

**FORM 37**

Rule 60(1)

**FINDING INTO DEATH WITH INQUEST**

*Section 67 of the Coroners Act 2008*

**(Amended pursuant to s76 of Coroners Act 2008  
on 2nd September 2011 at 1.30pm)**

**Court reference:** 1498/07

**Inquest into the Death of JOANNE ELIZABETH HOWELL**

Delivered On: 26th August, 2011

Delivered At: Coroners Court of Victoria  
Level 11, 222 Exhibition Street,  
Melbourne, Victoria 3000

Hearing Dates: 7th and 8th March, 2011

Findings of: Coroner Paresa Antoniadis SPANOS

Representation: Leading Senior Constable Greig McFARLANE, Police Coronial  
Support Unit, to assist the Coroner

Mr D. HOLDING of Counsel, instructed by Victoria Legal Aid,  
on behalf of Mr Paul CHARLTON

**FORM 37**

Rule 60(1)

**FINDING INTO DEATH WITH INQUEST**

*Section 67 of the Coroners Act 2008*

**Court reference:** 1498/07

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

**Details of deceased:**

Surname: HOWELL  
First name: JOANNE  
Address: 15/262 Poath Road, Hughesdale, Victoria 3166

AND having held an inquest in relation to this death on 7th and 8th March, 2011

at the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was JOANNE ELIZABETH HOWELL born on the 21st August, 1955

and that death occurred on or about 21st April, 2007

at 15/265 Poath Road, Hughesdale, Victoria 3166

from: 1(a) HEAD INJURY IN A WOMAN WITH EVIDENCE OF LIGATURE  
STRANGULATION

in the following circumstances:

**INTRODUCTION & PERSONAL CIRCUMSTANCES<sup>1</sup>**

1. Ms Howell was a 51 year old unmarried woman who resided at 15/262 Poath Road, Hughesdale and was employed by Chubb Security as a Data Entry Operator. Ms Howell had no children of her own but had adopted her sister's daughter Tanya-Lee (Tarnee) when she was seven. Tarnee moved out of home when she was about 16, two years before Ms Howell's death.

2. In mid 2006, Ms Howell was introduced to Mr Paul Charlton by a mutual friend, Mr Thomas MacDonald, who brought him to her house to fix her computer. They commenced a relationship a short time later and, by about December 2007, were living together at Ms Howell's

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<sup>1</sup> The circumstances in which Ms Howell died will be canvassed in greater detail below. This is only an introductory summary of matters which appeared to be uncontentious.

home as a de facto couple. The relationship was somewhat volatile, witnesses describing them as argumentative, often arguing over seemingly trivial matters.

3. On the morning of 21 April, 2007 matters came to a head with Ms Howell telling Mr Charlton that he had four weeks to move out and (as a ruse) that she was moving to Perth and the lease on the property expired in four weeks. By early afternoon, Mr Charlton had moved his things into the spare room, at Ms Howell's insistence. Apart from Mr Charlton, the last person known to have contact with Ms Howell was her friend Mr Howard William who spoke to her on her home telephone between approximately 8.00-8.20pm. During this conversation, Ms Howell told him about the recent breakdown of her relationship and that they had been arguing.

4. When formally interviewed by police, Mr Charlton stated that they had been arguing through the day, that he left home at about 9.30pm to take the dog for a walk, locking the door connecting the garage to the unit behind him, and exiting via the garage door. Mr Charlton further stated that having walked the dog for some two hours, he returned at about 11.15pm, using the garage remote to enter via the garage door. He then noticed damage to the internal garage door (consistent with it having been forced) and entered the unit to find Ms Howell deceased at the bottom of the internal staircase, in a dishevelled state with obvious facial injuries.

5. Mr Charlton called emergency services at 11.19pm and commenced cardiopulmonary resuscitation as instructed until ambulance and police arrived. Ms Howell could not be revived. She died at the scene of fatal injuries sustained earlier that night. The police immediately commenced their investigation of her death which was presumed to be a homicide, and her death was also reported to the coroner.

