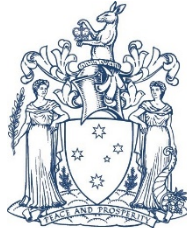

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 003705

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of James Bernard Williamson

Findings of: Judge John Cain, State Coroner

Delivered on: 18 April 2023

Delivered at: Coroners Court of Victoria
65 Kavanagh Street, Southbank

Hearing dates: 18 April 2023

Assisting the Coroner: Abigail Smith, Senior Coroner's Solicitor to the State Coroner

Keywords: Reportable death; mandatory inquest; hypoglycemia; suspected homicide; multiple injuries

INTRODUCTION

1. On 11 July 2020, James Bernard Williamson was 54 years old when he died at Ward 6 East of the Alfred Hospital.

2. At the time of his death, James resided at Unit 1 of 36 Bridle Road, Morwell (**Bridle Road apartment**). James never married or had any children. He is survived by his siblings and father.

3. James had a significant criminal history and was known to use illicit substances including heroin and methamphetamine (**ICE**). He had been on the methadone program for several years.

4. James also suffered from mental health issues and received treatment from Latrobe Regional Hospital. Mr Stephen Williamson (James's brother) stated that approximately six months before his death, James was taken off the methadone program which caused his physical and mental health to decline and that *he had nothing to control his cravings so he slipped back into his addiction*'.[1]

5. James was a diabetic and he managed his condition by self-administering insulin. Stephen stated that *he had difficulties maintaining his blood sugar levels* due to his lifestyle.[2]

6. From April 2020, James was supported by the National Disability Insurance Scheme (**NDIS**) and received assistance from 'Mind Australia'[3] with implementing his NDIS plan. It was reported that Mind Australia encountered several barriers with providing support to James including but not limited to drug use, erratic behaviours and COVID-19 lockdowns.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. James's death constitutes a *reportable death* under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria,[4] was unexpected and as a result of an injury.[5]

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[1] Statement of Stephen Williamson dated 17 July 2020 at Coronial Brief (**CB**), p 27.
[2] As above at CB, p 25.
[3] James had previously received day support and outreach services from Mind Australia from July 2011 to September 2014 and from October 2017 to June 2018 through the Mental Health Community Support Services.
[4] *Coroners Act 2008* (Vic) s 4.
[5] *Coroners Act 2008* (Vic) s 4(a).

8. 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.

9. I note the observations of the Victorian Court of Appeal in *Priest v West*, where it was stated:

   '*If in the course of the investigation of a death it appears that a person may have caused the death, then the Coroner must undertake such investigations as may lead to the identification of that person. Otherwise, the required investigation into the cause of the death and the circumstances in which it occurred will be incomplete; and the obligation to find, if possible, that cause, and those circumstances will not have been discharged*.'[6]

10. Consistent with this judgment, and mindful that the Act mandates that I must conduct an inquest, one of the purposes of the inquest is to investigate any evidence that may lead to the identification of the person (or persons) who may have caused the death, bearing in mind that I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.[7]

11. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[8] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[9]

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[10] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[11] or to determine disciplinary matters.

13. The expression *cause of death* refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

14. For coronial purposes, the phrase *circumstances in which death occurred*,[12] refers to the context or background and surrounding circumstances of the death. Rather than being a

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[6] *Priest v West and Percy* (2012) VSCA 327.
[7] *Perre v Chivell* (2000) 77SASR 282.
[8] *Coroners Act 2008* (Vic) s 89(4).
[9] *Coroners Act 2008* (Vic) preamble and s 67.
[10] *Keown v Khan* (1999) 1 VR 69.
[11] *Coroners Act 2008* (Vic) s 69 (1).

consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

15. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's *prevention* role.

16. Coroners are also empowered:

    a) to report to the Attorney-General on a death;[13]

    b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[14] and

    c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[15] These powers are the vehicles by which the prevention role may be advanced.

17. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[16] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[17] 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 that they caused or contributed to the death.

18. Detective Senior Constable Michael McNamara was appointed the Coroner's Investigator and submitted a coronial brief of evidence.

