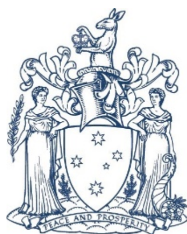

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000213

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:	Stephen Peter O'Brien
Date of birth:	22 September 1954
Date of death:	Between 7 and 10 January 2023
Cause of death:	1(a) Head injuries
Place of death:	16 Clapham Crescent, Wyndham Vale, Victoria, 3024
Keywords:	Family violence; elder abuse; undiagnosed mental illness; unreported family violence

INTRODUCTION

1. On 10 January 2023, Stephen Peter O'Brien was 68 years old when he was found deceased by police at his home, after his daughter called for a welfare check. At the time of his death, Stephen lived with his adult son, Scott, at their home in Wyndham Vale, Victoria. Stephen died from head injuries inflicted by Scott. At the time of the fatal incident, Scott was 43 years old.

Background

2. Stephen had nine siblings, including a twin sister, Susan. He was married and had two children, Samantha and Scott, and two grandchildren. His wife, Elizabeth, sadly passed away in 2022.

3. Stephen was a bricklayer and also worked in concreting and other manual labour jobs throughout his career. The family originally lived in Western Australia, however after Stephen lost his job, they family moved around. In the 1980s, the family moved to the Geelong area, where they remained. At the time of his death, Stephen worked casually packing vegetables at farms in the Werribee South area.

4. Scott is believed to have never left home and was unemployed at the time of the fatal incident. He reportedly began using cannabis at the age of 15, and by the age of 20 was very erratic. He was prescribed diazepam and received drug counselling.

5. There was no reported history of family violence between Scott and Stephen, however, records available to the Court suggest that there was a significant history of unreported family violence by Scott against his parents.

THE CORONIAL INVESTIGATION

6. Stephen'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 Detective Senior Constable Vin Schalken to be the Coronial Investigator for the investigation of Stephen's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, friends, the forensic pathologist, 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 Stephen Peter O'Brien 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 24 January 2023, I made a formal determination identifying the deceased as Stephen Peter O'Brien, born 22 September 1954, was based on DNA comparison.

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

Medical cause of death

13. Forensic Pathologist Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 11 January 2023 and provided a written report of her findings dated 3 November 2023.

14. The post-mortem examination revealed evidence of blunt force injury involving nearly the entire right side of the face and over the left side of the head and the posterior scalp, there were multiple, predominantly linear chop-type injuries. These findings are consistent with

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[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.

multiple blows to the left side and the back of the head with an implement capable of causing injuries with features of both blunt and sharp force injuries.

15. The neuropathology report completed by Dr Linda Iles indicated that there were linear lacerations through the dura matter, patchy subarachnoid haemorrhage with bilateral occipital and inferior right frontal contusions, laceration and disruption of the left parietal cortex extending into the left occipital horn of the lateral ventricle with linear haemorrhage over the right cerebral peduncle, distortion and disruption of the cerebellar hemispheres with evidence of early vascular axonal injury.

16. The injuries to the right side of the face may have represented a blow to the face, however it was also possible that this injury may have been caused or exacerbated by contact between Stephen's face and the floor.

17. The mechanism of death is a combination of severe brain injury and blood loss from the head injuries.

18. There were bilaterial conjunctival petechiae with bruising over the left side of the neck and bruising in the left anterior neck muscles. While the bruising may be due to blunt force injury to the neck, the application of a degree of neck compression could not be excluded.

19. There was a patterned injury over the left shoulder region and over the right side of the neck. The mechanism for these injuries was not known, however Dr Francis opined that a comparison with a potential implement might be possible.

20. Other autopsy findings included significant coronary artery atherosclerosis with cardiomegaly (an enlarged heart) with myocardial fibrosis. The lungs were emphysematous, and his kidneys showed benign nephrosclerosis.

21. Toxicological analysis of post-mortem samples identified the presence of paracetamol at a level consistent with therapeutic use. Alcohol was not detected.

22. Dr Francis provided an opinion that the medical cause of death was *1(a) head injuries.*

23. I accept Dr Francis' opinion as to the medical cause of death.

Circumstances in which the death occurred

24. On 1 January 2023, Scott caught a taxi from his home to the Geelong area. He attended six different accommodation venues and told the taxi driver that he was looking for accommodation in the Geelong area. The taxi driver eventually dropped him off at the Werribee Railway Station. From there, Scott caught another taxi to his home in Wyndham Vale, stopping on the way to purchase alcohol. During the journey, Scott told the taxi driver that he had been looking for accommodation in the Geelong area but was unable to find anything.

25. On 2 January 2023, Stephen was working at a farm owned by Thomas Patsuris and informed him that he was unable to work on 3 January 2023 as he had to take his son to the doctor. When Stephen returned to the farm on 4 January 2023, he informed Thomas that his son had mental health issues and thought he needed to take him back to the doctor. He also informed Thomas "*I think he's [Scott] going to do me in*".

