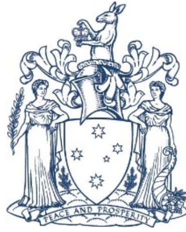

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004932

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Paul Kenneth Wright

Delivered On:	5 December 2022
Delivered At:	Melbourne
Hearing Dates:	5 December 2022
Findings of:	Coroner Simon McGregor
Counsel Assisting the Coroner	Kieren Malone
Keywords	Ravenhall Prison, stabbing, self-defence, Justice Assurance and Review Office, JARO, Community Corrections Order, CCO, Community Corrections Service, CCS, Corrections Victoria, Court Assessment and Prosecutions Services, CAPS, CCS Manager's Review.

THE CORONIAL INVESTIGATION

1. Paul's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

2. Paul's death is a reportable death as defined in the *Coroners Act 2008*. The court's jurisdiction is invoked due to the death occurring in Victoria and, subject to the second of the two-part definition, his death was violent and resulted from an injury.[1]

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Paul's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

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[1] *Coroners Court Act 2008* (Vic), section 4(1), (2)(a).

6. This finding draws on the totality of the coronial investigation into the death of Paul Kenneth Wright including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

Decision to hold an inquest

7. Under section 52(2)(a) of the *Coroners Act 2008*, an inquest must be held into a death if it is suspected that the death was the result of a "homicide". Whilst Division One, Part One of the *Crimes Act 1958* specifies the particular crimes that constitute homicide in Victoria, that same Act stipulates that self-defence is a complete answer to any such allegations, and that where the defence is made out, no homicidal crime can then be said to have been committed. On this view, with the findings I have noted below, the holding of an inquest would not be mandatory in this case.

8. However, the plain English definition of the word 'homicide' is broader and includes both lawful and unlawful killing of a human being by another. Accordingly, I directed this matter, featuring what I find to be a lawful homicide, to be dealt with as a summary mandatory inquest withing the ambit of section 52(2)(a) of the *Coroners Act 2008.*

BACKGROUND CIRCUMSTANCES

9. Paul had an extensive custodial history from a young age and had spent approximately half of his life in gaol.[3] He suffered from an acquired brain injury (**ABI**)[4] and was being treated for an opioid dependency and anxiety by his local general practitioner (**GP**), Dr Robert Weiss.[5]

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[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

[3] Coronial brief, statement of Marilyn Wright dated 17 September 2021, page 129.

[4] Justice Assurance and Review Office Report, page 1.

[5] Coronial brief, statement of Dr Robert Weiss dated 18 January 2022, page 128.

10. On 15 September 2021 at approximately 7.00pm, Paul arrived at his mother's residence in Langwarrin, after being released from Ravenhall Prison.[6] He later called his friend Mohamed Belhadj whom he had met at Port Phillip Prison. Mohamed stated that Paul sounded happy, and they arranged to meet on the weekend.[7]

11. On 16 September 2021 at 10.39am, Paul attended an appointment with Dr Weiss. Dr Weiss stated that Paul appeared well during the visit and did not appear to be drug or alcohol affected. He was "positive, keen to find work and improve his situation in life".

12. Paul also advised Dr Weiss that he had recently been released from prison. Dr Weiss prescribed Paul suboxone and a short course of diazepam due to anxiety regarding reintegration into the community.[8]

13. At approximately midday, Paul spoke to an associate, Graeme Tyler. Graeme stated that Paul spoke to him about drugs and then asked whether Kathleen Manion, an old acquaintance of his, was still in the Frankston area. Graeme stated that Paul appeared to be drug affected.[9]

14. Between 1.00pm and 3.00pm, Paul spoke to an acquaintance, Mark Jonker, outside the Frankston Health Care Medical Centre. Mark stated that Paul appeared to be drug affected.[10]

15. Paul then returned home however his mother stated that he became upset about missing his father's funeral due to being incarcerated. He later called Mohamed again and spoke about seeing Dr Weiss that day; Mohamed stated that Paul sounded intoxicated but was unsure whether it was from alcohol or medication.[11]