## PURPOSES OF CORONIAL INVESTIGATIONS

6. The primary purpose of the coronial investigation of a *reportable death*<sup>2</sup> is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.<sup>3</sup> The practice is to refer to the *medical* cause of death incorporating where appropriate the *mode* or *mechanism* of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death, and not merely circumstance which might form part of an open-ended narrative culminating in the death.<sup>4</sup>

7. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory authority or entity on any matter connected with the death, including recommendations relating to public health and safety or the

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<sup>2</sup> Section 4 of the Act requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear "*to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury*". Clearly, Ms Howell's death falls within this definition.

<sup>3</sup> Section 67 of the Act.

<sup>4</sup> See for example *Harmsworth v The State Coroner* [1989] V. R. 989; *Clancy v West* (Unreported decision of Harper, J in the Supreme Court of Victoria, 17/08/1994).

administration of justice.<sup>5</sup> These powers can be invoked to advance another purpose of the coronial investigation, previously accepted as implicit, now explicitly articulated in the legislation, that is, the *prevention* of similar deaths in the future.<sup>6</sup>

8. The coroner's role is not to determine criminal or civil liability arising from the death under investigation. However, given the circumstances in which Ms Howell died, it is important to stress that coroners are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence. Somewhat paradoxically, this prohibition does not apply to prevent a coroner from referring to a notification to the Director of Public Prosecutions. Such a notification is made by the principal registrar of the court, where the coroner investigating the death *believes* an indictable offence *may* have been committed in connection with the death.<sup>7</sup>

## THE EVIDENCE

9. This finding is based on the totality of the material the product of the coronial investigation of Ms Howell's death, that is the brief compiled by (then) Detective Senior Constable Brett Smith from the Homicide Squad of Victoria Police, the statements and testimony of those witnesses who testified at inquest and any documents tendered through them, and the submissions of Counsel. All this material, together with the inquest transcript, will remain on the coronial file.<sup>8</sup> I do not purport to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

## UNCONTENTIOUS MATTERS

10. At the completion of the police investigation and prior to the commencement of the inquest, it was apparent that a number of the matters required to be ascertained by the coronial investigation were uncontentious. These were the deceased's identity, the medical cause of her death and aspects of the circumstances, namely the place and approximate time of her death.

11. I formally find that the deceased was Joanne Elizabeth Howell, born on the 21 August 1955, late of 15/262 Poath Road, Hughesdale; that she died at some time between approximately 8.30pm and 11.19pm on the 21 April 2007 at her home, namely 15/262 Poath Road, Hughesdale; and that the medical cause of her death is "head injury in a woman with evidence of ligature strangulation".

<sup>5</sup> Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

<sup>6</sup> The Preamble of the Act includes the following - "... to contribute to the reduction of the number of preventable deaths ..." while the Purposes in section 1 include "(c) to contribute to the reduction of the number of preventable deaths ... through the findings of the investigation of deaths ... and the making of recommendations by coroners;"

<sup>7</sup> See sections 69 and 49(1).

<sup>8</sup> Since the **Coroners Act 2008** (the Act) came into operation on 1 November 2009, access to documents in a coronial file may be sought pursuant to section 115 of the Act.

## CONTENTIOUS CIRCUMSTANCES - THE FOCUS OF THE INQUEST

12. The focus of the broader coronial investigation of Ms Howell's death, including the inquest, as reflected by the witnesses required to attend the inquest to testify, was on those aspects of the circumstances surrounding her death which remained contentious or unclear at the conclusion of the police investigation, namely how she sustained the injuries which proved fatal and, by whose hand.

