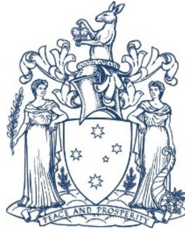


IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1110

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:	Brodie Moran
Date of birth:	5 February 2010
Date of death:	8 March 2018
Cause of death:	1(a) Suffocation
Place of death:	97 Alma Street, Tootgarook, Victoria

Amended pursuant to s.76 of the Coroners Act 2008 (Vic) on 14 May 2021 by order of the State Coroner, Judge Cain. Paragraph 39, 47, 49 and 58 were amended to correct the name of the referred medical practice. An amendment was also made to the cover page in respect of the date of birth.

INTRODUCTION

1. Brodie Moran (**Brodie**) was born at the Frankston Hospital on 5 February 2010 and was 8 years old at the time of his death. Brodie was attending Grade 2 at the Tootgarook Primary School and was the only child of Joanne Corinna Finch (**Ms Finch**) and Lee Moran (**Mr Moran**).

2. Brodie was known to be a beautiful, creative and thoughtful child. He was well behaved and never boisterous or unruly and was loved by all who knew him.[1]

3. Ms Finch was born and raised in England and travelled to Australia in 2005. Whilst in Australia, Ms Finch met with a former acquaintance, Mr Moran, who was already living and working in Melbourne. Ms Finch and Mr Moran commenced a relationship shortly after and started living together.[2]

4. Ms Finch fell pregnant around mid-2009 and was living with Mr Moran in a property they had purchased in Langwarrin, Victoria. On 5 February 2010, Ms Finch gave birth to Brodie at Frankston Hospital.

5. In 2014, Mr Moran was concerned about his employment in Australia and began looking for work overseas. He secured a job in Shanghai, China and was planning to travel first to settle in and have Ms Finch and Brodie join him the following six months. Mr Moran left Australia at the end of March 2014.[3]

6. Ms Finch ended the relationship with Mr Moran whilst he was in China around July 2015 and decided to remain in Australia with Brodie.

7. In October 2016, Ms Finch met Stephane Lucas (Mr Lucas) whilst working at a local café and moved into Mr Lucas' rental unit at 97 Alma Street, Tootgarook, Victoria shortly after. Ms Finch started working at a local nursery called the Digger's Club.

8. In July 2017, Ms Finch's grandmother died in England and she was reported to have been deeply affected by her loss. She and Brodie went to her grandmother's funeral in August 2017 before returning to Australia.

9. On 23 August 2017, Ms Finch's manager questioned her productivity and Ms Finch broke down crying about the loss of her grandmother and about whether she was a good mother or not. She

---

[1] *Coronial Brief*, Statement of Lee Moran dated 26 March 2018, 47
[2] Ibid, 39
[3] Ibid, 42

was taken home by the human resource manager and did not return to work. Ms Finch remained unemployed until February 2018, when she started working part-time at the Arc Café in Rosebud alongside her partner Mr Lucas who also worked at the company as a part-time chef.[4]

THE CORONIAL INVESTIGATION

10. Brodie'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.

11. 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.

12. 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.

13. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Brodie'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.

14. This finding draws on the totality of the coronial investigation into Brodies' death , 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. [5]

---

[4] *Coronial Brief*, Statement of Stephane Lucas dated 8 March 2018, 96

[5] 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.

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

Circumstances in which the death occurred

15. In the week leading up to Brodie's death, close acquaintances, co-workers and Mr Lucas reported that Ms Finch experienced a significant decline in her mental health.[6]

16. On 4 March 2018, the Sunday prior to Brodie's death, Ms Finch and Mr Lucas attended a camping weekend at Kennett River with the Volkswagen Club of Victoria. Ms Finch had been a member of this club during her relationship with Mr Moran. During the trip, one of the organisers spoke with Ms Finch who appeared upset and very down. Ms Finch confessed to the organiser that she felt like she had no friends.[7]

17. Later that evening, Ms Finch participated in a video chat with Mr Moran to facilitate time with Brodie.[8] During the video chat, Mr Moran disclosed that he was re-married and Ms Finch left the conversation midway to drink a glass of red wine. Ms Finch then disclosed to Mr Lucas that she was upset about Mr Moran re-marrying, that she wished Brodie had a better life and that she was a bad mother. Mr Lucas comforted her and she calmed down.[9]