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[6] Coronial brief, statement of Marilyn Wright dated 17 September 2021, page 129.
[7] Coronial brief, statement of Mohamed Belhadj dated 29 September 2021, pages 88-89
[8] Coronial brief, statement of Dr Robert Weiss dated 18 January 2022, pages 127-128.
[9] Coronial brief, statement of Graeme Tyler dated 6 October 2021, page 102.
[10] Coronial brief, statement of Mark Jonker dated 22 September 2021, page 96.
[11] Coronial brief, statement of Mohamed Belhadj dated 29 September 2021, page 89.

CIRCUMSTANCES OF DEATH

16. At 8.04pm, Paul spoke to Mohamed again on the phone who stated that Paul "seemed good" and agreed to speak the next day.12 Another friend of Paul's, Trent Harrison, stated that Paul left a message on his phone at approximately 7.59pm about catching up. Trent stated that Paul sounded drug affected in the message.[13]

17. At approximately 6.00pm, Paul ate dinner with his mother however she stated that he was still upset about his father's passing and ate only a small amount. Marilyn stated that Paul began ruminating on his life and his father before leaving the house that night without telling his mother where he was going.[14]

18. At approximately 10.40pm, Paul contacted a private taxi group and requested a taxi to take him from his address in Langwarrin to Frankston and back again. At 10.52pm, a taxi driven by Ravinda Pamar arrived at Paul's address and drove him to Langwarrin, dropping him off at the corner of Ebdale Street at 11.05pm. Paul then asked Ravinda to wait for him as he wanted to go back to Langwarrin. Ravinda stated that Paul had a bag with him which he took when he exited the taxi.[15]

19. On 16 September 2021 at approximately 10.45pm, Kathleen Pollock began having a bath at her residence in Frankston. At 11.20pm, she stated that she heard a noise outside and called out "who is it?" to which a person replied "Jonkers".[16]

20. Thinking she knew who the person was, Kathleen got out of the bath and dressed before opening the front door, revealing a male standing in the doorway wearing a navy-blue jacket, t-shirt, and a motorcycle helmet with the visor up. Kathleen stated that the motorcycle helmet was hers and had been left out the front with her scooter.[17]

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[12] Coronial brief, statement of Mohamed Belhadj dated 29 September 2021, page 89.
[13] Coronial brief, statement of Trent Harrison (undated), page 92.
[14] Coronial brief, statement of Marilyn Wright dated 17 September 2021, page 130.
[15] Coronial brief, statement of Satwinder Samra dated 22 September 2021, pages 116-117; statement of Ravinda Pamar dated 17 September 2021, pages 121-122.
[16] Coronial brief, statement of Kathleen Manion dated 17 September 2021, pages 83-85.
[17] Coronial brief, statement of Kathleen Manion dated 17 September 2021, pages 83-85.

21. Kathleen stated that the male pushed his way inside the residence before lunging at her and holding a serrated kitchen knife to her throat. She began screaming however the male pushed her down and held the knife on the top of her head. Kathleen stated that the male was yelling "stop harassing my family". Kathleen stated that she then recognised the male as Paul, however she stated that she had not seen him for a year and a half and had never had troubles with him in the past.[18]

22. Kathleen's son, Beau Muscat, stated that he was upstairs when he heard the gate latch unlock followed by knocking at the door. Beau walked downstairs and waited in the kitchen when he heard his mother open the door. He stated that he heard a male yell "give me the bag" before picking up a knife from the kitchen counter and entering the adjacent room where he stated that he observed a male (Paul) standing over his mother with a knife in his hand.[19]

23. Beau stated that Paul turned and lunged at him with the knife in his hand. Avoiding the strike, Beau stated that he stabbed Paul once in the stomach area in an act of self-defence.[20] Kathleen stated that the helmet fell off Paul's head during the scuffle.[21]

