IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 3627

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*
*Section 67 of the Coroners Act 2008*

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| Findings of: | **JUDGE JOHN CAIN, STATE CORONER** |
| Deceased: | **Ms JACINTA POMPEI** |
| Date of birth: | 25 June 1983 |
| Date of death: | 21 July 2015 |
| Cause of death: | I(a) Blunt force trauma to the head |
| Place of death: | 3/5 Mijuda Court, Kennington, Victoria, 3550 |
| Catchwords: | Homicide; family violence; intimate partner; death resulted directly from injury; unexpected, violent; not from natural causes, blunt force trauma to the head. |

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**HIS HONOUR:**

## BACKGROUND

1. Jacinta Pompei (**Ms Pompei**) was born in Bendigo, Victoria, on 25 June 1983. She was 32 years old at the time of her death. Ms Pompei is survived by her father, stepmother and five sisters.

2. Ms Pompei grew up in Bendigo and completed year 12 at the Bendigo Secondary College. After finishing her secondary education, Ms Pompei moved to Melbourne to study hairdressing at the Academy of Hairdressing in Carnegie.[1]

3. Ms Pompei developed a dependence on cannabis during her time in Melbourne and subsequently developed a mental health illness in the form of schizophrenia.[2] Ms Pompei was advised by family to return to Bendigo to receive treatment at the Alexander Bayne Centre and successfully completed a rehabilitation program.

4. Ms Pompei however suffered subsequent relapses over the years and had intermittent employment in a hairdressing apprenticeship and retail sales roles. During periods of relapse, Ms Pompei was received treatment at the Alexander Bayne Centre, a facility operated by Bendigo Health.[3]

5. Ms Pompei met Mr Justin Ellard (**Mr Ellard**) shortly after her 30th birthday in June 2013 whilst they were both being treated for schizophrenia at the Alexander Bayne Centre.[4]

6. In 2014, Ms Pompei and Mr Ellard moved in together and leased a unit, 3/5 Mijuda Court, Kennington where they both lived until the date of the fatal incident.

7. At the time of her death, Ms Pompei had started a new job for a few months, she was volunteering with a local non-profit on Friday evenings and was preparing to enrol in a certificate IV course in disability work.[5]

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[1] Records provided by Bendigo Health, Volume 6, 5
[2] Ibid
[3] Above n 1, 6
[4] Records provided by Bendigo Health, Volume 4, 108
[5] Above n 1, 214-226

## THE PURPOSE OF A CORONIAL INVESTIGATION

8. Ms Pompei's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria[6] and was violent, unexpected and not from natural causes[7].

9. 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 the death occurred.[9]

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

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

12. 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 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.

13. 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.

14. Coroners are also empowered:

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

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[6] Section 4 *Coroners Act 2008*
[7] Section 4(2)(a) *Coroners Act 2008*
[8] Section 89(4) *Coroners Act 2008*
[9] See Preamble and s 67, *Coroners Act 2008*
[10] *Keown v Khan* (1999) 1 VR 69
[11] Section 69 (1)
[12] Section 67(1)(c)
[13] Section 72(1)

(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.

15. 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.

**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**

16. On 23 July 2015, Mr Domenico Pompei visually identified the deceased to be his daughter, Jacinta Pompei, born 25 June 1983.

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

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

18. On 21 July 2015, Dr David Ranson, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Ranson provided a written report, dated 30 October 2015, which concluded that Ms Pompei died from blunt force trauma to her head.

19. Dr Ranson commented on the following in his written report:

(a) The autopsy revealed no evidence of significant natural disease that might be expected to have contributed directly or indirectly to the death.

(b) The autopsy also evidenced injuries that were confined to the head and included extensive external lacerations to the top, left and rear of the deceased's head. There was

[14] Section 67(3)
[15] Section 72(2)
[16] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[17] (1938) 60 CLR 336

also evidence of significant multiple fractures to the underlying skull beneath the areas of lacerations.

(c) Due to the extensive nature of the fragmentation of bones, it is difficult to determine the number of blows that the deceased sustained to the head.