19. This finding draws on the totality of the material which is the product of the coronial investigation into James's death. That is, the investigation and inquest brief and the statements, reports and any documents obtained through the investigation. In writing this

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[12] *Coroners Act 2008* (Vic) s 67(1)(c).
[13] *Coroners Act 2008* (Vic) s 72(1).
[14] *Coroners Act 2008* (Vic) s 67(3).
[15] *Coroners Act 2008* (Vic) s 72(2).
[16] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[17] (1938) 60 CLR 336.

finding, I do not purport to summarise all of the evidence but refer only in such detail as appears warranted by its forensic significance and interests of a narrative clarity.

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

20. On 13 July 2020, James Bernard Williamson, born 7 August 1965, was identified via fingerprint identification.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

22. On 11 July 2020, Specialist Forensic Pathologist, Professor Noel Woodford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy and provided a written report of his findings dated 1 December 2020.

23. The post-mortem examination revealed widespread areas of cutaneous healing injury (scabs) over the face, chest and limbs.

24. The internal examination showed healing fractures of the right-sided ribs and the laryngeal skeleton, as well as evidence of fracturing to the left zygoma and sternum.

25. A post-mortem CT scan confirmed the presence of these fractures, as well as fractures to the nose and chronic lung disease in the form of emphysema and fibrosis, focally severe coronary artery atherosclerosis, focal myocardial fibrosis (indicating an old heart attack) and changes in keeping with the history of diabetes mellitus and viral hepatitis.

26. Professor Woodford opined:

> '*…it is not possible to offer a definitive opinion as to whether all the injuries occurred within the same time-frame, or in the one incident. In addition, it is not possible to determine whether the injuries were…the result of inflicted trauma, or whether at least some could have been sustained accidentally (for instance falls resulting in fractured ribs)*'.[18]

[18] Medical Examiner's Report dated 1 December 2020, p 5.

27. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine (~0.03mg/L), diazepam (~0.06mg/L), nordiazepam (~0.03mg/L) and paroxetine (~0.02mg/L). Alcohol was not detected.

28. On 15 July 2020, Dr Linda Iles, the coordinator of neuropathology services at VIFM, conducted a brain examination and provided a written report of her findings dated 7 October 2020.

29. The examination revealed *neuronal loss and astrogliosis throughout the cortex, corpus striatum and hippocampi in a pattern indicative of hypoglycaemic brain injury*.[19]

30. As a result of the above findings, Professor Woodford provided an opinion that the medical cause of death was *hypoglycaemic encephalopathy complicating multiple injuries in a man with chronic lung disease and ischaemic heart disease.*

31. I accept Professor Woodford's opinion as the cause of death.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

<u>Surrounding circumstances</u>

32. On 5 March 2020, James and Mr Brenton Boyd were at the BP service station on Veston Drive, Morwell with another associate, when they were approached by Victoria Police officers undertaking general duties. Police located heroin on Brenton, and he was arrested and charged. The incident was captured on body worn camera footage, and at the time of the arrest, Brenton appeared to be angry with James.

33. On 23 June 2020, James visited Mr Paul Shill at his apartment in the 'Mid Valley Units' in Morwell. Paul stated that James *had lost his dog* and *he felt like the whole world had caved in, there wasn't much left for him*. Paul observed James to be in poor health, he was dishevelled, and Paul noticed bruising and scratches on his legs and arms.[20]

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[19] Neurological Report dated 7 October 2020, p 4.
[20] Statement of Paul Shill dated 9 July 2020 at CB, p 40.

34. James left Paul's apartment that afternoon and returned the following morning around 8.00am. They ate breakfast together. He stayed for approximately 2 hours before returning home.[21]

35. On 25 June 2020, between 3.00pm and 5.00pm, Mr Joseph Zubovic (James's neighbour) heard *banging* coming from James's apartment. Joseph recalled that *it sounded like things being thrown around* and saw a male exit James's apartment through the backdoor into the carport. Joseph did not speak to the male and had not seen him before.

36. That evening, Stephen invited James to his house. When he arrived, Stephen observed James to be clean shaven, wearing clean clothes, and he did not have any visible or obvious injuries.[22]

37. On around 1.00pm on 26 June 2020, Stephen received a phone call from James's mobile phone and recognised the male on the other end of the phone to be Brenton. He sounded intoxicated and then handed to the phone to James so also sounded intoxicated. Stephen told James to check his diabetes levels and to go to sleep. Stephen received a further phone call from James at 1.11pm which lasted for approximately 19 seconds. They did not speak during this phone call and Stephen thought that that James had called him unintentionally.[23]

<u>Proximate circumstances</u>

38. At approximately 5.00am on 27 June 2020, Joseph heard moaning coming from James's apartment. He stated that he called out to James, however he did not respond.

