IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 2762

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**IAIN WEST, ACTING STATE CORONER**
Deceased:	**Paul Francis O'Donnell**
Date of birth:	31 August 1967
Date of death:	18 June 2016
Cause of death:	Stab wound to the hip
Place of death:	3/7 Olive Grove, Keysborough, Victoria

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HIS HONOUR:

BACKGROUND

1. Paul Francis O'Donnell (**Mr O'Donnell**) was born on 31 August 1967. Mr O'Donnell was the seventh of eight children in his family, and also had an adopted brother and sister.

2. Mr O'Donnell was married three times and had three children from his first two marriages. Mr O'Donnell had two children with his first wife and had one child with his second wife.

3. There were no children as a result of Mr O'Donnell's third marriage. Approximately five years before his death, Mr O'Donnell's third wife took her own life as he slept beside her which affected him greatly.[1]

4. Helen Gaisbauer (**Ms Gaisbauer**) was Mr O'Donnell's partner at the time of his death. The two had been in a relationship for around four years prior to his death.

5. The factory in Keysborough where Mr O'Donnell resided with his partner, also housed his business "RMBM" where he worked as a mechanic working on BMW motor vehicles.

6. The living quarters at the rear of the factory consisted of a small room with a bed and kitchen area. Mr O'Donnell had been living at the factory for approximately 18 months before his death.[2]

7. Karl Lamblin (**Mr Lamblin**) was born on 24 April 1984. Mr Lamblin is the eldest of three children in his family. Mr Lamblin's mother, Kathleen, is Mr O'Donnell's older sister.

8. Mr Lamblin grew up in the Mount Evelyn area of Victoria and his parents separated when he was around 13 or 14 years of age. He was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) around the time of his parents' separation.

9. Mr Lamblin was educated until Year 10, after which he completed an apprenticeship as a boiler maker. He worked as a boiler maker with different companies for several years before moving to Queensland in 2012. He worked with an engineering company contracted to Santos, before returning to Victoria in 2014. He has been unemployed since his return to Victoria in 2014.

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[1] Coronial brief, Statement of Kevin Raymond O'Donnell dated 19 June 2016, 30
[2] *ibid*, 29

10. The relationship between Mr Lamblin and Mr O'Donnell had soured in recent years leading up to Mr O'Donnell's death.

11. Mr Lamblin had a poor relationship with his immediate and extended family for which he blamed Mr O'Donnell.[3] Mr Lamblin believed that Mr O'Donnell had spoken to family members around 2015, accusing Mr Lamblin of sexually assaulting his girlfriend at the time.[4] This was the reason why Mr Lamblin believes that none of his family speak to him anymore.[5]

12. Around June 2016, Mr Lamblin took a rare bass guitar belonging to Mr O'Donnell from his grandparents' home in Glen Waverley.[6] On 12 June 2016, Mr Lamblin took the guitar to Kevin Hoffman's house and left it there for safekeeping. Later that day, James Snaith, a friend of Mr O'Donnell was visiting Mr Hoffman, saw the guitar, recognised it as belonging to Mr O'Donnell and returned it to him.[7]

13. Mr Lamblin had planned to use Mr O'Donnell's guitar as bait to a conversation about their relationship which had soured in recent years. Mr Lamblin was upset and angry that his plan had been foiled and several associates of Mr Lamblin commented that he '*was not in a good place mentally, he was angry and out for blood about the guitar*'.[8]

THE PURPOSE OF A CORONIAL INVESTIGATION

14. Mr O'Donnell's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[9]

15. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[10] 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.[11]

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[3] Mental Health Report prepared by Pamela Matthews dated 14 May 2017, 7
[4] Coronial Brief, Appendix N, Police interview with Karl Lamblin on 23 June 2016, 274
[5] *ibid*, 278
[6] Coronial Brief, Statement of Kevin Hoffman dated 19 June 2016, 46
[7] Coronial Brief, Statement of James Snaith dated 19 June 2016, 71
[8] *ibid*
[9] Section 4 *Coroners Act 2008*
[10] Section 89(4) *Coroners Act 2008*
[11] See Preamble and s 67, *Coroners Act 2008*

16. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[12] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[13] or to determine disciplinary matters.

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

18. For coronial purposes, the phrase "*circumstances in which death occurred,*"[14] 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.

19. 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.

20. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[15]

    (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;[16] 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.[17] These powers are the vehicles by which the prevention role may be advanced.

21. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[18] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[19] The effect of this and similar authorities is that coroners should

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[12] *Keown v Khan* (1999) 1 VR 69
[13] Section 69 (1)
[14] Section 67(1)(c)
[15] Section 72(1)
[16] Section 67(3)
[17] Section 72(2)
[18] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[19] (1938) 60 CLR 336

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.

22. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

23. On 20 June 2016, a member of the Forensic Services Department (Victoria Police) took fingerprint impressions from the deceased which identified him to be Paul O'Donnell, born 31 August 1967.

24. 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

25. On 19 June 2016, Dr Heinrich Bouwer (**Dr Bouwer**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr O'Donnell's body. Dr Bouwer provided a written report, dated 12 September 2016, which concluded that Mr O'Donnell died from a stab wound to the hip.

26. Dr Bouwer commented that the mechanism of death was one of exsanguination (significant blood loss) caused by the external iliac artery being incised in the left hip region.

27. Toxicological analysis of post mortem specimens taken from Mr O'Donnell identified the presence of amphetamines, cannabis and paracetamol.

28. I accept the cause of death proposed by Dr Bouwer.

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

29. On 18 June 2016, the deceased spent most of the day at his factory working. His partner, Ms Gaisbauer and his mechanical assistant Jake Hewgill were also present for most of the day.[20] Mr Hewgill left at approximately 5.00pm.

