IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 000474

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:	Daniel Surtees
Date of birth:	8 May 1983
Date of death:	26 January 2020
Cause of death:	1(a) Complications of thermal burn injuries
Place of death:	Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	Family violence; homicide; history of family violence

INTRODUCTION

1. On 26 January 2020, Daniel Surtees was 36 years old when he passed away at the Alfred Hospital from complications arising from thermal injuries.

2. Daniel met his wife, Angela Surtees, in late-2009 to early-2010 and they married in 2015. They shared two daughters together, and Daniel had a daughter from a previous relationship who lived with her mother. Angela had a son and a daughter from a previous relationship. Her son lived with her and Daniel, whilst her daughter lived with her paternal grandparents.

3. Angela reportedly experienced intimate partner violence in multiple relationships, including with Daniel, and reportedly experienced sexual abuse during her childhood. Family members described Daniel and Angela's relationship as "*toxic*" and "*volatile*", as they often argued and were "*at each other's throats*". Daniel's mother-in-law observed that Daniel was "*a really great bloke when he was sober even when he had a couple [of drinks] he was fine…However, when he would have a lot he would get angry*".

4. In June 2017, Daniel physically assaulted Angela, resulting in Angela using a knife in self-defence. Police charged Daniel with unlawful assault and applied for a family violence safety notice (**FVSN**) to protect Angela. Daniel was later convicted of unlawful assault and a final family violence intervention order (**FVIO**) was granted for a period of 12 months. Daniel was recorded as a respondent in six other family violence incidents between 2005 and 2017.

5. In June 2019, a neighbour overheard an argument between Daniel and Angela in which Angela was overheard calling for help and expressing fear for her life. The neighbour was unable to provide the precise location of the argument and when police arrived at the scene, they were unable to locate Angela or Daniel.

THE CORONIAL INVESTIGATION

6. Daniel'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.

7. 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.

8. 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.

9. Victoria Police assigned Senior Sergeant Glen Weaver to be the Coronial Investigator for the investigation of Daniel's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating paramedics and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Daniel Surtees including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

11. On 26 January 2020, Daniel Surtees, born 8 May 1983, was visually identified by his brother, Luke Surtees.

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

Medical cause of death

13. Forensic Pathologist Professor Noel Woodford, Director of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy/examination on 27 January 2020 and provided a written report of his findings dated 7 May 2020.

14. The post-mortem examination revealed over 80% of the body surface area appeared to have sustained extensive deep burns. The severity and extent of the burning was associated with a very high mortality. There was also evidence at autopsy and on clinical examination of soot

[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.

inhalation which may have resulted in the inhalation of toxic smoke products as well as damage to the airways. These factors further increased the risk of death.

15. There was no natural disease identified of a type likely to have caused or contributed to the death.

16. There were no other injuries identified of a type likely to have caused or contributed to the death. No skeletal fractures were noted at either autopsy or on post-mortem CT scanning.

17. Prof Woodford explained that extensive burns such as those identified in this case are associated with marked biochemical and metabolic derangements, leading to cardiovascular instability, organ failure, marked fluid shifts and toxaemia.

18. In addition, Prof Woodford noted patchy areas of apparent sparing on the lower torso (front and back) as well as the head and neck region. Nevertheless, there was still evidence of focal burn injury and singeing of facial hairs. The relative sparing of the head and neck regional suggested that the deceased was not in a vertical position for a significant length of time after the fire started. However, Prof Woodword explained that the behaviour of fire can be unpredictable.

19. Toxicological analysis of ante-mortem samples (obtained more than 10 hours after admission) identified the presence of morphine, midazolam, ketamine and lignocaine, which were in keeping with being administered by medical personnel.

20. Prof Woodford explained that as the ante-mortem sample was obtained more than 10 hours after Daniel's admission to hospital, it was possible that some chemicals or substances present at the time of admission may not have been able to be detected, for example, possible toxic smoke products such as hydrogen cyanide and carboxyhaemoglobin.