26. On the morning of 6 January 2023, Stephen attended the Sphinx Hotel in North Geelong where he used his son's credit card to book a room for Scott. Later that afternoon, Stephen attended a liquor store with Scott where he purchased alcohol with Scott's credit card. Stephen had a final phone call with his sister, Kerry Roberts, and explained that he did not want to go home and that he was concerned about Scott's mental health. He noted that Scott thought he (Stephen) was a federal police officer and whenever Stephen returned home, Scott accused him of spying. Scott spent the night at the Sphinx Hotel as planned.

27. On the morning of 7 January 2023, Stephen re-attended the Sphinx Hotel and requested a refund for the remaining two nights' accommodation. Stephen was told to return or call at 1.00pm. Meanwhile, Scott attended the BCF store in Corio where he purchased more than $500 worth of camping supplies, including a 12-person tent.

28. At about midday, Stephen called Mark Alush, the owner of a farm in Werribee South, and advised that he intended to attend work on 9 January 2023. Stephen was last captured on CCTV leaving the Manor Lakes Shopping Centre in his Toyota Camry at 4.29pm that day. This was the last time he was known to be alive. Stephen's call charge records demonstrate that his phone was connected to a cell tower in Quandong East and remained connected to this tower until police located him on 10 January 2023.

29. At 8.06am on 8 January 2023, Scott exited their Wyndham Vale home by opening the garage door. One minute and 50 seconds later he returned, then left again shortly thereafter. Throughout the morning, Scott visited various stores in the Torquay area and purchased clothing and other items.

30. On 9 January 2023, Stephen failed to attend at Mark's farm. Mark tried contacting Stephen several times without success. That morning, Scott attended the St George Workers Club in Geelong West where he was observed using his Samsung tablet. He sought assistance from a staff member to purchase a plane ticket to Brisbane, which was purchased in the name "*Solo Williamson*". Scott also purchased accommodation for 9 January 2023 at the Kerwick Hotel in the Brisbane suburb of Redbank. This booking was made in Scott's own name.

31. Scott travelled via bus to Melbourne Airport, where he boarded a 9.50pm Jetstar flight to Brisbane, landing at 11.21pm. Shortly after midnight on 10 January 2023, Scott arrived at the Kerwick Hotel and realised it was closed, and he had missed the check-in time. Scott caught a taxi back to Brisbane Airport, re-booked the Kerwick Hotel for 10 January 2023 with a check in time of 2.00pm. After arriving at Brisbane Airport at 2.00am, he caught a flight back to Melbourne, departing at 12.55pm.

32. Between 2.00pm and 3.00pm on 10 January 2023, Mark attended Stephen's home with his niece and nephew, after another unsuccessful attempt to contact him. At 4.11pm, Samantha called 000 and requested a welfare check for her father. Samantha called 000 for a second time at 5.30pm, requesting an update.

33. The first police members attended Stephen's address at 4.50pm. Police observed Stephen through a window, lying on the floor and covered in blood. Police located an unlocked door and entered the property where they confirmed Stephen was deceased.

34. Scott was apprehended by police on 11 January 2023. He was assessed by a forensic medical officer, who determined that he was unfit to be interviewed. In April 2024, Scott was found not guilty by reason of mental impairment. As of February 2025, Scott was awaiting a bed to become available at Thomas Embling Hospital.

FURTHER INVESTIGATIONS AND CPU REVIEW

35. As Stephen's death occurred in circumstances 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].

36. I make observations concerning service engagement with Stephen and Scott as they arise from the coronial investigation into his death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and Stephen's death.

37. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[4] I make observations about services that had contact with Stephen and Scott to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

38. There was no reported family violence involving Scott with any party, including with his father. However, numerous people appear to have been aware of a significant history of unreported family violence by Scott against his parents. It appears that Stephen spent many years attempting to manage Scott's behaviour and violence in order to keep himself and his late wife safe. Some examples of the violence perpetrated by Scott include:

    a) Scott regularly tried to punch, "*shirt front*", or fight Stephen.

    b) Scott prevented Elizabeth's carers from coming into the home and also refused to allow Stephen to put Elizabeth into residential care.

    c) Scott physically assaulted Stephen several times, causing injuries including extensive bruising and black eyes. On at least one occasion, Stephen required hospitalisation for a facial fracture.

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[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.