39. On that same day, Stephen received a series of missed calls from James's mobile phone at 5.31am, 11.36am, 4.38pm, 4.42pm and 4.47pm. Stephen tried to call James at 5.01pm, however he did not answer. In his statement to police, Stephen stated that it was not uncommon for James to call him many times throughout the day.[24]

40. At approximately 5.30pm, Paul attended James's apartment to check on his welfare. When he arrived at the apartment the front door was off its hinges. The evidence before the Court

[21] Statement of Paul Shill dated 9 July 2020 at CB, p 40..
[22] Statement of Stephen Williamson dated 17 July 2020 at CB, p 28.
[23] Statement of Stephen Williamson dated 17 July 2020 at CB, p 29.
[24] Ibid.

suggests that the door had been removed from its hingers approximately a week earlier. Paul observed James to be on the couch with his head back and struggling to keep his eyes open.

41. Paul attended a neighbouring unit and spoke to Mr Arthur Strickland and requested that he contact triple zero. Paul returned to the apartment and James had managed to crawl from the lounge room to the front door. James reached out to Paul without saying anything, which frightened Paul, who ran from the address and returned to his residence and informed his wife of the incident.[25]

42. At 7.13pm, Victoria Police attended the Bridle Road apartment and spoke to Arthur before attending James's apartment. The police gained access through the back door of the unit which was wide open. James was observed to be in his lounge room slumped back on the couch with his head tilted back with dried blood around his nose, black eye and his breathing was laboured.

43. Police also observed:

> '*…upturned furniture in the lounge room, rubbish on the floors throughout the unit, including the bedrooms, blood smeared on the wall between the hallway and the lounge room…on the wall in the kitchen…on the couch and arm chair in the lounge room and used dishes across the sink and benches in the kitchen*.[26]

44. A crime scene was established.

45. At 7.21pm, a Mobile Intensive Care Ambulance paramedic arrived on scene and treated James for a number of injuries and hypoglycaemia. James was subsequently transferred to La Trobe Regional Hospital for observation and treatment.

46. Upon arriving at Latrobe Regional Hospital, James' injuries were assessed as non-life threatening and he was expected to come out of his induced coma by 29 June 2020. James was treated for broken ribs, facial fractures and pre-existing medical issues such as diabetes.

47. By 5 July 2020, James' condition had not improved, and he was transferred to the Alfred Hospital. On 6 July 2020, James was subject to a MRI brain scan which suggested hypoxic

[25] Statement of Paul Shill dated 9 July 2020 at CB, p 41.
[26] Summary of incident at CB, p 3.

ischaemic encephalopathy and an EEG performed on 7 July 2020 showed a moderate encephalopathy.

48. Based on a clinical examination of the MRI and EEG findings, it was concluded that James was suffering from a severe hypoxic brain injury, with limited possibility of meaningful survival. A decision was made to commence palliative care management.[27]

49. On 9 July 2020, police contacted the Alfred Hospital for an update on James's condition and were advised he was not expected to survive. The Victoria Police Homicide Squad were subsequently briefed.

50. On 10 July 2020, James's condition continued to deteriorate, and he was transferred to the Intensive Care Unit and then Ward 6 East of Alfred Hospital.

51. At 2.00am on 11 July 2020, James was pronounced deceased by an attending medical officer.

INVESTIGATION BY VICTORIA POLICE

52. Immediately following James' transfer to La Trobe Regional Hospital, Victoria Police commenced an investigation to ascertain the circumstances in which James had sustained his injuries. A number of witnesses were interviewed including James' associates, a door knock of adjoining apartments was conducted, search warrants were executed, and James' phone and bank records were obtained. Following James's death, the Victoria Police Homicide Squad assumed oversight of the criminal investigation.

53. On 28 June 2020, Crime Scene Officers attended James's apartment and obtained swabs from blood located on the lounge suite and walls within the unit for further analysis. The swabs were examined by Victoria Police Forensic Services, and it was determined that it belonged to James. An examination of the scene confirmed that James's wallet was missing, as well as the mobile phone that he had been using.

