Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated a death of Debbie Dubravka Killer

Find, pursuant to Section 28(1) of the Coroners Act 1995, that

a) The identity of the deceased is Debbie Dubravka Killer;
b) I am unable to determine the circumstances in which Ms Killer died;
c) I am unable to determine the cause of Ms Killer’s death; and
d) Ms Killer died between 26 September and 4 October 2017 at 5 Lialeeta Crescent, Smithton, Tasmania.

Introduction

Debbie Dubravka Killer was born in what was then Yugoslavia on 8 May 1950 and was aged 67 years. She married aged 18, had a daughter, Maya, and immigrated to Australia in about 1970, settling in Queensland. There she and her then husband had a son, David.

After her first marriage ended in the late 1980s Ms Killer seems to have been teaching (and possibly working as a translator) in New South Wales. There she met and commenced a relationship with Ian Thompson, to whom she was married for a short time.

Following the end of that marriage, and by then, sadly, estranged from her children, she moved to Queenstown in Tasmania and then to Smithton in 2011, where she lived for the rest of her life.

A private woman, Ms Killer kept herself busy with arts and crafts, in particular painting and knitting. Her friend Geertruida Mantje described Ms Killer as “an active member of the community”. She regularly attended a local church.
Circumstances of Death

On 4 October 2017 Tasmania Police Officers responded to a concern for welfare report (from a nurse at a local hospital) and attended Ms Killer’s residence in Smithton. The first officer to attend found the front and back door of the residence were both locked and secured. He said he checked all the windows and that they had no signs of forced entry, although he noticed that the bathroom window at the rear of the residence was ajar. Police had to climb through the bathroom window to enter Ms Killer’s residence.

I observe that the inherent contradiction in this description, that is to say that the windows were ‘secure’ but that one was ‘ajar’ through which the officer was able to effect entry, is obvious.

Police said that the residence was neat and tidy. Upon entering the living area they found Ms Killer naked lying on the floor in the kitchen, obviously deceased, and showing signs of decomposition.

Police described seeing the stove having been moved and some “upset kitchen items present”.

Investigation

Despite finding Ms Killer naked, decomposed and deceased in a room with signs of disturbance, the attending police decided not to call upon the assistance of Forensic Service officers. Nor was the scene photographed, something done very easily with a mobile phone (an item I observe that very few people in modern society do not possess and carry with them at all times) or indeed a Tasmania Police issued tablet (which has the capacity to easily take photographs).

The absence of any photographs and any forensic evidence at all compromised the coronial investigation.

The explanation offered by police for the decision not to have Forensic Services attend was that, in a discussion with Forensic Services personnel on the day, attending police were “reminded of the Tasmania Police manual… [that] Forensic Services would only attend deaths where it was suspected that it was a suicide, murder, fire-related, unidentified person or SIDS related” and that therefore the attendance of forensic officers and photographing of the scene was not required.

Whilst I accept that at the time police were on the scene it was clear enough that it was neither a fire nor SIDS-related death, I cannot accept that at the time suicide or murder
could or should have been ruled out. Moreover, at the time police attended the scene Ms Killer's body was unidentified, although was subsequently identified by her general practitioner.

Police subsequently claimed that the need to photograph did not fit with any of the categories in the Tasmania Police manual. As I have already said I do not accept that this was so. Whilst I acknowledge the investigating officer’s assertion that as an officer of in excess of “20 years of experience having attended many deaths both natural and unnatural, violent and nonviolent” he was satisfied that no other party was involved in death, I observe, with respect, this conclusion is one for the coroner to reach on the basis of evidence obtained as part of the investigation. In this case that evidence was simply unavailable.

Finally, it was also asserted that in relation to photographing scenes on personal devices that “…this is not a common practice, particularly if members have family that access devices such as smart phones.” Even if this is so (and I observe that it does not accord with my experience in this jurisdiction) it does not excuse a failure to take photographs on the Tasmania Police issued electronic tablet.

The decision not to have Forensic Services attend was a poor one. The decision not to photograph the scene was also a poor one. The rationale advanced for this decision, that is, that the death was not suspicious, is not one that I accept.

This finding, in draft, was sent to the investigating officer on 7 December 2018 with an invitation to make any comment about my proposed finding within 14 days. No reply was received within the time directed. A reply was received dated 10 January 2019.

Nothing in the reply persuades me that the criticism set out above is anything other than justified.

The investigation did discover that the last person to certainly see Ms Killer alive was her friend Ms Mantje who saw her on 26 September 2017. No other person appears to have been identified as seeing Ms Killer alive after that date and there is no evidence of any activity on her part after that date. However, given the circumstances in which her body was found it is impossible to be any more definitive than to say she died sometime between 26 September 2017 and 4 October 2017.
Post mortem examination

In any event, Ms Killer’s body was removed and transported to the mortuary at the Launceston General Hospital where Dr Devadas, a pathologist, carried out an autopsy upon it. After the autopsy Dr Devadas was unable to determine the cause of Ms Killer’s death.

Dr Devadas noted that Ms Killer had a history of hypertension, obesity, non-insulin-dependent diabetes mellitus, depression and a previous ovarian cystectomy. Notwithstanding these pre-existing conditions Dr Devadas found no fatal complications of any of them at autopsy.

Dr Devadas found no obvious scars or injuries on Ms Killer’s body.

Toxicological analysis of samples taken at autopsy revealed the presence of small amounts of alcohol. However, it is likely that this alcohol was the result of post-mortem changes in the body.

Finally, Dr Devadas noted in her affidavit that autopsy was limited “by moderately advanced decomposition changes, [but that] no clear anatomical cause of death was found”.

Conclusion

The circumstances surrounding Ms Killer’s death remain unclear. The cause of her death is unable to be determined. Whilst I am satisfied on the balance of probabilities that she died in her home given the circumstances in which she was found, the evidence does not allow me to reach a conclusion as to the date of that death. As noted above, she was last seen alive on 26 September 2017 before being discovered dead on 4 October 2017.

Whilst it seems unlikely that any other person was involved in Ms Killer’s death I cannot rule that possibility out particularly in light of the absence of any forensic evidence.

Finally, I cannot rule out suicide as a cause of death.

Comments and Recommendations

The circumstances of Ms Killer’s death are not such as to require me to make any recommendations pursuant to Section 28 of the Coroners Act 1995.
I do, however, find it necessary to comment that my investigation of Ms Killer’s death has been hampered by the manner in which the investigation was conducted by Tasmania Police.

I convey my sincere condolences to the family and loved ones of Ms Killer.

Dated 31 January 2019 at Hobart, Tasmania.

Simon Cooper
Coroner