[4] *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

d) When friends or family suggested that Stephen should defend himself, he replied stating that he could not hit Scott back, would not move away from Scott or 'kick him out' of the home.

e) Scott regularly shouted at his father when he was on the phone to someone else.

f) Scott regularly contacted Stephen whilst Stephen was not home, asking him to put money in his TAB account.

g) Stephen told his friends and family that he was stressed and frightened by Scott's behaviour, and often had to make phone calls from the car due to Scott's paranoia.

h) Stephen often booked accommodation for himself or for Scott to have a break from Scott's behaviour.

i) Scott had no friends and spent his days playing video games at home and drinking alcohol.

j) Scott reportedly had a diagnosis of schizophrenia but did not take any medication or receive any treatment for same. He often presented to services as "*functioning ok*".

k) Scott did not like people attending their home, threatening anyone who came to visit the house. He also verbally abused and threw rocks at his neighbours' home.

l) After Elizabeth passed away, one of Stephen's friends offered him free rent and work in Bendigo, however he declined "*because of Scott*".

m) On Christmas Eve 2022, Stephen disclosed that he would rather be in prison than "*live like this [with Scott]*".

n) Shortly before the fatal incident, Stephen disclosed that he thought his son might "*do me in*".

Risk and contributory factors

39. The family violence Multi Agency Risk Assessment and Management Framework (**MARAM**) details a number of "*evidence-based risk factors associated with greater likelihood and/or severity of family violence*" and factors which "*may indicate an increased risk of the victim being killed or almost killed*". These risk factors are divided into three categories: those which are specific to adult victim-survivors, those which are caused by

perpetrators' behaviour towards an adult or child victim-survivor, and those which are caused by perpetrators which are specific to children. The risk factors identified in this case based on the evidence provided include:

a) Controlling behaviours

b) Physical harm

c) Verbal abuse

d) History of family violence

e) Current unemployment

f) Mental health issues

g) Misuse of drugs or alcohol

h) Repeatedly harassing or messaging/emailing

i) Economic abuse

j) Serious harm

k) History of violent behaviour to others

l) Victim level of fear/belief they could kill

40. The risk factors specific to older people include the perpetrator's financial dependence on the victim and isolation.

Treatment by GP

41. Scott attended his local medical clinic and saw a general practitioner (**GP**) on 25 August 2022, after a gap of seven years. He consulted with the GP again on 28 September 2022 for a mental health care plan and was referred to a clinical psychologist within the same clinic. The referral letter noted that Scott had a history anxiety disorder, was isolated despite living with his father, was unemployed and noted no observation of psychosis or thought disorder. This is somewhat contradictory with the notes from Scott's medical record. The medical records from the August appointment noted that Scott disclosed "*conspiracy theories regarding his new accommodation*" and in both appointments, and that Scott wore a hoodie and sunglasses and

refused to take them off. The GP noted that the September appointment ended "*in a very unsatisfactory way and [he] would decline seeing Scott again*".

42. Scott missed his appointment with the clinical psychologist on 9 November 2022 and did not schedule a further appointment. He also missed a further scheduled appointment with another GP at the same clinic on 9 January 2023.

Opportunities for prevention and intervention

43. While Stephen's friends and family made various suggestions about reporting Scott's violence, physically defending himself and/or moving away from Scott, Stephen repeatedly declined same.

44. There is no evidence to suggest that Stephen was aware of, or ever attempted to engage additional supports for himself such as contacting The Orange Door, Senior Rights Victoria, Better Place Australia or a service such as Mind Australia, who offer support for carers of those experiencing mental illness.

45. Stephen's situation is unfortunately not unique, as indicated by the data and evidence outlined below.

Violence against carers of adults with mental health issues

46. Research by Mind Australia indicates that half of Australia's mental health carers have support needs that are not being met, and 35% of them do not know what support is available. In their submission to the Royal Commission into Victoria's Mental Health System (**RCVMHS**), Mind Australia noted that:

> *Aged carers are particularly vulnerable to being unsafe because often they have been caring on their own for a long time and adapting to the persons' illness by altering their own behaviours…. The other dimension of feeling unsafe relates to the safety of the person they are supporting. Where mental health carers and families are concerned about how the consumer is being treated in the system, on the streets, in EDs, by first responders, then their own feelings of safety are compromised…. These realistic fears can mean that families and carers are reluctant to engage with the system even when their own safety can be compromised….Family violence in a mental health context needs to be sensitively dealt with but it does need to be acknowledged. Families may not disclose violence because they see it as a result of the illness, not a*

deliberate act. In consultations within mental health carer organisations, carers often share that they don't want to use the word 'violent' in talking about the person they support. Carers can also feel terrible shame that they are not managing the illness in ways that prevent violence. ... Families and mental health carers may also be concerned about the consequences for the consumer and the family if they do make disclosure and do not want the person that they care about to get into trouble for something that they see as not their fault, but as a consequence of illness.

47. Mind Australia also noted emerging research that suggests between 10% and 30% of families experience violence as a consequence of behaviours of a person with mental illness.