13. The autopsy was performed by Dr Michael Burke, an experienced senior forensic pathologist from the Victorian Institute of Forensic Medicine (VIFM). Dr Burke attended the scene and was briefed there by police, he reviewed the circumstances as reported by the police to the coroner, and also reviewed postmortem CT scanning of the whole body undertaken at VIFM. Having done so, Dr Burke provided a detailed written report containing his findings, his opinion as to the cause of death and relevant comments.<sup>9</sup> Dr Burke found no evidence of any significant underlying natural disease. He noted that the results of toxicological analysis of postmortem samples revealed no alcohol or other commonly encountered drugs in blood, and only codeine and morphine in urine, at levels consistent with therapeutic use.

14. The forensic significance of Dr Burke's evidence went beyond the formulation of the medical cause of death as "head injury in a woman with evidence of ligature strangulation", to elucidating aspects of the circumstances in which Ms Howell died. At inquest, he explained the connotations or nuance of this formulation. He testified that, although it was not meant to convey a chronology or sequence of injury, he did rate the head injury as the most important injury and therefore gave it prominence in the formulation. He assessed the head injury as being sufficient to have caused death on its own, but considered that ligature strangulation probably contributed to death.<sup>10</sup>

15. Dr Burke was cross-examined at some length about possible scenarios in which the head injury could have been sustained and the ligature applied, particularly by Mr Holding on behalf of Mr Charlton, and particularly about the likely sequence of injury.<sup>11</sup> Despite being pressed, he was not ultimately prepared to indicate a preference for any particular sequence of injury based on purely pathological grounds.<sup>12</sup> He did maintain, however, that Ms Howell must have survived the head injury, almost certainly in an unconscious state for some time, perhaps of the order of 20-30 minutes, as there was evidence of early healing processes within the brain.<sup>13</sup> He also maintained that Ms Howell was still alive when the ligature was applied, as he found changes associated with strangulation, such as bruising to the larynx, which could only have occurred with a functioning circulation.<sup>14</sup>

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<sup>9</sup> Exhibit "A", Dr Burke's autopsy report.

<sup>10</sup> Transcript page 6 and following, especially at page 26.

<sup>11</sup> Transcript page 11 and following. I note that Dr Burke also commented about a number of other relatively minor injuries and about the absence of classical defensive injuries.

<sup>12</sup> Transcript page 27.

<sup>13</sup> Exhibit "A", pages 5-6, transcript page 5, 10, 15-19 163 - comment

<sup>14</sup> Exhibit "A" page 6, transcript pages 19-20.

16. Ms Howell appears to have been a fairly social person with a network of close friends with whom she was in regular contact, and in whom she confided. As a consequence, apart from her adoptive daughter, Tarnee, a number of witnesses were in a position to provide statements and to testify at inquest about the nature of the relationship between Ms Howell and Mr Charlton. They were consistent in characterising the relationship as somewhat volatile and/or dysfunctional, with frequent arguments, sometimes about seemingly trivial matters. There was also evidence that Ms Howell had maintained a degree of ambivalence about the relationship. While there was some evidence of a degree of physicality in their altercations, none of the witnesses had observed significant violence between them, and none characterised the relationship as violent.<sup>15</sup>

17. Even within the context of this lability, the evidence before me supports a finding that the relationship had broken down by Saturday morning, 21 April 2007 at the latest, with Ms Howell telling Mr Charlton that he had to move out in one month's time, and asking him to move his things into the spare room immediately.<sup>16</sup> A number of stressors were identified by the witnesses as having contributed to this turn of events - an accident in the preceding week in which Ms Howell wrote-off her vehicle and sustained some relatively minor but painful injuries; her reluctance to take sufficient time off work to recover due to a recent change of employment; fear for her safety as a passenger in Mr Charlton's vehicle when, in her perception, he drove dangerously and put her at risk;<sup>17</sup> and, matters of personality and incompatibility, all of which are encapsulated in a handwritten note probably written by Ms Howell on the day she died.<sup>18</sup>

