IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2000 1395

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**FRANCESCO (FRANK) BENVENUTO**
Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Hearing date:	8 December 2016
Delivered on:	8 December 2016
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Counsel assisting the Coroner:	Ms Jodie Burns, Senior Legal Counsel
Representation:	Nil
Catchwords:	Homicide, no person charged with indictable offence in respect of a reportable death, mandatory inquest

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HER HONOUR:

BACKGROUND

1. Francesco (Frank) Benvenuto (**Mr Benvenuto**) was born on 15 December 1947 in Calabria, Italy. He was the oldest of nine children. At the time of his death, Mr Benvenuto was 52 years old. He lived at 62 Reserve Road, Beaumaris, Victoria, with his wife and two of his three children.

2. Mr Benvenuto ran a wholesale fruit and vegetable business in Footscray.

3. At the time of his death, Mr Benvenuto had no criminal record. However, Mr Benvenuto was an associate of underworld figure Victor Peirce and was killed during what is commonly referred to as Melbourne's '*Gangland Wars*'.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. At the time of Mr Benvenuto's death the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the *Coroners Act 2008* (**the Act**) has applied to the finalisation of investigations into deaths that occurred prior to the commencement of the Act.[1] Mr Benvenuto's death constituted a '*reportable death*' under the *Coroners Act 1985* (Vic), as his death occurred in Victoria and was both unnatural and violent.[2]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The term '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

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[1] Coroners Act 2008, section 119 and Schedule 1. All references which follow are to the provisions of this Act, unless otherwise stipulated.
[2] Section 3, definition of 'Reportable death', *Coroners Act 1985.*
[3] Section 89(4) *Coroners Act 2008.*
[4] *Keown v Khan* (1999) 1 VR 69.

8. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all of the 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.

9. 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 'prevention' role.

10. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (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; 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. These powers are the vehicles by which the prevention role may be advanced.

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[5] 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.

12. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of 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), or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

13. While Mr Benvenuto's identity was not in dispute and he was not a person placed in "*custody or care*" as defined by section 3 of the Act, his death is considered to be a homicide. Therefore, it is mandatory to conduct an inquest into the circumstances of his death because no person or persons have been charged with an indictable offence in respect of the death.

[5] (1938) 60 CLR 336.

VICTORIA POLICE HOMICIDE INVESTIGATION

14. Immediately after Mr Benvenuto's death, Victoria Police commenced a criminal investigation because the death was considered to be a homicide.

15. Mr Benvenuto's death was initially investigated by the Homicide Squad and then transferred to the Purana Task Force. Despite this investigation, no person or persons have been charged with indictable offences in connection with Mr Benvenuto's death.

16. I note the observations of the Victorian Court of Appeal in *Priest v West*,[6] 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.*"

17. 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]

18. Section 7 of the Act specifically states that a coroner should avoid unnecessary duplication of inquiries and investigations, by liaising with other investigative authorities, official bodies or statutory officers. The rationale behind this provision is to allow for consideration of public interest principles that weigh against the potential benefits of any further investigation, such as further cost to the community. It also acknowledges that although a number of authorities or organisations may have the mandate to investigate, some are more appropriately placed than others to do so in any given circumstance.

19. In this case, I acknowledge that the Victoria Police through the Purana Task Force, has conducted an extremely thorough investigation in this matter.

20. In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Benvenuto's death is an unsolved homicide case which Victoria Police continues to investigate.

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[6] (2012) VSCA 327.
[7] *Perre v Chivell* (2000) 77 SASR 282.

21. The Coroner's Investigator, Detective Senior Constable Paul Thomas, has provided to the Court a statement in relation to this matter.

22. The confidential nature of the Victoria Police's ongoing investigation prevents me from reciting each and every matter which has been established by the Purana Task Force. However, Detective Senior Constable Paul Thomas' statement indicates that the following important matters have been established and are able to be disclosed:

    (a) an examination of the scene reveals that it is highly likely a .38/357 calibre handgun was used; and

    (b) that the movements of the offender/s are not known; and

    (c) that despite the extensive homicide investigation conducted by the Purana Task Force, the person or persons responsible for Mr Benvenuto's death have not been formally identified; and

    (d) that the homicide investigation into Mr Benvenuto's death is ongoing and the Purana Task Force file remains open.

