IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2477

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Ashley Wayne Phillips
Date of birth:	27 November 1972
Date of death:	26 May 2017
Cause of death:	1(a) Strangulation
Place of death:	2-3 Walton Avenue, Preston, Victoria
Catchwords:	homicide, community corrections order mismanaged

INTRODUCTION

1. On 27 May 2017, Mr Ashley Phillips was found deceased in a wheelie bin on the nature strip of a residence on Butler Street, Preston. At the time of his death, Mr Phillips was 44 years old.

2. Mr Phillips was born at the Sacred Heart Hospital in Coburg and grew up in the Broadmeadows region of Victoria. He completed his secondary studies at Essendon Technical School and was initially employed at Jarrod Springs making vehicle suspension springs. Mr Phillips worked in various roles over the years and prior to the fatal incident, he was employed with MAS imports who specialise in aquarium products.

3. Mr Phillips' father was diagnosed with Parkinson's disease early on in his life and passed away in 2009. This had a significant impact on Mr Phillips as his family was very close. Mr Phillips had a significant long term relationship in the past but this ended after six years and he moved in with his parents until the fatal incident.

4. Mr Phillips met Ms Natasha Hogan through Facebook around September 2015 and after a few months formed an intimate personal relationship. Ms Hogan was in a long term relationship with her partner, Jason Considine, who was incarcerated whilst Mr Phillips and Ms Hogan were intimate until April 2016 when they maintained a friendship.

5. In August 2016, Mr Considine was released from prison and Ms Hogan informed him that she had been unfaithful whilst he was in prison but did not disclose her relationship with Mr Phillips.

6. In March 2017, Ms Hogan reconnected with Mr Phillips over social media. Mr Considine was suspicious about Ms Hogan's social media activity and suggested that the couple involve another man. Ms Hogan suggested Mr Phillips and a few weeks prior to 25 May 2017, Ms Hogan started making plans for the three parties to engage in intimate relations together.

THE CORONIAL INVESTIGATION

7. Mr Phillip'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.

8. 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.

9. 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.

10. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Phillip'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.

11. This finding draws on the totality of the coronial investigation into the death of Mr Phillip, including evidence contained in the coronial brief and further evidence obtained under my direction. 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. [1]

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

Circumstances in which the death occurred

12. On the evening of the 25 May 2017, Ms Hogan arranged with Mr Phillips to come over to her unit in Walton Avenue, Preston to engage in intimate activity with herself and Mr Considine.

13. Mr Phillips arrived at approximately 10.24 pm and the three parties engaged in censual sexual relations. In the early hours of 26 May 2017, Mr Considine became jealous of the sexual activity occurring between Ms Hogan and Mr Phillips and attacked Mr Phillips in the lounge room causing a laceration to his head. Mr Considine then strangled Mr Phillips on the lounge room floor until he stopped breathing.

[1] 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.

14. Mr Considine then retrieved a recycling bin from another flat on Walton Avenue and Ms Hogan assisted him place Mr Phillips body into the bin headfirst. Mr Considine threw some clothes on top and wheeled the bin a few streets away, leaving it in Butler Street, Preston. In the meantime, Ms Hogan was cleaning Mr Phillip's blood on the floor.

15. At approximately 8.00am on 26 May 2017, a nearby resident observed the recycling bin on his nature strip and contacted the Darebin Council to arrange collection. On the morning of 27 May 2017, a waste disposal truck driver discovered Mr Phillips body as it was tipped into the truck and contacted police who attended the scene.

16. The police commenced an investigation which led them to the unit which the recycling bin was taken from and discovering Mr Phillips car nearby.

17. On 30 May 2017, police executed a search warrant at Mr Considine's unit and discovered blood on the lounge room carpet, DNA analysis of blood samples taken provided strong support for the proposition that the blood originated from Mr Phillips. Ms Hogan and Mr Considine were both arrested.

