IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006879

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Mrs A

Delivered On:	7 April 2022
Delivered At:	Coroner's Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing Dates:	7 April 2022
Findings of:	Judge John Cain, State Coroner
Counsel Assisting the Coroner	Nicholas Ngai, Family Violence Senior Solicitor
Catchwords:	Family violence; intimate partner homicide; mandatory inquest; murder-suicide

INTRODUCTION

1. Sometime between the late evening of 18 December 2020 and early morning of 19 December 2020, the body of Mrs A aged 77 years old was discovered by emergency services attending a housefire set at her residence.

2. At the time of her death, Mrs A lived with her husband, Mr B whose body was also discovered by emergency services at 33 Keats Avenue, Kingsbury, Victoria. There were no children of the relationship between Mrs A and Mr B.

3. On the 16 March 1943, Mrs A was born to parents, Alice Ursanscky and Keith Sharp. At the time of Mrs A's birth she had an older sister, Sandra Sharp, who was born in 1942.

4. At about the age of two, Mrs A was placed in an orphanage by her parents. At about the age of four, Mrs A was taken in by her Aunt and uncle, Alice Cochrane and Lawrence Cochrane who raised her as their own in Kew, Victoria. Alice and Lawrence Cochrane also had three other children at the time.

5. In 1983, Mrs A married Mr M in the Church of Scientology and became Mrs A. Prior to Mr M's death in 1991 they resided at 33 Keats Avenue, Kingsbury.

6. After the death of Mr M in 1991, Mrs A and Mr B formed a relationship and were married on the 15 April 2000. Following their marriage in April 2000, they continued to reside at the Kingsbury address.

7. Mrs A was a member of the Church of Scientology and was employed as a schoolteacher, predominantly working at Lalor North Secondary College as a Home Economics Teacher. Mrs A remained working at this school up until her death.

8. Mrs A is described as being confident, caring, energetic and an assertive woman, however family and friends indicate she seldom spoke of her private life. She appeared to have been devoted to her work as a teacher at Lalor North Secondary College.

9. Mrs A reportedly loved her job and had no intention of retiring from her role. Her final day at school was the 18 December 2020, where her Principal, Ms F described her as being

joyful and happy. Mrs A had packed up her bags with activities to complete over the holiday period.

10. Mrs A reminded Ms F that she would return to work in the new year.

THE CORONIAL INVESTIGATION

11. Mrs A's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Mrs A ordinarily resided in Victoria[1] and the death appears to have been unexpected and violent.[2]

12. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death.

13. 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.

14. 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.

15. 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.

---

[1] Section 4 *Coroners Act 2008*
[2] Section 4(2)(a) *Coroners Act 2008*

16. 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.[3]

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

Circumstances in which the death occurred

17. On the 19 December 2020, at approximately 3.35am, firefighters from Fire Rescue Victoria attended the Kingsbury address on Keats Avenue and discovered the deceased bodies of Mr B and Mrs A.

18. Police and Fire investigators were unable to determine the exact time that Mrs A was killed, however it is believed that between the time that Mrs A arrived home from her last day of work on the 18 December 2020 and 3.22am on the 19 December 2020, Mr B has struck Mrs A to the head before tying a ligature around her neck subsequently killing her.[4] It is most likely that this fatal assault has occurred once Mrs A has prepared to retire for evening. This can be evidenced as Mrs A was located deceased in her nightwear.[5]

19. At approximately 10:33PM on the 18 December 2020, Mr B drove his car out of the driveway of the Kingsbury address, before parking in front of Mrs A's car on the street outside 35 Keats Avenue, Kingsbury.[6] At 10:34PM, Mr B exited the vehicle, before locking it with the keypad and walking back towards the Kingsbury address.[7]

20. It is believed that prior to the fire being ignited, Mr B attended his garage, where he obtained containers of kerosene and petrol and commenced pouring these accelerants around the inside of the house, particularly in the hallway and within their main bedroom where Mrs A

---

[3] 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.

