a shed located on his parents' property to have a talk with Michelle and Madison went to talk with Shane in his bedroom.

37. In the shed, Wayne was argumentative and admitted to Michelle that he was using 'ice' in the previous few days.[33] Wayne argued with Michelle over a number of family issues and returned to the main house to get more alcohol from the fridge in the kitchen.

38. Over a period of an hour or more, Wayne was verbally abusive and aggressive to all present in the house. He was repeatedly asked to leave the house and he prevented both of his parents from ringing the police, either by knocking the phone out of his mother's hands or by intimidating his father.[34] He expressly threatened Michelle with violence on multiple occasions and Madison at least once.[35]

39. After Wayne threatened Madison, she returned to Shane's room. Shane was concerned that Wayne was not going to leave and that his behaviour, which was becoming increasingly aggressive and disturbing, had to be stopped.[36]

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[30] Above n 8, 74
[31] *ibid*, 75
[32] *ibid*
[33] Coronial Brief, Statement of Iolanda Brown dated 11 June 2016, 80
[34] *ibid* 81; above n 29, 77
[35] *ibid*
[36] Coronial Brief, Interview transcript of Shane Brown dated 11 June 2016, 330

40. Shane took an ornamental knife from his room and walked down the hallway. He approached Wayne and stabbed him in the left side of the chest.[37] Following the stabbing, Shane returned to his bedroom and threw the knife into his wardrobe. He then left the house on foot.[38]

41. Wayne's father called emergency services.[39] Wayne's mother also rang Wayne's sister, Kelly, and requested she call an ambulance. Kelly called emergency services and she told the operator she was unaware of what was happening but that she was worried as "*my brothers are very violent*".[40]

42. The Police were first to the scene and they saw Wayne lying on the kitchen floor. At this time, Wayne was still conscious and breathing.[41] Michelle was crouching over him holding a towel against his back. Family members were initially uncooperative with police in providing details of who had stabbed Wayne and about the instrument used to cause the injury.[42]

43. Paramedics arrived shortly after the Police and took over the treatment of Wayne, who was complaining that he was unable to breathe. He was moved from the kitchen into the living room to allow better access to him. Ultimately, he lost consciousness and was declared deceased at 9.55pm.[43]

44. After fleeing his home, Shane went to Kelly's home. He was emotional and said, "*I'm so stupid, I stabbed my brother*", he also expressed suicidal ideation.[44]

45. The next day, on Saturday 11 June 2016, in the early afternoon, Shane surrendered himself at the Dandenong Police Station and admitted to stabbing and killing Wayne.[45]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

46. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by a person within the family unit is particularly shocking, given that it is expected to be a place of trust, safety and protection.

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[37] *ibid*
[38] *ibid*, 341
[39] Above n 4, 87
[40] Coronial Brief, Statement of Kelly Brown, dated 11 June 2016, 100
[41] Coronial Brief, Statement of Senior Constable John Nichols, dated 11 June 2016, 136
[42] *ibid*, 139
[43] Coronial Brief, Statement of Joshua Poole, dated 18 June 2016, 111
[44] Above n 40
[45] Coronial Brief, Statement of Acting Sergeant Ewen McLean, dated 11 June 2016, 161

47. After reviewing the evidence in this matter, I requested that the Coroners Prevention Unit (**CPU**)[46] examine the circumstances of Wayne's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[47]

48. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Wayne and Shane was one that fell within the definition of 'family member'. The act of Shane stabbing Wayne was an act of physical violence and constitutes "*family violence.*"[48] Wayne also perpetrated family violence against Shane and other family members close to him.

49. In this case, as Wayne was the primary perpetrator of family violence against numerous family members, the CPU examined the perpetrator specific risk factors which applied to Wayne's ongoing use of family violence.