18. On 31 May 2019, in the Supreme Court of Victoria, Mr Considine was found guilty of the murder of Mr Phillip and Ms Hogan was found guilty of assisting Mr Considine. Mr Considine was sentenced to 21 years imprisonment with a non-parole period of 16 years. Ms Hogan was sentenced to one year and ten months imprisonment.[2]

Identity of the deceased

19. On 29 May 2017, Mr Ian Bray visually identified the body of the deceased to be his cousin, Ashley Wayne Phillips born 27 November 1972.

20. Identity is not in dispute and requires no further investigation.

Medical cause of death

21. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 27 May 2017 and provided a written report of his findings dated 17 October 2017.

22. Dr Bedford noted the following:

[2] *R v Considine and anor* [2019] VSC 386, 25

(a) the autopsy revealed injuries to the head with a laceration to the top of the head and minor lacerations to the left ear with bruising to the scalp and small foci of bruising to the brain;

(b) the anterior neck region has evidence of a broad band of abrasion change which is associated with some underlying haemorrhage into the muscles on the right side of the neck but without a laryngeal fracture;

(c) there two potential possibilities regarding the mechanism of death. Firstly, that is possible that the deceased was manually strangled as there are changes to the neck in keeping with pressure being applied and haemorrhage in the muscles to the right side of the neck. The deceased thus could have been deceased before being placed in the recycling bin; and

(d) Secondly, it is possible that the deceased was unconscious but still alive when placed in the recycling bin and the placement by inversion of the head and position of the body caused restriction to breathing and resulted in death;

23. Toxicological analysis of post-mortem samples identified the presence of methylamphetamines, alcohol, sildenafil (Viagra) and cannabis. None of these detected substances were at levels that suggest a connection to the mechanism of death in this case.

24. Dr Bedford confirmed that there was no significant natural disease present.

25. Dr Bedford provided an opinion that the medical cause of death was '1(a) Unascertained'.

26. In light of the evidence from the criminal trial of Ms Hogan and Mr Considine, the available evidence in the coronial brief and the medical evidence, I am of the opinion that Mr Phillips' cause of death was due to '1(a) Strangulation'.

FURTHER INVESTIGATIONS

Corrections and the management of Community Correction Orders

27. A community correction order (**CCO**) is a criminal sentence imposed by a court that allows offenders to complete their sentences in a community setting. Offenders on CCOs may have to comply with specific conditions imposed by the courts, such as mandatory drug or alcohol treatment, mental health treatment, and significant restrictions such as curfews and judicial monitoring.

28. At the time of the fatal incident, Mr Considine was the subject of a CCO and had a case manager from Corrections Victoria.

29. On 5 October 2015, Mr Considine was found guilty and convicted of multiple theft offences and burglary. Mr Considine was sentenced to four months imprisonment and upon release a 24-month CCO with conditions requiring him to participate in 120 hours of community work, be assessed and treated for drug abuse and dependency, participate in mental health assessment, and offending behaviour programs.[3]

30. Corrections Victoria is responsible for the management of offenders who are made subject to CCOs and usually a case manager from a regional Community Correctional Service (**CCS**) is assigned to each offender in their local catchment. The management of Mr Considine's CCO in the circumstances of this case raised significant concerns, including:

    (a) the appropriate identification of risk and risk profile assigned to Mr Considine and whether he should have been recommended for a CCO by a Corrections assessment officer;

    (b) the case management of Mr Considine's compliance with his CCO conditions; and

    (c) the timeliness of responses to Mr Considine's failure to comply with his CCO conditions.

Appropriateness of being assessed 'suitable' to complete a CCO

31. On 5 October 2015 when Mr Considine was found guilty and convicted of multiple offences, he was requested by the Court to be assessed by a Court Assessment and Prosecution (CAPS) officer from the local Community Correctional Service as to whether they recommend that Mr Considine is suitable for a CCO. The CAPS officer will provide the Magistrate with a report to assist them with deciding whether it is appropriate to sentence an offender with a CCO.