[27] Statement of Dr David McDonald dated 14 January 2020 at CB, p 65.

54. Police made enquiries with the Commonwealth Bank of Australia regarding James's bank accounts. Williamson's bank statements were supplied to investigating officers and no abnormalities were detected.

55. Police also obtained call charge records for the mobile phone number that James has been using. It was established that a phone call was made at 8.14am on 27 June 2020 to Morwell Taxis. The male caller gave the name of 'Wayne' and asked to be picked up from an address on Princes Drive, Morwell. The male was then dropped off at an address at Firmin Road, Churchill.

56. Police spoke to Mr Wayne Hawkins, a taxi driver with Morwell Taxis who told investigators that his clients had told him that James *had been bashed*. He did not know how this occurred or who was involved. He was unable to provide any further information and declined to provide a statement to police.[28]

57. During the course of the police investigation, a number of other witnesses told investigators that Brenton had engaged in a disagreement with James in relation to a drug dispute. To date, police have been unable to substantiate these comments.

58. Further enquiries were conducted on the addresses provided by Morwell Taxis and it was established that Brenton was listed as a resident at:

- the Princes Drive address in March 2020; and
- the Firmin Road address between April and May 2020.

59. A search warrant was executed at the address on Princes Drive, Morwell and investigators located James's sim card inside Brenton's Apple iPhone. The phone used by James was not located.

60. Brenton admitted to using methamphetamine and heroin with James on 26 June 2020 and being in possession of the sim card. He also admitted to hearing rumours that he had assaulted James, although he denied that this occurred.

[28] Summary of Incident authored by Detective Senior Constable McNamara.

61. A DNA sample was obtained from Brenton and submitted for comparison against the fingernail scrapings and blood located inside his unit. Police were unable to establish a link between the DNA sample and exhibits.[29]

62. Brenton was charged with 'Handle Stolen Goods', 'Negligently Deal Property Proceeds of Crime' and 'Commit Indictable Offence Whilst of Bail' in relation to the stolen sim card.

63. It is the opinion of the investigating police that:

> '*Williamson has engaged in a disagreement with Boyd in relation to a drug dispute…there is evidence that Boyd was arrested and charged by police for possessing Heroin where James Williamson was present with Boyd at the time. Boyd appears angry at James Williamson at the time of arrest. Several members of the public have [alluded] to this fact. DNA has not been able to link Boyd in relation to the injuries that Williamson has sustained. Boyd was found in possession of the Optus SIM card used by James Williamson'*.[30]

64. Despite a thorough and extensive investigation, police have been unable to establish how James's injuries occurred and the surrounding circumstances.

65. To date, no person or persons have been charged with indictable offences in connection with James's death. In light of this extensive investigation, I am satisfied that no investigation which I am empowered to undertake, would be likely to result in the identification of any person or persons who may have contributed or caused James' death.

66. It is important to note that it is not the purpose of a coronial investigation to investigate possible criminal conduct, to compile a brief of evidence in preparation for a future criminal trial. Section 69 of the Act expressly prohibits a coroner from including in a finding or a comment, any statement that a person may be guilty of an offence.

67. In making this finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that James's death may have been the result of a homicide.

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[29] Victoria Police Case Results Summary at CB, p 303.
[30] Summary of incident at CB, p 11.

68. I note that if new facts and circumstances become available in the future, section 77 of the Act allows any person to apply to the Court for an order that some or all of these findings be set aside. Any such an application would be assessed on its merits at the time.

FINDINGS AND CONCLUSION

69. Pursuant to section 67(1) of the Act, I make the following findings:

   a) the identity of the deceased was James Bernard Williamson, born 7 August 1965;

   b) the death occurred on 11 July 2020 at Alfred Health, The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from *hypoglycaemic encephalopathy complicating multiple injuries in a man with chronic lung disease and ischaemic heart disease*; and

   c) the precise circumstances in which James Bernard Williamson suffered his injuries are unknown however it appears likely the injuries were sustained as a result of the actions of a person or persons unknown.

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

Pursuant to section 73(1B) 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:

Alexander Williamson, Senior Next of Kin

Stephen Williamson, Brother

Detective Senior Constable Michael McNamara, Coroner's Investigator

Signature:

JUDGE JOHN CAIN
STATE CORONER

Date: 18 April 2023

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.