21. Prof Woodford provided an opinion that the medical cause of death was *complications of thermal burn injuries.*

22. I accept Prof Woodford's opinion as to the medical cause of death.

Circumstances in which the death occurred

23. On 25 January 2020, Daniel and Angela attended an engagement party in Corio together. Over a five-hour period, Daniel consumed about 14 cans of Jack Daniels bourbon. Whilst at the party, Daniel mistakenly believed some of the other partygoers were making disparaging

comments about him. Angela and some other partygoers tried to placate Daniel, however, were unable to calm him down. Daniel became verbally abusive to Angela and threatened to "*kick her head in*" and threatened to do the same to some of the partygoers who he had argued with. Angela decided to leave the party early with Daniel.

24. Angela drove home from the engagement party, with Daniel seated in the front passenger seat and their two children in the rear seats. Angela's son from her previous relationship was also located in the back seat. Daniel was agitated regarding the party, continued his argument with Angela and began striking the dashboard with his fists. During the drive home, he damaged the lid of the centre console.

25. When Daniel and Angela arrived home, they continued their argument. A neighbour heard continuous yelling for about 20 minutes that evening. At some point, Daniel was out the front of the family home where he threw a rubbish bin to the ground and later yelled at a man passing by the front of the house. When the man and his friend returned later that evening, Daniel apologised and explained that he was "*having a really bad day*".

26. Angela provided different versions of the events that occurred that night. It appears that Angela and Daniel continued to argue in the sunroom, whilst the three children watched television in the lounge room. Police originally alleged that Daniel brought a jerry can of petrol into the sunroom, whilst in the sentencing remarks for Angela, it was noted that the jerry can had been in the sunroom for the past day or two and was ordinarily stored in the backyard shed.

27. Regardless of how the jerry can came to be in the sunroom, Angela unscrewed the lid and splashed a "*considerable amount*" of petrol over Daniel. Daniel reportedly lunged at Angela in response. Police alleged that Daniel also grabbed Angela by the throat during this time, however when Angela later underwent a forensic physical examination, there was no evidence of same.

28. Angela obtained a disposable lighter, ignited it and threatened Daniel by holding the lighter near him. The petrol caught alight, and Daniel became largely engulfed in flames. The prosecution case against Angela that she did not intend to ignite Daniel, rather, she only intended to cause him fear that he might catch on fire.

29. Daniel ran out onto the front lawn and began rolling around on the grass in an attempt to extinguish himself. Angela's sleeve also caught fire, which she put out before using the garden

hose to douse Daniel and extinguish the fire. Angela told her eldest son to call 000 and hand her the phone. An ambulance arrived quickly and transported Daniel to University Hospital Geelong. Daniel was later airlifted the Alfred Hospital where he was admitted to the Intensive Care Unit.

30. Angela initially remained at home, called her mother and requested she and her husband come over to look after her children. Angela's stepfather remained at the home whilst Angela's mother drove her to University Hospital Geelong, where she provided an account of what occurred to medical staff. Police arrested Angela at University Hospital Geelong, and she was provided with her caution and rights. After receiving treatment for her burns, she was transported to Geelong Police Station and was interviewed in relation to the incident.

31. Daniel's injuries were deemed non-survivable, and he passed away on 26 January 2020 at the Alfred Hospital. Following his death, Angela was initially charged with one count of murder, however later pleaded guilty to one charge of manslaughter.

32. Angela was originally sentenced to 12 years' imprisonment with a non-parole period of eight years. Angela appealed this sentence and was resentenced to 10 years and six months' imprisonment, with a non-parole period of seven years.

FURTHER INVESTIGATIONS AND CPU REVIEW

33. As Daniel's death occurred in circumstances where there was a reported history of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of his death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3] In particular, the CPU considered the incident in June 2019 between Daniel and Angela, and whether there were any opportunities to intervene prior to the fatal incident.

34. The CPU noted the statement of the neighbour, Amanda Jensen, who overheard the argument between Daniel and Angela. Ms Jensen stated that she heard a male (Daniel) yell "*something about [Angela] either sleeping or flirting with someone and from memory she told [Daniel]*

[2] 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.

[3] 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

that he was drunk". Ms Jensen stated that she and her adult son were watching the couple argue on the street through their door, and she witnessed the male punch the female, however the punch was "*sloppy as the male appeared to be drunk or under the influence of something*".