32. The CAPS officer will provide the Magistrate with a brief pre-sentence report or an extended pre-sentence report. The brief pre-sentence report normally consists of interviewing the offender to confirm their understanding of a CCO, providing the offender with information about the role of CCS and CCO order requirements, completing a risk assessment, considering the conditions requested by the court and whether they adequately address the offender's risk/need profile, and determining the CCS reporting location based on the residence of the offender.

33. An extended pre-sentence report considers the same issues in greater detail, may require more than one session with the offender, and results in a detailed written report to the court. CAPS

[3] Corrections management file – Jason Considine, 183-185

officers can request an adjournment from the court for the completion of an extended pre-sentence assessment to be undertaken. This would typically occur for complex cases or where the information CCS requires to undertake the assessment is not readily available when the assessment is requested.

34. I note that when this assessment was completed for Mr Considine, he was deemed suitable to complete a CCO despite his substantial criminal history and failure to comply with multiple previous community based orders (two prior orders) and parole orders (two prior parole orders). Given his assessment as at high risk (which was corrected in November 2015) of re-offending and his former compliance background with other court orders, it would appear a concern that a more thorough pre-sentence report was not conducted in the circumstances of this case.

35. Consequently, Mr Considine was only subject to a brief pre-sentence assessment which contained limited information about his offending history and compliance with previous CCS orders. I note that the available evidence suggests that the original assessing officer could have requested an adjournment given the significance of Mr Considine's offending history and compliance with previous CCS orders to provide the judicial officer with a more comprehensive Extended Pre-sentence Assessment, this in turn may have influenced the judicial officer to consider whether a CCO was appropriate or a longer term of imprisonment or additional conditions like judicial monitoring or stricter residential conditions. Whilst this may not have prevented Mr Phillips death, this affected the risk to the community generally given the lack of in-depth risk assessment.

36. An internal case practice review conducted by Corrections indicated that at the time of assessing his suitability for a CCO, Mr Considine was incorrectly assessed as moderate risk on the second page of the presentence report, even though the first page indicates high risk of offending according to VISAT entries. This assessment on file wasn't corrected until 11 November 2015 where his assessment was High Risk of general re-offending. Corrections concedes this oversight and acknowledges that the correction wasn't made until 11 Nov 2015.

37. The internal case practice review also noted that a full risk assessment was not performed within the first six weeks of commencing a CCO as Corrections policy dictated. This also affected the assignment of supervision frequency with his case manager, he was incorrectly assigned fortnightly to three weekly when as a High-Risk priority one offender, he should have had more regular supervision. Corrections concedes that as a High-Risk priority one offender, he should have been subject to more frequent supervision.

Failure to properly case manage Mr Considine

38. I confirm that despite drug use being identified as one of Mr Considine's top three criminogenic needs in his risk assessment for re-offending, he was not properly assessed to commence a treatment program until 28 December 2016 (8 weeks after his initial assessment). Mr Considine's address was updated and this was not properly provided to his drug counsellor and accordingly Mr Considine never adequately engaged with his drug counsellor and this was never properly monitored by his CCO case manager.

39. Corrections concedes that Mr Considine failed to attend three appointments before being exited from the program. Although the case manager did not provide Mr Considine's updated address to the drug counsellor, it is confirmed that Mr Considine's first appointment on 28 December 2016 was sent to his correct address and his case manager orally directed him to attend STAR on 26 January 2017. Mr Considine failed to attend both appointments. His case manager had maintained regular contact with the STAR counsellor. With respect to non-compliance requirements, once a case manager is aware that an offender is unable to complete a drug treatment program as part of a condition of a CCO, this constitutes a breach and contravention action should be considered as the offender's CCO conditions will remain outstanding at the order's expiry.[4]

40. Mr Considine never completed any urinary drug testing throughout his CCO management and none of his non-compliance in this regard was appropriately monitored or raised during the few supervision sessions that he attended with his case manager.

41. Mr Considine failed to attend 11 supervision appointments with his case manager and ceased attending appointments in person from 6 January 2017 (last in person appointment that he attended). He then subsequently spoke to his case manager on the phone four times advising that he would not be able to attend in person supervision appointments.