20. Toxicological analysis of postmortem specimens taken from the deceased identified the presence of clozapine and desmethylvenlafaxine at levels consistent with therapeutic use.[18]

21. I accept the cause of death proposed by Dr Ranson.

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

22. On 20 July 2015 at approximately 11.20pm, Mr Ellard armed himself with a standard claw hammer and entered the rear bedroom of their flat. Ms Pompei was sleeping on a double bed within that room.[19]

23. A nearby neighbour heard a chilling scream around this time and went to open their back door but did not hear anything else. The neighbour noted the time on her microwave as being approximately 11.23pm.[20]

24. Whilst Ms Pompei was lying face down on the bed, Mr Ellard struck her numerous times to the rear of the head with the hammer. Mr Ellard then placed the hammer in the nearby bathroom sink.

25. At approximately 1.12am on 21 July 2015, Mr Ellard called emergency services and he admitted that he had killed Ms Pompei and asked that the police attend. Mr Ellard also confirmed that Ms Pompei was observed to be breathing until 12.30 am but was no longer breathing at the time of the call.[21]

26. At approximately 1.20am, police attended 3/5 Mijuda Court with emergency services and Mr Ellard surrendered himself to police. Police members found Ms Pompei deceased on a bed in the rear bedroom of the unit and subsequently arrested Mr Ellard for the murder of Ms Pompei.[22]

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[18] Clozapine was detected at a concentration of 2.3 mg/L and Desmethylvenlafaxine was detected at a concentration of 0.7 mg/L
[19] *DPP v Justin Kain Ellard* SCR 2016 0038, Prosecution summary, 1
[20] *Coronial Brief,* Witness statement dated 27 July 2015, 51
[21] *Coronial Brief,* Appendix A, 103-106
[22] *Coronial Brief,* Statement of Sergeant Matt Hunt dated 24 July 2015, 58

## COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

*Family Violence*

27. For the purposes of the *Family Violence Protection Act 2008* (Vic) (the Act), the relationship between Mr Ellard and Ms Pompei clearly fell within the definition of "*domestic partner*"[23] under that Act. Moreover, in causing blunt force trauma to Ms Pompei's head and causing her death, Mr Ellard's actions constitute "*family violence.*"[24]

28. Considering Ms Pompei's death occurred in circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)[25] examine the circumstances of Ms Pompei's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD) and to review Mr Ellard's mental health treatment in the proximate period prior to Ms Pompei's death.[26]

29. The available evidence indicates that there was no discernible history of family violence between Mr Ellard and Ms Pompei.

*Mr Ellard's mental health treatment*

30. Mr Ellard has an extensive mental health history including multiple admissions to mental health facilities and compulsory treatment under the *Mental Health Act 2014*.[27] He has a diagnosis of treatment resistant paranoid schizophrenia and co-morbid substance use (cannabis and alcohol).[28]

31. At the time of the fatal incident, Mr Ellard was voluntarily engaged in treatment with the mental health team at Bendigo Health since January 2014.[29] Mr Ellard's treatment plan required him to attend regular meetings with his treating team, but the regularity was not specified. The treatment team were working towards a shared care program with Mr Ellard's general practitioner if he remained stable.[30]

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[23] Family Violence Protection Act 2008, section 9(1)(b)
[24] Family Violence Protection Act 2008, section 5(1)(a)(i)
[25] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[26] 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
[27] Medical records provided by Bendigo Health, Volume 15, 3-5
[28] Treatment resistant schizophrenia refers to patients who do not respond well to pharmacological treatment with antipsychotic medication. Clozapine is considered the preferred antipsychotic for such individuals.
[29] Records provided by Bendigo Health, Volume 15, 59-62
[30] Ibid

32. Mr Ellard's treatment resistant schizophrenia meant that medication only partially controlled his symptoms. He therefore always displayed a level of impairment even when considered to be stable.[31] The available evidence suggests that when stable, Mr Ellard presented with primarily negative symptoms of schizophrenia such as disorganised behaviour and limited self-care.[32]

33. Mr Ellard's clinicians noted that early warning signs of a mental state deterioration were missing appointments, becoming isolative, worsening home and self-care (dishevelled, poor hygiene) and refusing treatment providers entry to his home.[33] When acutely unwell, Mr Ellard would experience delusions, homicidal thoughts and display aggressive and abusive behaviour towards others.[34]

34. Mr Ellard was known to have a chronic delusional belief that he was Jesus and this belief had been present since approximately 2000.[35] Mr Ellard's treatment team were also aware that when psychotic he held delusional beliefs.[36] Mr Ellard's case manager discussed Mr Ellard's belief about being Jesus with him on 2 July 2015 and he did not report engaging in any behaviour in response to this belief.[37]