18. The next day, Monday 5 March 2018, Ms Finch broke down at work, telling her colleagues that she felt like a failure, that she did not have any friends and that she did not fit in anywhere. Ms Finch's colleagues and boss observed her mood to have improved by the following day.[10]

19. On Thursday, 8 March 2018, Mr Lucas left the house at approximately 4.45am for work. At approximately 5.30am a neighbour heard a young boy scream that sounded like Brodie. The neighbour didn't hear anything further.[11]

20. At 1.25pm on the same day, Ms Finch contacted emergency services over the telephone and confessed to suffocating Brodie and that she had done this around 5.00am.[12] Ms Finch remained on the phone with the emergency service operator until Police and Ambulance paramedics arrived on scene at her residence on Alma Street, Tootgarook at approximately 1.38pm.[13] Ambulance paramedics found brodie lying in the bottom bunk in a bedroom close to the front

---

[6] *Coronial Brief*, Statement of Stephane Lucas dated 19 March 2018, 91
[7] *Coronial Brief,* Statement of Charmain Tennant dated 28 March 2018, 77
[8] *Coronial Brief*, Statement of Stephane Lucas dated 19 March 2018, 91-92
[9] Ibid, 92
[10] *Coronial Brief*, Statement of Lucy Galloway dated 12 May 2018, 82
[11] *Coronial Brief*, Statement of Stephane Lucas dated 8 March 2018, 97; Statement of Jane Griffin dated 8 March 2018, 102
[12] *Coronial Brief*, Exhibit 4 – Transcript of 000 call, 277-299
[13] *Coronial Brief*, Statement of Gregory Rundle dated 11 May 2018, 119

door. He was pronounced deceased upon inspection by paramedics and Police arrested Ms Finch and she was conveyed to the Rosebud Police Station.[14]

Identity of the deceased

21. On 13 March 2018, Lee Moran visually identified the deceased to be his son, Brodie Moran, born 5 February 2010.

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

Medical cause of death

23. Dr Essa Saeedi, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of the deceased and provided a written report of their findings dated 30 July 2018.

24. Dr Saeedi commented on the following:

    (a) Post mortem examination revealed: non-dysmorphic male child with early decomposition changes; petechial haemorrhages surrounding the right eye and involving the right eye conjunctiva; an abrasion inferior to the nose; minor abrasions and bruises involving the upper and lower limbs; heavy congested lungs with changes suggestive of asthma; normal larynx without evidence of fracturing or haemorrhage; minor hippocampal dysplasia;

    (b) Suffocation is a non-specific term used to describe death caused by reduction of the oxygen concentration of the atmosphere or by obstructing the nose or mouth (smothering). The signs that can be seen with suffocation are variable and non-specific ranging from obvious injuries to the body including the face and neck to no signs at all. Minimal petechial haemorrhages and minor skin changes were noted involving the face. These signs can be seen with cases of suffocation however they are non-specific and can be seen due to other causes; and

    (c) There was no evidence of natural disease that may have caused or contributed to death. The deceased did have lung changes suggestive of asthma however these changes appear to be minor.

[14] *Coronial Brief*, Statement of Leading Senior Constable Adam Devlin dated 9 March 2018, 125-132

25. Toxicological analysis of post-mortem specimens did not reveal the presence of alcohol or common drugs or poisons.

26. There is no evidence identified during the postmortem examination that any other person was involved in Brodie's death.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

27. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Ms Finch and Brodie was one that fell within the definition of 'family member'[15] under that Act. Moreover, Ms Finch's actions in fatally suffocating Brodie constitutes 'family violence'.[16]

28. In light of Brodie's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)[17] examine the circumstances of his death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[18]

29. The available evidence suggests that whilst Ms Finch had engaged with health services in the past, the only service that she was engaged with in the proximate period leading to the fatal incident was her General Practitioner at the South Coast Medical Clinic and two sessions with a counsellor at the Family Life Community House in November 2017 until December 2017.