18. There is evidence from a number of sources that Ms Howell said at various times that she was afraid of Mr Charlton, afraid of his anger and/or afraid of what he might do. In his statement, Mr Williams relates his telephone conversation with Ms Howell shortly before her death when she told him, among other things, that they had been arguing, that she had given Mr Charlton 30 days to move out, that she couldn't live with him anymore and that she was scared of his anger. He described her as "shakey" in his statement and at inquest expanded on this in the following terms - "I did notice that she was choking on the phone and that's - that's when I heard the door open. I think that was Paul coming home and she said, "Look, I've got to go". She said, "I think it's Paul" and there was a tremor in her voice ... She seemed scared".<sup>19</sup> At inquest, Mr Williams adopted his statement, but also agreed that when Ms Howell had previously spoken of being afraid of Mr Charlton and his temper, it was mostly because she didn't like his driving habits.<sup>20</sup>

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<sup>15</sup> See statements of Claire Bamber, Toni Perriman, Catherine Tormey and Howard Williams being Exhibits "B", "C", "D" and "E" respectively, and statements of those witnesses who were not required to testify at inquest (Thomas McDonald, Rosalind McDonald and Tanya-Lee Stevenson) in Exhibit "K" balance of inquest brief. Also transcript pages 33-41, 48-49, 53, 66, 68-69, 87-89, 96, 99-106,

<sup>16</sup> Exhibits "B", "C", "D" and "E" and transcript pages 61-66, 68, 70, 77, 81, 83-86.

<sup>17</sup> Transcript pages 34-35, 42, 51, 62-63, 70-72, 83 and following.

<sup>18</sup> Three handwritten pages reproduced at pages 197-199 of the inquest brief, Exhibit "K". While the first two pages appear to be one note or letter addressed to "Paul", the content of which would suggest it was written on Saturday 21 April 2007, the third page may be a separate note written at another time. See transcript pages 93-94.

<sup>19</sup> Transcript page 108.

<sup>20</sup> Exhibit "E" page 2 and transcript page 98. I note that Mr Williams testified that during the Horsham incident which he believed occurred over the New Year's Eve weekend 2007, Mr Charlton said

19. At the time she made her statement, Ms Bamber did not mention that Ms Howell had ever told her she was afraid of Mr Charlton but, at inquest, she testified that she had done so probably about twice in the two weeks preceding her death.<sup>21</sup> Not surprisingly, Ms Bamber was cross-examined about this omission from her statement. Whilst I accept that she was still affected by her friend's death when she made her statement, I do not accept this aspect of her evidence.

20. On the other hand, I do accept Ms Perriman's evidence that during a meeting on Thursday 19 April 2008, the last time they met, Ms Howell told her that one day she could see herself happily growing old with Mr Charlton or ending up with a knife through her throat.<sup>22</sup> To be clear, while I accept that Ms Howell expressed these sentiments, their forensic significance is ambiguous. Was this meant to be taken literally, or was this simply a graphic way of articulating to a friend her ambivalence towards the relationship and its very volatility?

21. The police investigation failed to identify anyone other than Mr Charlton as a person of interest in relation to Ms Howell's death.<sup>23</sup> When interviewed, Mr Charlton brought Mr Mark Spiers to the attention of the police as a person who had visited Ms Howell unannounced in late 2006 and who she was not pleased to see, indeed appeared to fear.<sup>24</sup> Although Mr Spiers could not be located by police in order to attend the inquest, I find it improbable that he had any involvement in Ms Howell's death. In part, this is based on the credible account of his movements on 21 April 2007,<sup>25</sup> and in part on the improbability that she would have failed to mention him to any of her friends if she had any ongoing contact with him or concerns for her safety arising from his cameo re-appearance in her life after an absence of many years. For the same reason, I find it improbable that Ms Howell could have known she was at risk from someone or had concerns for her safety without mentioning it to at least one of her close friends.

22. On any view, there was only a narrow window of opportunity for an unidentified third party to enter the unit and cause Ms Howell's injury and death. Ms Howell had a lengthy telephone conversation with Mr Williams on the telephone for about twenty minutes from 8.00pm. Another call was apparently made by Ms Howell from her landline at 8.34pm.<sup>26</sup> Mr Charlton's call to "000" was made at 11.19pm, leaving something like two and three quarter hours at the outside.<sup>27</sup>

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that 'he couldn't take this any more and was going to kill her'. He couldn't explain why this had been omitted from his statement, and that he later remembered that the words had been uttered but he didn't necessarily take them literally at the time - transcript pages 95-98.