42. Prior to the fatal incident, Mr Considine was in police attendance three times for re-offending and committing further indictable offences whilst on a CCO. This occurred on 20 January 2017, 7 March 2017 and 16 April 2017. During a case manager call to Mr Considine on 27 March 2017, Mr Considine expressed anxiety about attending the service due to his non-compliance and outstanding warrants for re-offending.

[4] Deputy Commissioner's Instructions – 10.4.3 – Understanding and addressing non-compliance (Version 1, January 2017), 12

43. It was clear from Corrections case notes that Mr Considine was arrested by Police at his home and his address and whereabouts were known to his CCO case manager. Mr Considine's case manager was also in contact with child protection case managers who were involved with Mr Considine and Ms Hogan in the proximate period prior to the fatal incident. The children were living with Mr Considine's parents and subject to a Care by Secretary Order.

44. Had earlier contravention action taken place and a robust system of information sharing between Victoria Police and Corrections, Mr Considine may have been brought before the Courts and re-sentenced with a term of imprisonment likely or at the very least more restrictive conditions varied on this CCO. This was a missed opportunity to intervene in the death of Mr Phillips. Corrections acknowledge that the level of monitoring afforded to Mr Considine did not satisfy CCS policy requirements.

Failure to take contravention action in the appropriate timeframe

45. The policies and procedures that were operational at the time of Mr Considine's CCO required an intervention step to be considered when three unacceptable non-compliance events have accrued. This requirement was met as early as 12 October 2016 yet contravention action against Mr Considine as not authorised until 20 May 2017 (8 months later) after the fatal incident.

46. CV confirms that case managers in 2016-2017 were guided by Deputy Commissioner's Instruction 10.3 – Non-Compliance Management – Court Orders and then from 1 January 2017, the Deputy Commissioner's Instruction 10.4.2 – Understanding and addressing Non-Compliance. A review of the relevant Deputy Commissioner's Instruction indicates that during 2016:

    (a) The key requirements for case managers are that *"investigation of all non-compliance is to commence within five working days of notification and resolved within three weeks of the instance of non-compliance"*.[5]

    (b) For Priority 1 offenders (Mr Considine was categorised as a Priority 1 High Risk Offender), "*there is a significant risk to the community through the offender's non-compliance and all non-compliance incidents for this category of offender are to be followed up on the same day as the scheduled appointment or indiscretion is reported"*.[6]

[5] *Deputy Commissioner's Instruction 10.3 – Non-Compliance Management – Court Orders*, Issue May 2016, page 1.
[6] Ibid.

(c) Activating an intervention step should have been considered when: two or more consecutive absences from the same program area have occurred **or where a Priority 1 offender has accrued three or more unacceptable absences**.[7]

47. In the period of 1 January 2017 until 25 May 2017, the relevant Deputy Commissioner's Instruction[8] outlined that:

(a) It is a mandatory requirement to respond to serious non-compliance within 24 hours or one business day (once known) and all other non-compliance must be responded to within 72 hours or three business days.

(b) Serious non-compliance includes re-offending during the CCO and non-compliance with a treatment condition.

(c) Although the new instruction since 1 January 2017 requires contravention action to be considered a last resort, it should be considered when efforts to engage the offender have been exhausted, risk to the community it too high and further offending has occurred.

48. The failure to take earlier action through proactive monitoring of Mr Considine's CCO compliance was a significant missed opportunity to intervene in the circumstances leading to Mr Phillips' death. Whilst Mr Phillips' death may not have been prevented had earlier contravention action been authorised, it was a missed opportunity to hold Mr Considine accountable for his actions and undergo any court-ordered rehabilitation, while he make amends for his offending behaviour.