30. At the time of Brodie's death, the above services that were involved with treating Ms Finch were primarily focused on her mental health needs and there were no prevention opportunities identified in the provision of these services.

Maternal filicides research

31. The tragedy of a parent killing a child, especially a mother is a devasting event in society. The research into filicides (the killing of a child by a parent), is relatively new and underdeveloped.

---

[15] Family Violence Protection Act 2008, section 8
[16] Family Violence Protection Act 2008, section 4
[17] 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
[18] 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

Research has shown that when a young child is murdered, the most frequent perpetrator is a victim's parent or stepparent.[19]

32. Research suggests that filicidal mothers in psychiatric samples had frequently experienced psychosis, depression, suicidality, and prior mental health care.[20] It is also noted that significant life stressors were often present in the circumstances leading up to the fatal incident[21] and that almost all the mothers had altruistic or acutely psychotic motives.[22] A small New Zealand study that interviewed six mothers after their filicides found that psychotic mothers who had committed filicide often killed suddenly without much planning, whereas depressed mothers had contemplated killing their children for days to weeks prior to their crimes as is the case with Ms Finch.[23]

33. I requested that the CPU review data from the Victorian Homicide Register relating to homicides between 1 January 2010 and 31 December 2020 involving maternal filicides.[24] This revealed 16 homicides during that period where a mother was involved in the death of her child or children. Of the 16 cases identified, at least 8 cases involved a mother who had a known or suspected mental health condition.

34. It is difficult to narrow down risk factors for maternal filicides as risk is increased when the mother is experiencing financial difficulties, unemployment and serious mental health issues, but these are common risk factors amongst many parents and especially single mothers.[25] This presents difficulties in prevention opportunities due to the commonality of these risk factors amongst non-filicidal mothers.

---

[19] Bureau of Justice Statistics, US Department of Justice. Homicide trends in the United States: infanticide, available online at: www.ojp.usdoj.gov/bjs/ homicide/children.htm.

[20] Susan Hatters Friedman and Phillip J. Resnick, '*Child Murder by mothers: patterns and prevention*' (October 2007), available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174580/#__sec1title

[21] Cheung PTK. Maternal filicide in Hong Kong, 1971-1985. *Med Sci Law.* 1986;26:185–192; Friedman SH. Hrouda DR. Holden CE, et al. Filicide-suicide: common factors among parents who kill their children and themselves. *J Am Acad Psychiatry Law.* 2005;33:496–504

[22] Friedman SH. Hrouda DR. Holden CE, et al. *Child murder committed by severely mentally ill mothers: an examination of mothers found not guilty by reason of insanity*. Journal of Forensic Science (2005) 50:1466–1471

[23] Stanton J. Simpson A. Wouldes T. *A qualitative study of filicide by mentally ill mothers*. Child Abuse Neglect. (2000) 24:1451–1460

[24] The Victorian Homicide Register (VHR) is a state-based suicide surveillance system that contains detailed information on people who die by homicide and the circumstances surrounding their death. The VHR uses enhanced data (pertaining to stressors, service contacts and legal system contacts), this enhanced data is coded into the VHR after the coronial briefs of evidence are received and the Coroner has made a determination regarding circumstances of death. Data was extracted from the Victorian Homicide Register, data includes both open and closed cases and the data set is from 1 January 2010 to 31 December 2020.

[25] Susan Hatters Friedman and Phillip J. Resnick, '*Child Murder by mothers: patterns and prevention*' (October 2007), available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174580/#__sec1title

Mental health history

35. Ms Finch's first known episode of mental illness was in 2010 when she was diagnosed with post-natal depression following Brodie's birth. Nine months after Brodie's birth she was admitted to Rosebud Hospital with Brodie for a few days and commenced on an antidepressant medication. Medical records indicated a stable mood and a plan to reduce and cease her antidepressant a few months after discharge, however it is unclear whether this occurred. From this time on, she experienced episodic fluctuations in her mental health resulting in episodic changes in treatment, which is usual in the course of most mental illnesses.

