



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003427

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person.

Readers are warned that there may be words and descriptions that may be culturally distressing.

Findings of:	Coroner David Ryan
Deceased:	Sheldon Jay Broderick
Date of birth:	27 August 1973
Date of death:	21 June 2022
Cause of death:	1(a) Head injury
Place of death:	The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria

INTRODUCTION

1. On 21 June 2022, Sheldon Jay Broderick was 48 years old when he passed away at the Alfred Hospital. At the time of his passing, Sheldon lived in the Corio area in Victoria. Sheldon is survived by his children, Schehera, Mackaela and Baydan, his mother Janice and his five siblings.

THE CORONIAL INVESTIGATION

2. Sheldon's passing 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.
3. 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.
4. Under section 69 of the Act, a coroner must not include in a finding or comment any statement that a person is, or may be, guilty of an offence.
5. Section 49 of the Act provides that the principal registrar of the Court must notify the Director of Public Prosecutions if the coroner investigating the death believes an indictable offence may have been committed in connection with the death.
6. 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.
7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Sheldon's passing. The Coronial 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.

8. On 19 September 2024, the Coroners Court of Victoria received a request from Schehera Broderick, Sheldon's daughter, requesting that an inquest be held into her father's death pursuant to section 52(5) of the Act.¹ On 2 October 2024, I determined that it was not necessary to hold an inquest.²
9. This finding draws on the totality of the coronial investigation into Sheldon's passing including evidence contained in the coronial brief. While 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

10. Early in the morning on 20 June 2022, Sheldon attended the Gateway Hotel in Corio. He had previously told his friend that he was "*going to the pokies*". He left the hotel at 2.19am. Later that morning, Sheldon broke into a fish & chip shop at 4 Corangamite Drive in Corio. He entered through the front window after smashing a hole in it with a concrete drain cover which he had found nearby. The hole was made at the bottom of the window close to the level of the footpath in front of the shop.
11. Jake Mouat, who was 31 years old at the time, lived next door to the fish & chip shop. He woke to his alarm at around 4.45am on 20 June 2022. He then heard a disturbance outside and woke his partner. Mr Mouat stated that he was concerned that someone may have been breaking into cars on the street, so he got dressed and went outside to investigate further. When he got outside, he heard the sound of breaking glass and concluded that someone was breaking into the neighbouring fish & chip shop. He then returned inside and at 4.52am, he called the previous owner of the shop and they agreed to contact the current owners and Victoria Police. The previous owner then contacted emergency services at 4.54am.
12. Without waiting for police to arrive, Mr Mouat then went back outside taking his cricket bat with him "*for protection*". He then confronted Sheldon who was inside the shop and told him that "*you're not going anywhere*" and that the police had been called. A neighbour also heard

¹ Form 26, Request for Inquest into Death dated 19 September 2024.

² Form 28, Decision by Coroner whether an Inquest will be held into Death dated 2 October 2024.

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.

Mr Mouat yell “*stay inside, I’ve called the police*”. Mr Mouat recalled that Sheldon had tried unsuccessfully to exit the shop at the rear before returning to the broken window.⁴

13. Mr Mouat stated to police that Sheldon then threatened him with a knife and ducked his head and began to scramble out through the broken window, which was at ground level, while waving the knife around. Mr Mouat stated that he was “*fearful for my life*”. According to Mr Mouat, while Sheldon was attempting to scramble through the broken window, he struck Sheldon with the bat on the leg to prevent him from exiting the shop. He stated that Sheldon continued to try to escape while armed with the knife and he was in fear of his life and concerned for his family so he hit Sheldon again with the bat, possibly in the arm and then twice in the head, the second blow rendering him unconscious. Mr Mouat stated to police that he then pushed Sheldon’s torso back inside the window so that only his leg remained outside the shop before contacting emergency services at 4.58am. He advised the operator that a burglar had tried slashing him with a knife through the window of the shop and he had used a cricket bat to knock him out and had disarmed him.⁵
14. Mr Mouat’s partner and a number of neighbours went outside and witnessed the immediate aftermath of the incident. They observed Mr Mouat with the bat in one hand and a knife in the other and Sheldon lying inside the broken shop window.⁶
15. A short video was extracted by police from Mr Mouat’s mobile phone which appears to have been recorded by him at around 5.05am which shows Sheldon lying slumped over in the hole in the window of the shop. It was uploaded to Snapchat and the following caption was callously added, “*Just knocked this bloke out cold trying too (sic) slash me after breaking into the fish and chip shop*”.
16. Victoria Police arrived at 5.06am and Ambulance Victoria shortly afterwards. Paramedics treated Sheldon at the scene before he was transported by air ambulance to the Alfred Hospital. Clinicians reviewed a computed tomography (CT) scan which showed that Sheldon had suffered a non-survivable brain injury.