30. Later that evening, Ms Gaisbauer and Mr O'Donnell spent time in the living area at the back of the factory and watched television whilst lying on the bed.[21]

31. At 7.26pm, Mr O'Donnell left his factory to walk his dog and left the factory through the driveway area and turned right to proceed along Olive Grove.[22] While he was out, at 7.30pm, CCTV captured Mr Lamblin arriving at the factory area carrying a back pack. Mr Lamblin had with him at least one large knife.[23] Mr Lamblin entered the front of Mr O'Donnell's factory through an unlocked front pedestrian door.

32. At approximately 7.38pm, Mr O'Donnell returned back to his factory after walking his dog, which was captured on CCTV cameras.[24] At this time Mr Lamblin confronted Mr O'Donnell in the main workshop area near the sliding door to the back kitchen/living area.

33. An argument broke out and a scuffle ensued that resulted in Mr Lamblin stabbing Mr O'Donnell in the left hip area with a large knife.[25] At this time, Ms Gaisbauer, upon hearing the commotion got up off the bed and opened the sliding door to the workshop area where she observed Mr Lamblin standing and holding a knife and Mr O'Donnell lying on the ground.[26]

34. Ms Gaisbauer picked up a vacuum cleaner with a long hose and used it to attempt to push Mr Lamblin while telling him to leave. Mr Lamblin slowly backed out of the workshop area while waving the knife at Ms Gaisbauer in a threatening manner.[27]

35. At approximately 7.42pm, Mr Lamblin was captured on CCTV cameras fleeing through the front door of the factory and heading in an easterly direction along Olive Grove.[28]

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[20] Coronial Brief, Statement of Helen Gaisbauer dated 19 June 2016, 12
[21] *ibid*
[22] Coronial Brief, Appendix M, CCTV timeline and log, 252
[23] *ibid*
[24] *ibid*, 253
[25] The Queen *v Karl Lamblin* [2017] VSC 306, 2
[26] Coronial Brief, Statement of Helen Gaisbauer dated 19 June 2016, 13
[27] *ibid*
[28] Coronial Brief, Appendix M, CCTV timeline and log, 253

36. At 7.44pm, Ms Gaisbauer contacted emergency services with Ambulance Victoria Paramedics arriving at approximately 7.55pm.[29] Paramedics attempted to revive Mr O'Donnell, but by 9.00pm he was pronounced dead.[30]

37. On 23 June 2016, Mr Lamblin was found hiding in a vacant house in Doncaster and was arrested. Mr Lamblin later disclosed that he had been affected by the use of methamphetamine (ice) during and after the incident that led to Mr O'Donnell's death.[31]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

38. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by a family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

39. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr O'Donnell and Mr Lamblin was one that fell within the definition of '*family member*'[32] under that Act. Moreover the actions of Mr Lamblin stabbing Mr O'Donnell and causing his death constitutes 'family violence'.[33]

40. In light of Mr O'Donnell's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[34] examine the circumstances of Mr O'Donnell's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[35]

41. The CPU identified the presence of a number of risk factors for family violence in relation to Mr Lamblin. In particular, Mr Lamblin had made threats to harm Mr O'Donnell to a number of his associates, he was a regular user of illicit substances including methyl amphetamine

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[29] Coronial Brief, Statement of Gillian Upjohn dated 23 June 2016, 106
[30] Coronial Brief, Statement of Gregory Arthur Nicholls dated 10 July 2016, 109
[31] Above n 3, 9
[32] *Family Violence Protection Act 2008,* section 8.
[33] *Family Violence Protection Act 2008*, section 5(1)(a)(i)
[34] 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
[35] 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

(ice), he was unemployed and he suffered from mental health issues including Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder.[36]

42. This case demonstrates the complex circumstances in which family violence homicides can occur in the broader context of familial relationships. I note that research into the forms of family violence that occur outside of intimate heterosexual relationships is underdeveloped and thus an understanding of the unique cases, dynamics and consequences of these experiences of family violence is less known.[37]

43. Despite the presence of a number of known risk factors for family violence, the CPU identified limited opportunities for the legal system, health system of family violence service providers to intervene to reduce the risk of family violence between Mr O'Donnell and Mr Lamblin due to the lack of service contact both parties had leading up to the death of Mr O'Donnell.

44. On 1 March 2017, in the Supreme Court of Victoria, Mr Lamblin pleaded guilty to manslaughter in relation to Mr O'Donnell's death. On 31 May 2017, he was sentenced to ten years' imprisonment with a non-parole period of seven years.[38]

45. I am satisfied that the available evidence does not identify any obvious missed opportunities that could have prevented Mr O'Donnell's death.

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

FINDINGS AND CONCLUSION

47. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Paul Francis O'Donnell, born 31 August 1967;

    (b) the death occurred on 18 June 2016 at 3/7 Olive Grove, Keysborough, Victoria, from a stab wound to the hip; and

    (c) the death occurred in the circumstances described above.

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[36] Above n 3, 9
[37] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 5, 1.
[38] *The Queen v Karl Lamblin* [2017] VSC 306, 6.

48. I convey my sincerest sympathy to Mr O'Donnell's family.

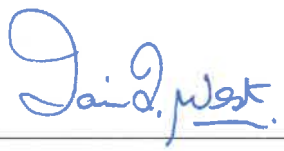
49. Pursuant to section 73(1A) of the Act, I direct that a copy of this finding be published on the Coroners Court website.

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

    (a) Mr John O'Donnell, senior next of kin; and

    (b) Detective Acting Sergeant Christopher Dane Saulle, Victoria Police, Coroner's Investigator.

Signature:



IAIN WEST

ACTING STATE CORONER

Date: 7 November 2018