IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 004138

DECISION BY CORONER WHETHER AN INQUEST WILL BE HELD INTO DEATH

Form 28 Rule 53(1)

*Section 52(6) of the **Coroners Act 2008***

Decision of:	Coroner Ingrid Giles
Deceased:	Richard Paul Devlin
Date of birth:	28 December 1965
Date of death:	5 August 2021
Applicant:	Alison Greenwood
Date of Application:	18 October 2023
Date of Decision:	9 August 2024
Representation:	Mr Danny Barlow, Dawes & Vary Riordan Solicitors for Ms Greenwood Mr Morgan McLay of Counsel, instructed by Minter Ellison, for Moira Shire Council Ms Kirsten Hughes, Lead Lawyer Public Law, for WorkSafe Victoria

INTRODUCTION

1. Richard Paul Devlin (**Mr Devlin**) died on 5 August 2021, after being shot outside his home in Numurkah by Andrew Robert Paterson (**Mr Paterson**), with whom he had worked at the Moira Shire Council.

2. On 6 August 2021, Mr Paterson was charged with the murder of Mr Devlin. He pleaded guilty and was sentenced on 2 December 2022 in the Supreme Court of Victoria by her Honour Justice Jane Dixon to 26 years imprisonment with a non-parole period of 21 years.[1] The motive for the murder related to a workplace grievance arising out of Mr Paterson's employment with Moira Shire Council.[2]

3. On 18 October 2023, Mr Devlin's wife and senior next of kin,[3] Alison Greenwood (**Ms Greenwood**), requested that I hold an inquest into the death, pursuant to s 52(5) of the *Coroners Act 2008* (**Coroners Act**). I have determined **not** to hold an inquest into the death of Mr Devlin for the reasons that follow.

REQUEST FOR INQUEST

4. On 18 October 2023, Ms Greenwood filed a Form 26 'Request for inquest into death' (**Request for Inquest**) together with correspondence setting out the reasons why an inquest was sought. In summary, it was submitted that an inquest was justified as:

   (a) the full circumstances leading to the murder are not clear and significant aspects of the background circumstances were not considered in the criminal proceedings.

   (b) the question of whether Mr Devlin's death was preventable is an open question, and a matter of significant public interest in the context of a local government workplace.

   (c) it is possible that an inquest may uncover systemic defects or risks not currently known which may prevent similar deaths and thereby reduce the risks of those occurring.

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[1] *DPP v Andrew Robert Paterson* [2022] VSC 746 (Dixon J) (**Sentencing Remarks**).
[2] Sentencing Remarks, [10].
[3] The 'senior next of kin' is defined under the s 3(1) of the Coroners Act. The Coroners Act sets out a 'cascading hierarchy' or 'order of priority' for who will be considered the senior next of kin of the deceased. The senior next of kin is the main point of contact throughout a coroner's investigation and has particular rights in relation to the coronial investigation.

5. At the time of submitting the Request for Inquest, Ms Greenwood had not had the benefit of reviewing the coronial brief of evidence.

6. On 15 January 2024, I determined not to decide whether or not an inquest should be held in order to provide Ms Greenwood and any interested party with the opportunity to provide further submissions on the Request for Inquest following review of the coronial brief.

7. On 29 February 2024, the coronial brief[4] was released to Ms Greenwood and other interested parties, including Moira Shire Council, WorkSafe Victoria (**WorkSafe**), and other members of Mr Devlin's family. The coronial brief comprised the brief of evidence for the criminal prosecution of Mr Paterson and additional material gathered by the Court relevant to the investigation of the death.

8. I invited written submissions from any interested party, at their discretion, on the Request for Inquest. Submissions were expected to address relevant provisions in the Coroners Act, including its objectives and sections 52(3)(b) and 71, as well as the proposed scope of any inquest.