36. In April 2017, Ms Finch began attending South Coast Medical Clinic. She reported to Dr David Fineberg that she had been on antidepressant venlafaxine 150mg for a few years and was currently stable with no stressors and good protective factors. Coping strategies were discussed and her venlafaxine was reduced to 75mg, with a plan to further reduce to 37.5mg and stop the medication if she was doing well. The medical record was unclear whether Joanne requested this decrease or whether it was suggested by Dr Fineberg in the setting of a stable mental state.

37. In July 2017, Ms Finch' grandmother died in England and she travelled to England with Brodie for the funeral. She returned to Australia a month later and returned to work at a nursery a week after arriving home.

38. Over the months following Ms Finch' return from England, her managers at work had noted her productivity had reduced and that she appeared sad and distracted.

39. In September 2017, Ms Finch saw general practitioner (GP) Dr Ruth Mitchell at South Coast Medical Clinic for the first time. She reported increased anxiety due to the breakdown of her relationship with her partner, her grandmother's funeral, issues with relatives and with the Will. Ms Finch also advised that she had self-increased her venlafaxine back to 150mg and requested a medical certificate for Centrelink, which was provided.

40. On 23 October 2017, Ms Finch's workplace manager, Robert, attempted to discuss her productivity and she began crying. Robert took Ms Finch to see another workplace colleague, Elizabeth. Elizabeth stated that Ms Finch was speaking gibberish about not being able to work, not being a good mother, about the death of her grandmother and her mental health plan. Elizabeth spent two hours attempting to console Ms Finch and during that time, Ms Finch repeated several times "*I am a good mother Elizabeth, I am a good mother*".

41. Elizabeth decided to drive Ms Finch home. During the drive home, Ms Finch continued to be upset and Elizabeth described her as talking in riddles. Elizabeth had to stop at one point because Ms Finch was so upset. Elizabeth went with Ms Finch into her house and Ms Finch calmed down, however was anxious about her house being a mess. She stopped crying and told Elizabeth that she would take some ibuprofen for a headache and that she needed sleep. Elizabeth set Ms Finch's alarm so she could collect Brodie from school and asked her to call her partner, Mr Lucas. Ms Finch initially declined to contact Mr Lucas, but agreed when Elizabeth stated she would not leave until she did. Elizabeth asked to see the message that Ms Finch sent Mr Lucas and his response, which indicated that Ms Finch would see her doctor the following day and Mr Lucas would be home that night.

42. On 23 October 2017, Ms Finch saw Dr Mitchell for a routine pap smear during which her mental state was reviewed. Ms Finch reported that work was ok and that she felt supported at work but unable to work there at present. Ms Finch also asked for a Centrelink Certificate for three months and reported that 150mg of venlafaxine suited her. In her statement, Dr Mitchell reported discussing a referral to a private psychologist, however Ms finch declined as she could not afford it. She was given contact details for public mental health services which do not incur a cost to the patient.

43. Ms Finch attended an intake session at Family Life Community House in November 2017 after self-referring, and one further session in December 2017. Between November 2017 to March 2018, Ms Finch cancelled or did not attend several sessions and arrived unannounced on several occasions and was unable to be seen. In December 2017, Ms Finch sent a text cancelling an appointment and stated that she could not attend until after school holidays.

44. On 23 January 2018, Ms Finch saw Dr Mitchell and reported to feel much better and wanted to resume working up to 15 hours per week. Her Centrelink certificate was altered to allow her to work and her venlafaxine remained the same.

45. On 2 February 2018, the last time Ms Finch saw Dr Mitchell, she reported poor sleep and worry about starting work the following week. She asked about sleeping tablets and was advised to try an antihistamine-based tablet. She asked to increase venlafaxine to 225mg which Dr Mitchell agreed to.

Review of the mental health treatment provided to Ms Finch

46. I directed mental health specialists within the CPU to review the mental health services that had proximate contact with Ms Finch, including her General Practitioner (**GP**) and the Family Life Community House where Ms Finch received counselling. There were no identified issues with the services provided by these two health services.

47. The treatment provided by GPs at South Coast Medical Clinic was appropriate. There was no evidence in the medical record or Dr Mitchell's statement that Ms Finch had thoughts of homicide and other than an entry stating that Ms Finch had a seven-year-old son, there was no other mention of Brodie in Ms Finch's medical record[26]. There was no evidence that Dr Mitchell was aware of the full extent of Ms Finch's distress or poor coping, which only became evident after Brodie's death following information disclosed by various friends, family members and employers/co-workers.