48. The RCVMHS recommended that the Victoria Government commission non-government organisations to use consistent branding and deliver one family and carer-led centre in each of the eight regions to:

    a) Provide tailored information and supports for families, carers and supporters in the region;

    b) Work with families, carers and supporters to help identify their needs and connect them to the supports that will best respond to those needs;

    c) Provide access to increased funds for immediate practical needs including short term respite brokerage; and

    d) Deliver support for family and carer peer support groups in the region.

49. These have been rolled out across Victoria, including in the Geelong region, however it seems unlikely that Stephen would have sought assistance from one of these hubs if it was in operation at the time, as it relied on him self-identifying as a carer requiring assistance.

50. Stephen was a 'hidden' carer in that he did not identify as a mental health carer and was not receiving benefits to care for his son. It seems unlikely that he would have proactively sought help from police or a support service, as he may not have realised that Scott's behaviour constituted family violence. He was likely unaware that there is a network of services and options for both himself as a carer and to proactively engage with Scott and assist with his mental ill health. It is critical that efforts are made to identify these carers and provide them with information about the support that is available and assist them with access to support.

51. I urge the Victorian Government to implement the recommendation from Mind Australia in their submission to the RCVMHS by developing mechanisms that assist in identifying 'hidden' mental health carers and families such as Stephen, that do not rely on self-identification. This could be through GP's, community health centres, My Aged Care, primary health networks, schools and other educational settings, and workplaces. This might take the form of:

    a) A carer checklist or a carer assessment tool

    b) A flyer listing current and relevant mental health carer supports

    c) A series of questions that do not use the word 'carer' at all but talk about supports and what their rights accessing supports might be.

52. I therefore intend to make a recommendation to that effect.

Elder abuse

53. In a study with older people who had experienced elder abuse and eventually became clients of Seniors Rights Victoria, four key barriers to disclosing and/or taking action were identified and include:

    a) Fear of negative consequences for the abuser (including homelessness)

    b) Fear of negative consequences for themselves

    c) Belief that the abuse was not the perpetrators' fault

    d) Stigma (fear or experience of shame and embarrassment)

54. Seniors Rights Victoria have also identified an ongoing issue of awareness of various forms of elder abuse and need for clear information on where and how to get assistance. Respect Victoria also acknowledges specific barriers to report, including:

    a) Fear, including fear of retaliation or family breakdown

    b) Older people may not recognise that what they are experiencing is elder abuse

    c) Older people may feel that they are responsible for the behaviour of the perpetrator

    d) Feelings of guilt and shame

e) Belief that aggression and violence is a normal part of family life

f) Fear that seeking help will lead to being placed in residential care

g) Lack of knowledge about available sources of help

55. It would appear that many of the above barriers were present in Stephen's case. As suggested above, even if Stephen was aware of the supports that were available to him, he may have been hesitant to ask for assistance.

56. I note the recommendation made by Seniors Rights Victoria and the Council on the Aging in their recent submission to the *Inquiry into Capturing Data on Family Violence Perpetrators* to raise awareness through targeted campaigns and greater investment in community education to educate older people about the various forms of elder abuse and the importance of seeking help, providing clear information on where and how to get assistance to empower them to report abuse, thus improving data collection and enabling timely intervention. I therefore intend to make a recommendation to the Victorian Government to fund and support such initiatives.

57. I also note that Stephen's case, sadly, is one of several cases being investigated by the Court in which an adult child with undiagnosed or untreated mental health issues has assaulted and killed an older or elderly parent. My recommendations are therefore aimed at improving awareness for elderly Victorians who have contact with or care for adult children with mental illness.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Stephen Peter O'Brien, born 22 September 1954;

b) the death occurred between 7 and 10 January 2023 at 16 Clapham Crescent, Wyndham Vale, Victoria, 3024, from *1(a) head injuries*; and

c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That the **Victorian Government** implement the recommendation from Mind Australia in their submission to the RCVMHS by developing mechanisms that assist in identifying 'hidden' mental health carers and families that do not rely on self-identification. This could be through GPs, community health centres, My Aged Care, primary health networks, schools and other educational settings and workplaces.

(ii) That the **Victorian Government** implement the submission by Seniors Rights Victoria and the Council on the Aging to the *Inquiry into Capturing Data on Family Violence Perpetrators*, namely, to raise awareness through targeted campaigns and greater investment in community education to educate older people about the various forms of elder abuse and the importance of seeking help, providing clear information on where and how to get assistance to empower them to report abuse, thus improving data collection and enabling timely intervention.

(iii) That the **Victorian Government** fund pilot programs of integrated response models of care specifically for both victim survivors and perpetrators of elder abuse, given the barriers to engage with support for this type of family violence.

I convey my sincere condolences to Stephen'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:

Samantha O'Brien, Senior Next of Kin

Victorian Government

Detective Senior Constable Vin Schalken, Coronial Investigator

Signature:

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Judge John Cain
State Coroner
Date: 11 March 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.