35. A review of the mental health records provided by Bendigo Health suggests that Mr Ellard displayed some early warning signs in the two weeks prior to the fatal incident. On 2 July 2015 he was noted as being "*slightly dishevelled*"[38] and on 9 July 2015 it was noted that Justin was "*reportedly more irritable and agitated*".[39] Mr Ellard's presentation deteriorated significantly on 14 July 2015 while under the influence of substances, where he was documented as blunted in affect, with pieces of food on his face and with a very messy flat.[40]

36. However, Mr Ellard's presentation improved on 15 and 16 July 2015 when he attended appointments with mental health clinicians and although noted to be dishevelled in his appearance, he was cooperative and engaged in treatment planning.[41] Clinicians noted no identified thought or perceptual disturbances.[42] The available evidence confirms that minimal

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[31] Medical records provided by Bendigo Health, Volume 15, 3-5
[32] Ibid
[33] Medical records provided by Bendigo Health, Volume 9, 133-134
[34] Medical records provided by Bendigo Health, Volume 14, 271
[35] Above n 31, Ibid
[36] Above, n 34, Ibid
[37] Medical records provided by Bendigo Health, Volume 15, 189
[38] Ibid
[39] Ibid, 195
[40] Ibid, 217
[41] Ibid, 221
[42] Ibid, 229

typical early warning signs of mental state deterioration were present prior to the fatal incident.

37. I confirm that the available evidence indicates that the mental health treatment provided to Mr Ellard was appropriate in the proximate period leading up to the fatal incident. Mr Ellard's treatment team were assertive in maintaining regular contact, conducting risk assessments and encouraging him to comply with his prescribed medication.

38. I note that when treatment providers developed concerns regarding Mr Ellard's substance use and probably non-compliance with medication, a psychiatric review was appropriately organised and took place eleven days prior to the fatal incident.

39. I confirm that research indicates that synthetic cannabis use is known to induce psychotic symptoms[43] and in individuals with schizophrenia, cannabis use is associated with poor clinical outcomes, symptom exacerbation and more violent behaviour.[44]

40. In this case it is not clear if Mr Ellard's use of synthetic cannabis contributed to the fatal incident. When interviewed by two consultant psychiatrists after the fatal incident, Mr Ellard acknowledged use of synthetic cannabis in the lead up to the fatal incident; however, no specifics were given on when or how much.[45] The available evidence suggests that Mr Ellard was not suffering from a drug-induced psychosis at the time of the fatal incident, but synthetic cannabis use may have aggravated his underlying psychosis.[46]

41. Mr Ellard was charged with the murder of Ms Pompei and on 3 November 2016 in the Supreme Court of Victoria, he was found not guilty by reason of mental impairment. Mr Ellard was found liable to a 25-year custodial supervision order in the custody of the Victorian Institute of Forensic Mental Health.[47]

42. I am satisfied, having considered all the available evidence, that no further investigation is required.

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[43] Yeruva, R., Mekala, H., Sidhu, M 7 Lippmann, S. Synthetic *Cannbinoids – "Spice" Can Induce a Psychosis: A Brief Review. Innovations in Clinical Neuroscience* (2019) 16(1-2):31-32. Available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6450675/

[44] Schultz, B., rodriguez-Cabezas, L., Angres, D., & Smith, M.J. *Treatment Strategies for Cannabis Use in Schizophrenia. Current Treatment Options in Psychiatry* (2015) 2:168-181. Available online at: https://link.springer.com/article/10.1007/s40501-015-0043-8

[45] Psychiatric reports of Dr Kevin Ong dated 19 September 2016 and Dr Lester Walton dated 5 May 2016

[46] Psychiatric report of Dr Lester Walton dated 5 May 2016, 4

[47] *DPP v Justin Kain Ellard* SCR 2016 0038

## FINDINGS AND CONCLUSION

43. Having investigated Ms Pompei's death, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Jacinta Pompei, born 25 June 1983;

    (b) that Ms Pompei died on 21 July 2015, at 3/5 Mijuda Court, Kennington, Victoria, from blunt force trauma to her head; and

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

44. I convey my sincerest sympathy to Ms Pompei's family.

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

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

    (a) Mr Domenico Pompei, Senior Next of Kin; and

    (b) Detective Senior Constable Matthew Walsh, Coroner's Investigator, Victoria Police.

Signature:

**JUDGE JOHN CAIN**

**STATE CORONER**

Date: 9 April 2020