48. At Ms Finch's request, on 23 October 2017 Dr Mitchell provided Ms Finch with a medical certificate to provide to Centrelink, covering a period of three months,. The provision of a medical certificate does not necessarily indicate increased risk and the duration of a medical certificate does not correlate with the severity of illness.

49. Dr Mitchell attempted to refer Ms Finch to a private psychologist at the October 2017 appointment however, Ms Finch declined as she was unable to pay the gap-payment[27]. Dr Mitchell provided Ms Finch with contact details to refer herself to Peninsula Health mental health services which do not incur a cost. There was also no evidence that Ms Finch satisfied the criteria for compulsory treatment under the *Mental Health Act 2014* (Vic) during any appointments at South Coast Medical Clinic and therefore she was unable to be forced to engage with services against her wishes.

50. Despite this, Ms Finch did engage in general counselling Family Life Community House[28] in November and December 2017 and attempts were made by Family Life Community House to continue engaging with Ms Finch until her death, however her compliance with appointments

---

[26] Brodie's medical records was not provided to CPU and therefore it is unknown whether he saw a GP and/or whether Joanne raised any concerns during Brodie's GP appointments.

[27] This was not documented in the medical record, but was included in Dr Mitchell's statement.

[28] General counselling typically is provided by a counsellor who is not a registered psychologist, mental health nurse, social worker or other registered mental health professional. General counsellors typically complete a training course which includes education about depression, anxiety and suicide however they do not require a tertiary degree in a health or wellbeing related area. General counselling typically involves talking through problems in a supportive manner, however not necessarily a structured psychotherapy program that would be provided by a registered mental health practitioner. General counselling typically incurs little or no cost.

was poor. For effective outcomes in therapy with any counselling or private practitioner, engagement is paramount. In addition, it cannot be concluded that a referral to or engagement with a private psychologist or public mental health service would have prevented Brodie's death.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Brodie Moran born 5 February 2010;

    (b) the death occurred on 8 March 2018 at the 97 Alma Street, Tootgarook, Victoria from I(a) Suffocation; and

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

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

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

COMMENTS

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

54. The unexpected, unnatural and violent death of a young child is a devastating event. Violence perpetrated by a family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

55. Ms Finch experienced depression and anxiety for several years, with expected fluctuations in mental state and changes in treatment during that time. Most recently, her mental state appeared to be affected by the death of her grandmother in July 2017.

56. A review of all the available evidence from Ms Finch's two workplaces, her ex-husband, her current partner, her friends, Brodie's school and her GP, it was apparent that she was experiencing significant distress and was not coping. However, the entirety of this information was not available to a single person or service before Brodie's death.

57. While the extent of Ms Finch's distress was not known to those around her, multiple people noted some level of distress and encouraged her to attend her GP, which Ms Finch said she

would, but often did not. When she did attend her GP, it appeared that she did not disclose the incidents which made her family and friends concerned for her wellbeing. It was also not apparent to any individual or service that Ms Finch was at risk of harming Brodie, as the only indication of this was found in her internet history, which was only discovered as a result of Brodie's death.

58. The treatment provided by GPs at South Coast Medical Clinic was appropriate. Attempts were made to engage Ms Finch with a mental health professional and she did not satisfy criteria for compulsory treatment under the *Mental Health Act 2014* (Vic). The prescribing of venlafaxine by her GP was appropriate and within clinical guidelines. Ms Finch increased the dose twice over five months, which is a gradual increase in the context of clinical guidelines indicating increases after not less than four days.

59. 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.

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

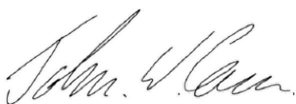
Mr Lee Moran, Senior Next of Kin

Ms Anjali Woodford, Kennedy's (Australasia) Pty Ltd

Dr Ruth Mitchell

Detective Leading Senior Constable Justin Tippett, Coroner's Investigator

Signature:



JUDGE JOHN CAIN

STATE CORONER

Date: 20 May 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.