[4] *Coronial Brief*, Statement of Detective Acting Sergeant Daniel Basile dated 8 March 2021, 175-177; Statement of Forensic Officer John Desmond Kelleher dated 4 January 2021, 156

[5] Ibid

[6] *Coronial Brief*, Exhibit 2 – CCTV footage provided to the Court

[7] Ibid

laid deceased.[8] It is further believed that Mr B then continued to prepare to set the house on fire by leaving the front door ajar and propping open the rear door with the container of kerosene.[9]

21. At approximately 3:18AM, Mr B is visible on CCTV to exit the front door of the Kingsbury address igniting what appears to be a stove lighter.[10] Mr B walked around the front of the house out of sight. A short time later he re-appeared with what appeared to be the stove lighter still ignited before re-entering the house.[11]

22. At 3:22AM, a bright explosion occurs inside the Kingsbury address as the fire is lit from within.[12] CCTV footage provided to the Court indicates that no one is observed leaving the house following the commencement of the fire until Fire Rescue Victoria members arrive.[13] There are no other persons or vehicles observed leading up to or following the commencement of the fire.

23. At approximately 3:25AM, a neighbour was walking along Keats Avenue when he heard a smoke alarm and noticed smoke coming from the Kingsbury address. After pausing briefly, the neighbour realised a fire was occurring and ran home to obtain a charger so he could call triple zero.[14]

24. At approximately 3:35AM, Fire Rescue Victoria attended the Kingsbury address.[15] Firefighters approached the front door of the house and noticed the front security door and front wooden door were both left ajar.[16]

---

[8] *Coronial Brief*, Statement of Detective Acting Sergeant Daniel Basile dated 8 March 2021, 176
[9] Ibid
[10] *Coronial Brief*, Exhibit 2 – CCTV footage provided to the Court
[11] Ibid
[12] Ibid
[13] Ibid
[14] Ibid
[15] Ibid
[16] *Coronial Brief,* Statement of Firefighter Benjamin De Bondt undated, 55-56

25. Firefighters began extinguishing the fire in front of them and to the left of the hallway. Once inside the house, firefighters inspected the second room to the right of the hallway and observed two bodies lying on the bed.[17]

26. Other firefighters in attendance approached the rear door of the house. They observed that the security door was unlocked, and the wooden door was propped open with a metal fuel can.[18]

27. After a short while, the scene was attended by multiple members of Victoria Police. Due to the serious nature of the incident a crime scene was established awaiting specialist examiners to attend and forensically examine the scene. Both Mr B and Mrs A were confirmed deceased onsite.[19]

Identity of the deceased

28. On 24 December 2020, Mrs A born 16 March 1943, was identified via a forensic odontologist's report.

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

Medical cause of death

30. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 19 December 2020 and provided a written report of her findings dated 17 June 2021.

31. Dr Baber noted the following from her post-mortem examination:

    a) Death was due to neck compression. There may have been some contribution from the blunt force trauma to the head in terms of immobilising the deceased prior to neck compression;

[17] Ibid, 57
[18] Ibid, 59-60
[19] *Coronial Brief*, Statement of Firefighter Glen Walton dated 19 December 2020, 46-47

b) Some natural disease was identified but had no bearing on the cause of death;

c) There was no evidence of defence-type injuries; and

d) There was no evidence of vitality during the fire, i.e. no soot or heat effect to the upper or lower airways.

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

33. Dr Baber provided an opinion that the medical cause of death was 1 (a) Neck Compression in the setting of blunt force trauma to the head.

34. I accept Dr Baber's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

Fire and criminal investigations

35. This case resulted in a significant criminal investigation was undertaken by Detective Senior Constable Edwards of the Reservoir Family Violence Investigation Unit. Victoria Police Fire and Explosion Unit Forensic Officers John Kelleher and Nicole Bond handled the fire aspect of the investigation.

36. The fire investigators noted the following about the scene:[20]

a) Stove lighter determined to be likely source of ignition for the fire was located on the bed next to Mr B' hand/face.

b) There were no signs of forced entry to the house.

c) Both bodies of Mr B and Mrs A were found on the bed, Mrs A had visible signs of a head injury and a ligature tied around her neck.