35. Ms Jensen stated that the pair continued walking down the street and the argument continued. Ms Jensen called 000 as she was concerned that the argument appeared to be escalating. After her first call to 000, she stated she heard words to the effect of "*please stop, you are hurting me! Please help me*". At this time, Ms Jensen called 000 again. Ms Jensen and her son went outside their home and listened to the ongoing argument for some time, then eventually returned inside and went to bed. Ms Jensen's statement suggested that she did not speak to police after the two phone calls. This statement was made on 4 February 2020, about eight months after the June incident and a few weeks after the fatal incident.

36. In their submissions to the Court, Victoria Police noted Ms Jensen's first call was placed at 10.38pm. The 000 call-taker recorded:

> *DISPUTE – M VS FRE – F SLEEPING WITH SOMEONE OR SIMILARNK VTHREATS – I'M GONNA SMASH YOU IN THE FACE…NIL W SIGHTEDALL HEARD NIL SIGHTEDPOSS D/A AFFECTEDGONE QUIETLAST HEARD 2 MINS AGONIL CHILDREN PRESENTNIL ORDERS MENTIONED=== DO NOT SEE CALLER*

37. The above comments suggested that the caller did not sight the male or the female and it was a possible domestic argument. There was no record of a physical assault occurring in those notes.

38. Ms Jensen placed a second call at 10.46pm, with the 000 call-taker recording the following:

> *FURTHER CALL RE FAMILY DISPUTEOPP AACALLER CAN HEAR F YELLING OUT FOR HELP AND CRYING…NIL SEEN HEARD ONLY…SOUNDS LIKE M IS BEING V*

39. The above comments suggested that the caller did not sight either party, but it sounded as though the male was being violent.

40. Upon a review of the Emergency Services Telecommunications Authority (**ESTA**) computer aided dispatch (**CAD**) event report, the following entry was noted:

S/T COMP. HEARD ONLY. STATED M AND F WERE IN STREET ARGUING AND WALKING. UNKNOWNDIRECTION OF TRAVEL. NOT KNOWN IF LIVING IN AREA. NOT HEARD FOR OVER 1 HR

41. Despite Ms Jensen's statement, it would appear that police spoke with her, and she explained that she only heard the argument and did not witness anything. Police added a comment to the CAD event report stating that they patrolled the arear but did not sight the male or the female.

42. The CPU were initially critical of the apparent failure for police to speak to Ms Jensen about what she witnessed, particularly given her statement that she witnessed an assault between Daniel and Angela. However, I note that her statement was made eight months after it occurred in June 2019, and only weeks after the fatal incident. Upon a review of the CAD event report, there was no record of a physical assault, and the call-taker noted that the witness did not see anything, only heard the incident.

43. In circumstances where the CAD event report notes were made at the time of the incident and Ms Jensen's statement was made many months later, I am of the view that the CAD event report is likely to be more accurate. This is not intended as a criticism of Ms Jensen's statement; rather I accept that with the passage of time including the fatal incident on 25 January 2020, that her memory may have faded or changed.

44. I therefore make no criticism of the police response to the incident between Angela and Daniel in June 2019. I have not identified any prevention opportunities in relation to this matter.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Daniel Surtees, born 8 May 1983;

    b) the death occurred on 26 January 2020 at Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from *complications of thermal burn injuries*; and

    c) the death occurred in the circumstances described above.

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

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.

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

Luke Surtees, Senior Next of Kin

Alfred Health

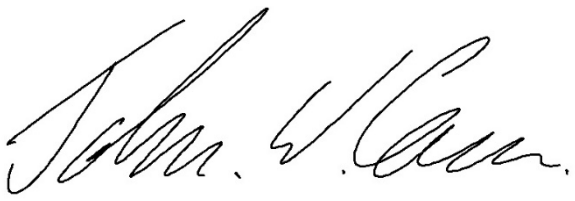
Sally McKay

DonateLife Victoria

Victoria Police (C/- Russell Kennedy Lawyers) Senior

Sergeant Glen Weaver, Coronial Investigator

Signature:



Judge John Cain
State Coroner
Date: 19 November 2024

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.