21 Transcript page 44-46. I note that in part her evidence was that she felt her friend was afraid. This is quite another matter from Ms Howell having said, in terms, that she was afraid of Mr Charlton and/or what he might do.

22 Exhibit "C" page 8 and transcript page 65.

23 Transcript page 155 and following.

24 Exhibit "K" page 230, record of interview page 21. Mr Charlton referred to him as "Mark" and police later identified him as Mark Spiers, found him in bed when they called in the early hours of 22 April 2007, and investigated his movements on 21 April 2007.

25 Mr Spiers' statement appears at pages 148-152 of Exhibit "K".

26 Exhibit "K" pages 286-289.

27 Exhibit "K" page 300.

23. Within these parameters, consideration needs to be given to possible access points. The front door seems unlikely, given the damage apparently caused to the door connecting the garage to the interior of the unit when it was forced. Accepting as probable that the door was forced to gain entry to the unit, there were two possible access points to the garage - the door to the rear garden which could, in turn, have been accessed by someone climbing the rear fence, and the tilting garage door itself.

24. Sergeant Smith's<sup>28</sup> evidence regarding the back fence was that although it was possible that someone could climb over it into the backyard, he would have expected to see damage to the climber which covered the fence at the time, and there was no apparent damage seen. Photos of the same fence and climbing plant produced by Mr Holding at inquest, showed areas of fencing not encumbered by the climber, which appeared to have been pruned in the ensuing period.<sup>29</sup> The possibility that an unknown person may have climbed the rear fence and entered the garage through its rear door, and then forced entry into the unit through the connecting door, cannot be entirely excluded.

25. As part of their investigation, police tested the tilting garage door in order to ascertain the time it would have remained open after Mr Charlton left with the dog and its potential as an access point. Accepting that Mr Charlton did not see anyone enter as he was leaving, the maximum duration of the cycle from closed to fully open to closed again was found to be about 1 minute 48 seconds.<sup>30</sup> Obviously, the first and the last few seconds of the cycle need to be disregarded as the available space could not accommodate anybody when the door was just starting to open or almost closed. Again, the possibility that an unknown person gained access to the unit in this way, cannot be excluded.

26. At inquest, I heard evidence from Mr Raj Singh, his then wife Ms Kylie Singh and her friend Ms Amanda Burgess who spent the evening of 21 April 2007 with them in their adjoining unit to Ms Howell's.<sup>31</sup> Mr Singh heard a loud noise come from Ms Howell's unit at about 9.15pm but conceded that it could have been any time between about 9.00pm and 9.30pm. He had difficulty identifying the noise but maintained it was an unfamiliar noise, not like a door slamming or banging, and agreed that a dullish thud was "kind of like how it sounded".<sup>32</sup> Ms Singh thought the sound was of a wardrobe door being slammed and described it as "kind of like an echoe thud" but definitely one loud sound, not a series of them.<sup>33</sup> She also placed the sound somewhere between 9.00pm and 9.30pm. As did Ms Burgess<sup>34</sup> who described the noise at inquest in the following terms - "I think we did [stop the movie] ... It certainly stopped because it

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<sup>28</sup> The investigating member had been promoted to Sergeant by the time of the inquest.

<sup>29</sup> Transcript pages 161 and following, Exhibit "K" statement of Sgt Oldfield at page s 17-25 esp at 22, statement of DSC Karen Porter at page 129 and photos from page 188. Exhibit "J" was a batch of seven colour photos produced by Mr Holding on behalf of Mr Charlton.

<sup>30</sup> Transcript pages 153 and following and Exhibit "K" pages

<sup>31</sup> Their statements were Exhibits "F", "H" and "I" respectively. I note that neither Mr nor Ms Singh testified that they heard arguing coming from Ms Howell's unit on 21 April 2007, although they heard them on several occasions before.