24. Paul continued to swing the knife towards Kathleen and Beau before stopping and sitting down near the front door. Beau then immediately contacted 000, and despite his apparent distress, relayed the operator's instructions to Kathleen whilst the two of them did their best to prove first aid to Paul, initially by checking his airway. Whilst doing this, Kathleen discovered a small laceration and attempted to use a t-shirt as a compression bandage until police arrived.[22]

25. At 11.26pm emergency services attended the address and found Paul to be in an unresponsive state with a puncture wound to the left nipple. Despite intensive resuscitation efforts, Paul was unable to be revived and was verified as deceased at 11.48pm.[23]

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[18] Coronial brief, statement of Kathleen Manion dated 17 September 2021, pages 84-85.
[19] Record of interview dated 17 September 2021, pages 17-21.
[20] Record of interview dated 17 September 2021, pages 17-23.
[21] Coronial brief, statement of Kathleen Manion dated 17 September 2021, pages 84-85.
[22] Coronial brief, statement of Kathleen Manion dated 17 September 2021, pages 85-86.
[23] Coronial brief, statement of Nicole Paulding dated 25 October 2021, page 147; statement of Jake Donovan dated 23 September 2021, page 149.

26. Ambulance Victoria paramedic Jake Donovan stated that Paul was discovered with socks on both hands and a plastic bag containing zip-ties was located in Paul's underwear.[24]

27. No charges were laid by Victoria Police against Beau following Paul's death.

MEDICAL CAUSE OF DEATH

28. After his death, Paul was conveyed to the Victorian Institute of Forensic Medicine (**VIFM**) and, on 17 September 2021, Dr Gregory Young, a specialist forensic pathologist, performed an autopsy.

29. The post-mortem examination revealed a stab injury to the left side of the chest which passed through the left serratus anterior muscle, left 5th intercostal space, pericardial sac, anterior right ventricle, and intraventricular septum of the heart.

30. The wound was associated with injuries to the left 5th and 6th costal cartilages and a 350ml haemopericardium. There were also two incised injuries to the face, as well as sequelae of resuscitation attempts.

31. There was no evidence of any significant natural disease which may have caused or contributed to the death.

32. Toxicological analysis of post/ante-mortem samples identified the presence of methylamphetamine and its metabolite amphetamine, buprenorphine and its metabolite norbuprenorphine, naloxone, temazepam, oxazepam, paracetamol, as well as the heroin metabolites morphine and codeine.

33. Dr Young formulated a cause of death as a stab injury to the chest.

34. I agree with this formulation.

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[24] Coronial brief, statement of Jake Donovan dated 17 September 2021, page 151.

INVESTIGATIONS AND REVIEWS

35. Upon receiving the report of Paul's death, I commenced this investigation. As part of the investigation, a report was obtained from the Justice Assurance and Review Office (JARO) which detailed the circumstances surrounding Paul's recent incarceration and release on 15 September 2020.

Circumstances surrounding Paul's remand and release

36. On 14 September 2020, Paul was remanded into custody on multiple charges, including aggravated burglary. On 15 September 2021, he was sentenced to a combined Community Corrections and Imprisonment Order (**CCO.IMP**) of 373 days imprisonment (with his pre-sentence detention days counting as time served) and an eight-month CCO.[25]

37. During his time in custody, Paul regularly met with custodial staff for case management meetings and had local plan goals focussed on improving his knowledge and skills, maintaining his health, and addressing his legal issues.

38. Paul was a generally compliant prisoner who was engaged in employment whilst in custody. Paul provided seven urinalysis samples each of which was negative.[26]

39. On 15 September 2021, Paul was released from custody and commenced the CCO component of his sentence. The CCO included the following conditions:

    a) Assessment and treatment (including testing) for drug abuse or dependency as directed;

    b) Mental health assessment as directed;

    c) Any other treatment and rehabilitation as directed (with the support of an NDIS plan);

[25] Justice Assurance and Review Office Report, page 1.
[26] Justice Assurance and Review Office Report, pages 2-3.

d) A return to Melbourne Magistrates' Court on 12 November 2021 at 9.30am for a Judicial Monitoring Hearing; and

e) To participate in the services specified in the Justice Plan.[27]