⁴ Record of interview of Jake Mouat dated 20 June 2022.

⁵ Statement of Jake Mouat dated 20 June 2022.; Record of interview of Jake Mouat dated 20 June 2022.

⁶ Footage has been extracted by police from Mr Mouat’s mobile phone which appears to have been recorded by his partner at around 4.57am.

17. Sheldon was declared brain dead on 21 June 2022 at 6.25pm. He remained on life support to enable family to spend time with him before he was extubated on 22 June 2022 at 3.00pm.
18. Victoria Police seized the 20cm knife from the scene and subsequent analysis detected DNA traces from both Sheldon and Mr Mouat. Further, the knife was confirmed to have come from the shop by the owner of the premises. After providing a statement at the scene, Mr Mouat was conveyed to the Geelong Police Station where he was formally interviewed.

Identity of the deceased

19. On 22 June 2022, Sheldon Jay Broderick, born 27 August 1973, was visually identified by his sister, Shandell Buckley.
20. Identity is not in dispute and requires no further investigation.

Medical cause of death

21. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine, performed an autopsy on 24 June 2022 and provided a written report of her findings dated 13 September 2022
22. Dr Baber observed a skull fracture with subdural and subarachnoid haemorrhages.
23. In a supplementary report dated 22 May 2023, Dr Baber confirmed that she did not observe any bruising to the legs or shoulders which she stated was inconsistent with any account of Sheldon being struck on the legs or shoulders.
24. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine, cannabis and a number of other drugs which were consistent with the provision of emergency medical treatment.
25. Dr Baber provided an opinion that the medical cause of death was *1(a) Head injury*.
26. I accept Dr Baber's opinion.

CRIMINAL PROCEEDINGS

27. On 1 July 2022, Mr Mouat was charged with the manslaughter of Sheldon. He had no prior criminal convictions. He was subsequently committed for trial after a committal hearing was held in the Magistrates' Court of Victoria on 2 March 2023.
28. On 21 June 2023, the Director of Public Prosecutions discontinued the prosecution. The Coronial Investigator had been advised that the basis of the discontinuance was that there was no reasonable prospect of conviction due to self-defence.

FINDINGS AND CONCLUSION

29. It is the role of Victoria Police to respond to incidents of unrest and crime in the community. They are specially trained for this task and are able to deploy force when necessary but are also able to use de-escalation techniques which are capable of resolving situations without violence. Members of the public should only intervene with force where it is necessary to protect themselves or others. It is regrettable that Mr Mouat did not exercise more caution and wait for police to arrive before arming himself and confronting Sheldon. A more restrained approach would have likely avoided the tragic outcome of Sheldon losing his life.
30. Pursuant to section 67(1) of the Act, I make the following findings:
 - a) the identity of the deceased was Sheldon Jay Broderick, born 27 August 1973;
 - b) the passing occurred on 21 June 2022 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, from head injury; and
 - c) the passing occurred in the circumstances described above.

I convey my sincere condolences to Sheldon'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.

Pursuant to section 49(1) of the Act, I direct the Principal Registrar to notify the Director of Public Prosecutions that I believe an indictable offence may have been committed in connection with Sheldon's passing.

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

Schehera Broderick, Senior Next of Kin

Alfred Health

Senior Constable Leigh Smyth, Coronial Investigator

Signature:



Coroner David Ryan

Date : 20 January 2025

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.