<sup>32</sup> Transcript page 115-118.

<sup>33</sup> Transcript pages 131-135.

<sup>34</sup> Transcript pages 123-124.



was quite loud and it wasn't like your normal, you know, noise. It was quite a thud."<sup>35</sup> Whilst I accept the evidence of each of these witnesses that between 9.00pm and 9.30pm, they heard a single loud sound, akin to a thud, the evidence does not allow me to find to the requisite standard that this was a sound associated with Ms Howell's injuries or represents the time she was injured.

27. As already mentioned in this finding, I have not and do not purport to summarise the whole police investigation. However, aspects of that investigation are relevant to the possible motive of any unknown assailant. Apart from the forced connecting door, police found Ms Howell's unit undisturbed with no overt signs of violence or a struggle, and nothing apparently missing or stolen. Apart from Mr Charlton's description of the dishevelled state he found her in,<sup>36</sup> there was no evidence that Ms Howell had been sexually assaulted, although the absence of such evidence does not preclude sexual assault.<sup>37</sup>

28. Police were unable to either corroborate or undermine Mr Charlton's account of walking the dog for some two hours leading up to his discovery of Ms Howell's body. I note that according to his account, the argument with Ms Howell on 21 April 2007 was a continuation of the earlier argument about his bad driving and putting her at risk, and that he did not acknowledge any definitive breakdown or rift had occurred as recently as that day. This is contradicted by other clear and cogent evidence of a significant breakdown in the relationship, and is colourable in my view.

29. Mr Charlton was co-operative with the police investigation, participated in a formal interview, gave consistent accounts to police of his movements on 21 April 2007 and was a man of no prior criminal history.<sup>38</sup> He exercised his right against self-incrimination, as he was entitled to do, and I did not require him to testify at inquest.<sup>39</sup>

## CONCLUSION

29. The standard of proof in coronial matters is the civil standard of proof on the balance of probabilities with the *Briginshaw* gloss or explication.<sup>40</sup> The effect of the authorities is to require the coroner to consider the seriousness of the matters alleged and the consequences of an adverse finding for any person, in reaching a reasonable satisfaction that a matter is proven. I

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<sup>35</sup> Transcript page 125.

<sup>36</sup> Exhibit "K" page 210 and following.

<sup>37</sup> Exhibit "A" page 4.

<sup>38</sup> Transcript page 161.

<sup>39</sup> Transcript pages 137-146 for ruling made Section 57 of the Act.

<sup>40</sup> *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."* Briginshaw v Briginshaw (1938) 60 CLR 336 esp at 362-3  
Re State Coroner; ex parte Minister for Health (2009)261 ALR 152 at [21]  
Anderson v Blashki [1993] 2 VR 89 at 95  
Secretary to the Department of Health & Community Services v Gurvich [1995]2 VR 69 at 73-74

have applied that standard to the totality of the evidence before me in order to make the findings I am required to make in relation to the remaining contentious matters.

30. I do not disregard the phenomenon of coincidence, but I find it highly improbable that on the evening of 21 April 2007, the day when a difficult relationship broke down, at least to the extent that Ms Howell asked Mr Charlton to leave her home in one month and leave her bedroom immediately, an unknown assailant forced his/her way into the unit, inflicted fatal injuries on Ms Howell and left without leaving any sign of a struggle or taking anything. Moreover, that he/she did so opportunistically, while Mr Charlton was out walking the dog. On my assessment, the evidence supports a finding that Mr Charlton caused or contributed to Ms Howell's death.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1. Having formed the belief that an indictable offence may have been committed in connection with Ms Howell's death, I direct the Principal Registrar to notify the Director of Public Prosecutions accordingly.

Signature:

  
PARESA ANTONIADIS SPANOS  
CORONER



2nd September, 2011

For distribution to: The HOWELL family.  
Mr Paul CHARLTON  
Sgt Brett SMITH c/o Boronia Police