40. Following Paul's release from custody on 15 September 2021, he failed to make contact with Cranbourne Community Corrections Service (**CCS**) as required by the conditions of his order. On 19 September 2021, Cranbourne CCS received notification that Paul was deceased.[28]

Subsequent CCS and JARO reviews

41. After Paul's death, Cranbourne CCS staff notified managers and completed an Incident Report dated 20 September 2021 and a Manager's Review dated 28 September 2021. The subsequent JARO investigation found that these actions were in line with the standards prescribed by Justice Services.[29]

42. The JARO review acknowledged that there was limited opportunity for Corrections Victoria or Cranbourne CCS to engage with Paul and provide additional transitional and reintegration support. JARO found that Paul's custodial management met the standards prescribed by Corrections Victoria.[30]

CCS Manager's Review

43. The CCS Manager's Review found that Paul presented with several complexities, including the length of time he had been on remand prior to sentencing, his diagnosis of an ABI, as well as low IQ in line with an intellectual disability.[31]

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[27] Justice Assurance and Review Office Report, page 1.
[28] Justice Assurance and Review Office Report, page 2.
[29] Justice Assurance and Review Office Report, page 2.
[30] Justice Assurance and Review Office Report, page 3.
[31] Justice Assurance and Review Office Report, page 3.

44. As the timeframe between Paul's discharge from custody and his death was short, this inhibited the case manager's ability to engage him on the order and treatment conditions. Nonetheless, the Manager's Review identified several matters of concern relating to the appropriateness of his CCO.

45. During a pre-sentence assessment conducted by the Melbourne Court Assessment and Prosecution Service (**CAPS**) on 6 September 2021, Paul was deemed unsuitable for a CCO based on his criminal history, limited protective factors and non-compliance with previous court mandated orders. At the time of the assessment, Paul was directed to contact CCS within two clear working days should he be sentenced to a CCO.[32]

46. *CCS Practice Guideline (PG) 9.2.2 – Court Assessment* highlights several areas that CAPS staff should consider, including identifying any issues relevant to the Court if the offender was to be immediately released from custody (such as Paul's case).

47. Additionally, PG 9.2.2 highlights consideration for an adjournment to allow an Extended Pre-Sentence Assessment to take place for offenders with complex needs, inclusive of an intellectual disability. There was no evidence that this occurred in Paul's case.[33]

48. Despite being found unsuitable for the CCO, it is unclear why the CAPS assessor failed to recommend a supervision condition on Paul's CCO. This should have been recommended and aligns with section 3.5.5 of *PG 9.2.2*.[34]

49. Although Paul was advised he had two working days to initiate contact with Cranbourne CCS following his discharge from custody, the Manager's Review found that, given the complexities he presented with, there were opportunities for the Advanced Case Manager (**ACM**) to initiate contact the afternoon he was released or the following morning to confirm an appointment time for Paul to attend in person for induction purposes.[35] This would have

[32] Justice Assurance and Review Office Report, page 3.
[33] Justice Assurance and Review Office Report, page 3.
[34] Justice Assurance and Review Office Report, page 3.
[35] The JARO report notes that the ACM was not required to initiate contact with Paul prior to his two-day report, in line with *PG 10.2.1 – Intake – Court Case Management*.

also provided opportunity to confirm Paul's residential address and to establish if he had obtained a mobile phone.[36]

50. The Manager's Review recommended that the issues identified above be addressed via debriefs with the Supervisors of the Melbourne Court and Prosecutions Team, as well as the allocated ACM and their supervisor.[37]

51. On 28 September 2022, the Court was provided with a copy of the CCS Manager's Review and accompanying statement from Leala Downey, Acting Manager Court Practice, Dandenong CCS in response to a request for a statement describing the debriefs conducted as per the CCS Manager's recommendation described above.