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

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

23. On 9 May 2000, the Deceased was visually identified by his brother, [redacted], to be Francesco Benvenuto, born 15 December 1947.

24. Identity is not in dispute in this matter and therefore requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

25. On 9 May 2000, Professor Stephen Cordner, a Forensic Pathologist, practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Benvenuto's body. Professor Cordner provided a written report, which concluded that a reasonable cause of death was '*Near contact gunshot wound of neck*'. Professor Cordner commented that Mr Benvenuto had "*no natural disease to cause or contribute to death*".

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

26. Sometime before 12.00 noon on Monday, 8 May 2000, Mr Benvenuto visited a friend, Sam Muscat (**Mr Muscat**), with whom he shared a common interest in pigeon racing. Mr Benvenuto had generally visited Mr Muscat between 11.20am and 11.30am each morning in the previous week.

27. According to Mr Muscat, approximately seven or eight minutes into Mr Benvenuto's visit, he took a telephone call on his mobile phone. Mr Benvenuto walked away from Mr Muscat to take the call, which Mr Muscat considered uncharacteristic of Mr Benvenuto.

28. Telephone records revealed that Mr Benvenuto received telephone calls from public payphones at 11.38am and 11.42am.

29. Mr Benvenuto left Mr Muscat's home approximately ten minutes after the telephone calls. Mr Muscat described Mr Benvenuto as looking "*different*" after the telephone calls.

30. Mr Benvenuto arrived home at approximately 2.35pm and ate lunch with his wife and their cleaner.

31. At approximately 3.30pm, Mr Benvenuto left home with a trailer load of rubbish which he was intending to take to the tip. Mr Benvenuto drove north along Dalgetty Road, Beaumaris.

32. Between 3.46pm and 4.05pm, witnesses observed Mr Benvenuto's car and trailer parked across the driveway at 161 Dalgetty Road, Beaumaris, sticking out from the kerb. Witnesses saw Mr Benvenuto slumped forward in the driver's seat and assumed that he was asleep.

33. Telephone records revealed that Mr Benvenuto had made a telephone call to an associate, Victor Peirce, at 3.46pm. At 3.50pm, Mr Peirce returned the call, leaving a voice message saying "*yeah Frank, it's me. I don't know what happened, we got cut off or whatever. Can you give me a ring? Ta, ta*".

34. At 4.05pm, a witness checked on Mr Benvenuto and discovered that he was deceased. The witness and a neighbour telephoned emergency services.

35. Ambulance officers arrived on the scene at 4.22pm. One of the paramedics removed Mr Benvenuto's mobile telephone from his left hand and confirmed that he had a puncture type wound to the left side of his neck and was deceased. The puncture type wound was

approximately one centimetre in diameter and had a dark edge around the circumference. Resuscitation was not attempted.

36. The paramedic noticed that Mr Benvenuto's foot was on the brake pedal and that the handbrake was not engaged. The paramedic engaged the handbrake.

37. Victoria Police officers arrived at 4.30pm.

FINDINGS AND CONCLUSION

38. Having investigated the death of Mr Benvenuto and having held an Inquest in relation to his death on 8 December 2016, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Francesco (Frank) Benvenuto, born 15 December 1947; and

    (b) that Mr Benvenuto died on 8 May 2000, at 161 Dalgetty Road, Beaumaris, Victoria, from a gunshot wound to the neck;

    (c) that the death occurred in the circumstances set out above;

    (d) that despite an extensive criminal investigation conducted by Victoria Police, no person or persons have been identified, to date, as being responsible for causing Mr Benvenuto's death. On that basis, I am satisfied that no investigation which I am empowered to undertake, would be likely to result in the identification of the person or persons who caused Mr Benvenuto's death.

39. I note that in the future, if new facts and circumstances become available, 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 application would be assessed on its merits at that time.

40. I convey my sincerest sympathy to Mr Benvenuto's family and friends.

41. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

    (a) [redacted], senior next of kin.

    (b) Detective Senior Constable Paul Thomas, Coroner's Investigator.

(c) Detective Senior Sergeant Michael J Dwyer, Officer in Charge of the Purana Task Force, Victoria Police.

(d) Inspector Michael Hughes, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 8 December 2016