50. The CPU identified the presence of known risk factors for family violence, in particular, Wayne had harmed his victims on previous occasions, had made threats to harm other family members, had threatened to suicide, persistently breached FVIOs, appeared to misuse alcohol and other illicit substances (including methylamphetamine), exhibited jealous and controlling behaviour towards Michelle, was unemployed, had mental health issues, and had a history of violent behaviour towards others. Five of these risk factors, the threat to commit suicide, drug/alcohol misuse, jealous behaviour, controlling behaviour and unemployment, also indicate an increased risk of a victim being killed or almost killed.[49]

51. Wayne and Michelle's relationship was also unstable, and potentially in the initial stages of separation. Separation is a relationship-specific risk factor that can also indicate an increased risk of violence, including fatal violence.[50]

52. Despite the presence of a number of known risk factors for family violence, the CPU identified limited opportunities for the legal system, health system or family violence service providers to intervene to reduce the risk of family violence between Wayne and his immediate family. It is clear in this case that the justice system and family violence perpetrator responses were unable to sufficiently address Wayne's ongoing use of family violence. Despite repeated

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[46] 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

[47] 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-focussed recommendations aimed at reducing the incidence of family violence in the Victorian community

[48] *Family Violence Protection Act 2008*, section 5(1)(a)(i)

[49] *ibid*, 28

[50] *ibid*

charges and incarceration for family violence related offending, Wayne continued to perpetrate family violence against a range of family members up to the day of his death.

53. Family violence is unfortunately overrepresented in Aboriginal communities.[51] Data presented in the Royal Commission into Family Violence (**the Royal Commission**) indicates that:

(a) Aboriginal people are more likely to experience family violence;[52]

(b) family violence homicides account for 67% of all homicides where both victim and offender are Aboriginal or Torres Strait Islander;[53]

(c) 44% of all male Aboriginal and/or Torres Strait Islander homicide victims were victims of domestic/family homicide;[54]

(d) 70% of indigenous homicides involve alcohol use by both perpetrator and victim.[55]

54. I note that the Royal Commission supports the existing 10 year plan for responding to family violence in Aboriginal communities and makes a number of recommendations regarding increased funding for culturally sensitive prevention and intervention initiatives.[56] I support these recommendations made by the Royal Commission to address family violence within Aboriginal families and communities.

55. On 10 May 2017, Shane was convicted of manslaughter and sentenced to six years and three months' imprisonment with a non-parole period of three years and three months.[57]

56. I am satisfied that the available evidence does not identify any obvious missed opportunities that could have prevented Wayne's death.

57. I am also satisfied, having considered all of the available evidence, that no further investigation is required.

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[51] Royal Commission into Family Violence: Report and recommendations. Aboriginal and Torres Strait Islander peoples, pp 1297

[52] Royal Commission into Family Violence: Report and recommendations. Aboriginal and Torres Strait Islander peoples, pp. 11-13 [1297-1299]

[53] Royal Commission into Family Violence: Report and recommendations. Aboriginal and Torres Strait Islander peoples, pp 1264

[54] Royal Commission into Family Violence: Report and recommendations. Review of family violence-related deaths, p. 230 , 1264

[55] Royal Commission into Family Violence: Report and recommendations. Perpetrators, pp. 960.

[56] See Aboriginal Affairs Victoria, 'Strong Culture, Strong Peoples, Strong Families: Towards a Safer Future for Indigenous Families and Communities—10 Year Plan' (Department of Planning and Community Development, October 2008)

[57] *R v Brown* [2017] VSC 240, 28

FINDINGS AND CONCLUSION

58. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Wayne Brown, born 11 April 1978;

    (b) the death occurred on 10 June 2016 at 155 Camms Road, Cranbourne, Victoria, from a stab wound to the chest; and

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

59. I convey my sincerest sympathy to Wayne's family.

60. Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this finding be published on the internet.

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

    (a) Colin and Iolanda Brown, senior next of kin; and

    (b) Detective Senior Constable Luke Farrell, Victoria Police, Coroner's Investigator.

Signature:

IAIN WEST
ACTING STATE CORONER
Date: 7 December 2018