52. In her statement to the Court, Ms Downey affirmed that contact with Paul had not been attempted by CCS during the period of 15-16 September 2021 following his release as he was still within the prescribed two-day reporting period of his CCO, and due to his ACM being involved with another individual at the time who was in crisis and at significant risk.

53. Ms Downey stated that she discussed the findings of the Manager's Review, including the recommendation, with the supervisor of the Dandenong CCS Courts and Prosecution Service (**CAPS**) where it was identified that the CAPS Central Business Unit was in the process of developing a state-wide CAPS training programme which would adequately address the identified issues in the Manager's Review.

54. Ms Downey further discussed the debrief with the Senior Review Officer, Reviews, Investigation and Monitoring, Justice Services where it was decided that the debrief would not occur, instead preference would be given to the adoption of a more consistent approach through the delivery of the CAPS training programme.

[36] Justice Assurance and Review Office Report, pages 3-4.
[37] Justice Assurance and Review Office Report, page 4.

FINDINGS AND COMMENT

55. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[38] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

56. In light of the evidence distilled above, it is reasonable to find that Beau's conduct constituted a lawful use of force to defend both his mother and himself, pursuant to section 322K of the *Crimes Act 1958*. In plain English, this is referred to as an act of 'self-defence' or 'defence of another'. Therefore, I am satisfied that no referral to the Office of Public Prosecutions is required of this court.

57. Beau's conduct actions could also be said to be in defence of his family's property; however I note that, under section 322K of the *Crimes Act 1958*, the defence of self-defence is only available if the accused's actions are to defend themselves or another person.

58. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

    a) the identity of the deceased was Paul Kenneth Wright, born 27 September 1975;

    b) the death occurred on 16 September 2021 at 3/46 Dandenong Road West, Frankston, Victoria, 3199, from a *stab injury to the chest*; and

    c) the death occurred in the circumstances described above.

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[38] Briginshaw v Briginshaw (1938) 60 CLR 336 at 362-363: '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 issues had 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…'.

59. Whilst the exact reason for Paul's attendance at Kathleen and Beau's residence on the night of 16 September 2021 remains uncertain, I am satisfied that, on the basis of probabilities, Beau's conduct was in self-defence pursuant to Section 322K of the *Crimes Act 1958* and was reasonable given the circumstances as they appeared to Beau at the time of the act.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

60. On 28 September 2022, the Court was provided with a copy of the CCS Manger's Review and accompanying statement from Leala Downey, Acting Manager Court Practice, Dandenong CCS in response to a request for a statement describing the debriefs conducted as per the CCS Manager's recommendation described above.

61. In her statement to the Court, Ms Downey affirmed that contact with Paul had not been attempted by CCS during the period of 15-16 September 2021 following his release as he was still within the prescribed two-day reporting period of his CCO, and due to his ACM being involved with another individual at the time who was in crisis and at significant risk.

62. I note that Ms Downey stated that she discussed the findings of the Manager's Review, including the recommendation, with the supervisor of the Dandenong CCS Courts and Prosecution Service (**CAPS**) where it was identified that the CAPS Central Business Unit was in the process of developing a state-wide CAPS training programme which would adequately address the identified issues in the Manager's Report.

63. Ms Downey further discussed the debrief with the Senior Review Officer, Reviews, Investigation and Monitoring, Justice Services where it was decided that the debrief would not occur, instead preference would be given to the adoption of a more consistent approach through the delivery of the CAPS training programme.

64. On the basis of the information provided by Ms Downey with regards to the adoption and delivery of the state-wide CAPS programme, I am satisfied that appropriate measures have been taken to address the issues identified by the CCS Manager's Review and that no further recommendations are required by this court.

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

Pursuant to section 73(1A) 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:

Marilyn Wright, Senior Next of Kin

Zoe Gunn, Justice Assurance and Review Office

Marius Smith, Chief Executive Officer, Victorian Association for the Care and Resettlement of Offenders.

Detective Senior Constable Abbey Justin, Victoria Police, Coroner's Investigator

Signature:

CORONER SIMON McGREGOR
CORONER
Date: 5 December 2022

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 inquest. 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.