COMMENTS

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

Corrections Victoria

[7] Ibid, page 4
[8] Deputy Commissioner's Instruction 10.4.2 – Understanding and addressing Non-Compliance

49. Corrections Victoria has a significant role in ensuring that offenders who are subject to CCOs have the opportunity to maintain and improve their social and economic support networks in a community setting, are accountable for their actions and undergo any court-ordered rehabilitation, while they make amends for their offences. By providing case management services to offenders subject to CCOs, there is a responsibility to ensure that risks to the community and safety of the offender's family members/intimate partner are minimised.

50. This case and other similar family violence homicide related deaths[9] in this period highlight systemic issues in the way CCO offenders are case managed including but not limited to: poor risk identification and management, inadequate drug testing and compliance, failures to attend supervision and seek treatment and inadequately prepared judicial monitoring reports.

51. Corrections Victoria has informed the Court that in 2017 as a part of statewide changes, the organisation has introduced the Professional Practice Stream (PPS). This framework separates practitioners into three streams depending on their core role and provides more in-depth supervision and training according to their work stream. The PPS reportedly aims to '*improve the application of evidence-based approaches by CCS practitioners and shift the focus from compliance to offender management, and to increase the quality and integrity of offender case management*'[10]. Corrections Victoria also advised that offender compliance could now be reviewed by '*newly created practices'* such as the establishment of Risk and Review Panels and Compliance Review Hearings.

52. An Enhanced Supervision Framework has also been introduced which has been designed to '*reinforce accountability, support professional development and assist CCS staff to achieve best practice*'.[11] Supervision is now required to occur fortnightly with the understanding that case managers will discuss their management of offenders on their caseloads.

53. The Victorian Auditor-General's Office prepared a report in February 2017 on the management of CCOs and they noted in their report that, "*there is a shortage of adequately trained staff to meet the increase in offenders on CCOs, business processes are inefficient, and the fragmented information management environment impedes timely decision-making and effective coordination*."[12]

[9] COR 2016/2831, COR 2016/2914, COR 2016/6105 and COR 2015/4974
[10] Corrections Victoria, Response to the Court dated 31 July 2020, 4
[11] Ibid
[12] Victorian Auditor-General Office, *Managing Community Correction Orders*, report dated February 2017, available online at: www.audit.vic.gov.au/sites/default/files/20170208-Community-Corrections.pdf

54. I note that the evidence from Corrections Victoria provided in the inquest into Kylie Cay's death[13] indicated that the organisation was heavily reliant on paper files and that an overhaul of the current paper-based system with appropriate prompts for compliance, would greatly improve the efficient case management of CCO offenders to ensure that non-compliance does not get out of control and continue for long period of time unchecked.

RECOMMENDATIONS

55. Pursuant to section 72(2) of the Act, I make the following recommendations to:

Corrections Victoria:

I endorse the recommendation of Deputy State Coroner English in her findings into the death of Kylie Cay[14] and recommend that Corrections Victoria introduce an electronic case management system to enhance Community Correctional Services management of an offender's compliance with their Community Corrections Order. The system needs to address issues identified in this case such as the lack of awareness of non-compliance, lack of supervision and the supervisors' awareness of non-compliance, and the ability to address non-compliance early. The system should allow case managers the ability to create a schedule outlining how each condition will be completed and contain key milestones that must be reached. This will ensure that starting at induction, case managers and offenders will have a clear case plan to complete and comply with conditions. The system should also allow supervisors the ability to oversee the management of serious offenders with an automated overview of their compliance which allows early interventions to occur when non-compliances are logged.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was Ashley Wayne Phillips, born 27 November 1972;

(b) the death occurred on 26 May 2017 at 2-3 Walton Avenue, Preston, Victoria from 1(a) Strangulation; and

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

[13] COR 2016/2831, 46
[14] COR 2016/2831

57. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.

58. I convey my sincere condolences to Mr Phillip's family for their loss.

59. 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.

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

Mrs Marlene Phillips, Senior Next of Kin

The Honourable Natalie Hutchins, Minister for Corrections

Ms Rebecca Falkingham, Secretary, Department of Justice and Community Safety

Detective Leading Senior Constable Simon Florence, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 3 August 2021

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 investigation. 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.