[20] *Coronial Brief*, Statement of Forensic Officer John Desmond Kelleher dated 4 January 2021, 151-156; Exhibit 34 – Fire Rescue Victoria 'Fatal Fire Investigation Report', 310-315

d) Front and back doors were left open which is likely to have assisted with airflow to the house during the fire. The rear door was propped open with a container of kerosene.

e) Signed letters left by Mr B addressed to Mrs A (dated 10 December 2020) and a close friend (dated 11 December 2020):

   i. Letter to Mrs A - Mr B includes his reasons for committing suicide. He also indicated his proposed method would be by either hanging himself or burning the house down with both of them in it, which indicated premeditation.

   ii. Letter to a close friend – Mr B indicated he intended to do this following the end of the school year. This incident occurred in the early morning after the school term finished for Mrs A, which again indicates premeditation.

   iii. Mr B' signatures on both letters are an extremely good likeness for the signature he previously provided on his marriage certificate.

f) A document dated 26th of November 2020 and titled 'Info for MRS A 26/11/2020' was found in the Kingsbury residence and included details of various bank accounts, email addresses, RACV and password information in relation to his computer. The date of this document correlates with a comment made in his suicide letter to Mrs A. In his suicide letter, Mr B indicates he started contemplating suicide on the 27th of November 2020.

g) The main fires were concentrated in the hallway outside the bedroom and within the bedroom itself where the couple were located.

h) Accelerant used to assist with starting the fire was determined to be petrol and kerosene. Both of which were located on scene.

i) CCTV footage from a neighbouring property on Keats Avenue, Kingsbury shows Mr B minutes before the fire with what appears to be a stove lighter in his hand. Leading up to and following the fire, no other persons or vehicles are observed

attending or leaving the address. The footage appears to depict Mr B not wearing pants which is consistent with how he was ultimately located.

j) Dash camera footage from Mr B's vehicle, showing Mr B moving his vehicle out of the driveway and onto the street outside 35 Keats Avenue, Kingsbury at 10:33PM on the 18th of December 2020. This would appear to have protected his vehicle from the subsequent fire.

k) House and car keys were left in the letter box of the Kingsbury address, which would indicate Mr B keeping the keys safe and away from the fire.

37. Inspection of the Kingsbury address and subsequent investigation lead criminal investigators to conclude that Mr B initially struck Mrs A causing a head injury (skull fracture) as referenced by Forensic Pathologist, Dr Baber. It appears that Mr B then used a ligature which he tied around the neck of Mrs A causing her subsequent death.[21]

38. It is then believed that Mr B began preparing to set the house on fire in order to cause his own death.[22] Mr B attended the rear shed where he obtained containers of petrol and kerosene and concentrated their use in the hallway outside Mrs A's bedroom and within the bedroom itself. Mr B then obtained the stove lighter and set the house on fire. Once the fire ignited, Mr B went and laid on the bed next to the already deceased Mrs A. Mr B left the stove lighter next to him and the resultant fire ultimately caused his death.

39. Victoria Police Fire Forensic Officer John Kelleher in his conclusion determined that the:

> '*cause of the fire was the ignition of combustible material in the second bedroom and in the hallway, assisted by the presence of both petrol and kerosene around the bed and across the top of the bed. This fire may have spread into the hallway through ignition of the cardboard flooring boxes by radiant heat, but it is possible that material in the hallway was ignited separately.*[23]

40. In relation to 'sources of ignition', Forensic Officer John Kelleher states that:

---

[21] *Coronial Brief*, Statement of Detective Senior Constable Steven Willer dated 8 March 2021, 165-169
[22] Ibid
[23] *Coronial Brief*, Statement of Forensic Officer John Desmond Kelleher dated 4 January 2021, 156

"There were no appliances likely to ignite a fire in the bedroom or in the hallway. There was no evidence of smoking in the house. The obvious source of ignition was the stove lighter on the bed. No other ignition sources were identified in the vicinity. Whilst there were light switches and appliances elsewhere in the house, the mixture of petrol and kerosene is less volatile than petrol alone, and these are unlikely to be ignition sources."[24]

Family violence investigation

41. 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.

42. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr B and Mrs A was one that fell within the definition of '*spouse'*[25] under that Act. Moreover, Mr B's actions in fatally assaulting Mrs A constitutes '*family violence'*.[26]

43. In light of Mrs A's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[27] examine the circumstances of Mrs A's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[28]

44. The available evidence suggests that Mr B' exhibited behaviours that aligned with more traditional gender roles and beliefs of their generation. There was no evidence however to suggest that there were concerns of family violence between the couple in the lead up to the fatal incident.

---

[24] Ibid
[25] Family Violence Protection Act 2008, section 9
[26] Family Violence Protection Act 2008, section 8(1)(a)
[27] 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
[28] 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

45. At the time of the couple'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.

COMMENTS

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

Homicide-suicides in advanced age couples

46. The available evidence in this case suggests that in the lead up to the fatal incident, Mr B and Mrs A experienced several significant relationship stressors including potential separation, financial disputes, Mr B health and the stress over isolation from the COVID pandemic. Mr B had concerns about his own deteriorating health even though Mrs A was in general good health for her age.[29]

47. Research into intimate partner homicide-suicides has identified a unique set of characteristics regarding homicide-suicides amongst elderly couples. Findings indicate that individuals amongst this population have often been married for many decades, may have been suffering from a significant illness at the time of the fatal incident and may have been experiencing financial problems and/or social isolation.[30]

48. Mrs A's murder, and the subsequent suicide of Mr B, appear to have several characteristics consistent with the category of homicide-suicides amongst aged couples. Mr B and Mrs A were an elderly couple who had been married for many years and both of them had been experiencing declining health in the years and months leading up to the fatal incident.

49. Both Mr B and Mrs A also suffered from social isolation due to the COVID pandemic lockdown restrictions in Victoria that prevented them from seeing close friends and family members.

---

[29] *Coronial Brief*, Statement of Dr Rina Melvani dated 2 April 2021, 130

[30] Australian Government-Australian Institute of Criminology, *Murder-suicide in Australia,* No. 176 2008 <https://aic.gov.au/publications/cfi/cfi176>

50. Research highlights that in cases such as these, the act of homicide and suicide may be consensually agreed upon, '*whereby there has been an agreement that this course of action is preferable to living with a debilitating illness or unfavourable living conditions*.'[31] Police investigations into the death of Mr B and Mrs A, however, found no indication that Mrs A was aware or agreeable to Mr B' actions.

51. Mr B was likely to have been suffering from an undiagnosed mental health condition in the lead up to the fatal incident as several close friends and family noted his mood swings, periods of high energy and periodic manic behaviour.[32]

52. Mr B and Mrs A both told close friends in the 15 months leading up to the fatal incident that they were contemplating separation. In April or May 2019 Mrs A told a friend that she and Mr B were separating as they '*did not see eye to eye'*.[33] A friend of Mr B indicated in a statement that he had been told the couple were planning to separate in August 2020.[34]

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

FINDINGS AND CONCLUSION

54. 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 16 March 1943;

    b) the death occurred between 18-19 December 2020 at 33 Keats Avenue, Kingsbury, Victoria, 3083, from neck compression in the setting of blunt force trauma to the head; and

    c) the death occurred in the circumstances described above.

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

---

[31] Roger Byard, '*Murder- Suicide; An Overview',* Forensic Pathology Reviews (2005) Vol 3, 345.
[32] *Coronial Brief,* Various Statements of close friends and family.
[33] *Coronial brief*, Statement of Julian Bassett dated 20 March 2021, 117
[34] *Coronial brief*, Statement of Ken Young dated 6 February 2021, 121

Pursuant to section 73(1) 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:

Ms G, Senior Next of Kin

Ms H, Senior Next of Kin

Mr Scott Gan, Austin Health

State Trustees Limited

Detective Senior Constable Matthew Edwards, Coroner's Investigator

Signature:

_____

Date:

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 inquest. 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.