9. I received written submissions from Ms Greenwood, Moira Shire Council and WorkSafe which were duly exchanged with the interested parties. No other party sought to be heard on the Request for Inquest. I also provided the parties with the opportunity to file written submissions in reply. Ms Greenwood was the only interested party who wished to avail herself of this opportunity, and submissions in reply were filed with the Court on her behalf on 10 May 2024, and provided to the interested parties.

THE LEGISLATIVE FRAMEWORK

Jurisdiction

10. Mr Devlin's death constituted a *'reportable death'* pursuant to s 4 of the Coroners Act as his death occurred in Victoria and was unexpected, unnatural and violent.

[4] Coronial Brief, Version 2 dated 16 February 2024 (redacted) (**CB**).

Purpose of the coronial jurisdiction

11. The purpose of a coronial investigation is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and, with some exceptions, the circumstances in which the death occurred.[5]

12. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

13. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to circumstances that are sufficiently proximate and causally related to the death.[6] This means there should be a proper and sufficient connection between the investigation and the death. While the investigation is not confined only to matters of strict causation, it does not necessarily extend to include all circumstances which might be part of the narrative culminating in death. As noted in *R v Doogan; Ex parte Lucas-Smith & Ors*,[7] the Coroner's power of inquiry "*does not extend to the resolution of collateral issues relating to compensation or the attribution of blame"*.[8]

14. The broader purpose of coronial investigations is to contribute to a reduction of the number of preventable deaths, both through the observations made in findings and by the making of comments and recommendations by Coroners. This is generally referred to as the prevention role. However, a Coroner is not permitted to inquire for the sole or dominant reason of making a recommendation. The power to comment arises as a consequence of the obligation of the Coroner to make findings (if possible) as to the identity of the deceased, the cause of death and the circumstances in which the death occurred.[9]

15. It is important to stress that the purpose of a coronial investigation is to establish the facts. It is not the role of the coroner to lay or apportion blame or determine any criminal or civil liability arising

[5] Coroners Act, s 67.
[6] *Harmsworth v State Coroner* [1989] VR 989 at 996.
[7] (2005) 193 FLR 239.
[8] Ibid, [29].
[9] *Thales Australia Ltd v Coroners Court of Victoria* [2011] VSC 133, [67].

from a reportable death.[10] Coroners are specifically prohibited from making a finding or comment or any statement that a person is, or may be, guilty of an offence.[11]

Coronial inquest

16. Section 52(5) of the Coroners Act provides that a person may request a coroner hold an inquest into any death that the coroner is investigating.

17. An 'inquest' is defined in section 3(1) of the Coroners Act as *"a public inquiry that is held by the Coroners Court in respect of a death or fire"*. It is part of an investigative process which is concerned with setting the public mind at rest where there are unanswered questions about a reportable death.[12]

18. The Coroners Act provides that an inquest must be held in certain circumstances. This includes where the Coroner suspects the death was the result of homicide.[13] However, it is not necessary for an inquest to be held if a person has been charged with an indictable offence in respect of the death.[14]

19. In this matter, a person – Mr Paterson – has been charged with an indictable offence – murder – in respect of the death. Accordingly, it is not mandatory for an inquest to be held into Mr Devlin's death. However, I retain the discretion to hold an inquest if I consider it appropriate to do so.[15]

20. In exercising the discretion to hold an inquest, it is necessary to consider "*the relative costs of holding one and doing without one, duly weighing the benefits (if any) which the inquest might produce against the disadvantages (if any) which investigation (or further investigation) short of an inquest might entail*".[16]

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[10] *Keown v Khan* (1999) 1 VR 69.
[11] Coroners Act, s 69(1).
[12] *Domaszewicz v State Coroner* [2004] VSC 528; 11 VR 237, [28], per Ashley J.
[13] Coroners Act, s 52(2)(a).
[14] Coroners Act s 52(3)(b).
[15] Coroners Act, s 52(1).
[16] *Clancy v West* [1996] 2 VR 647, 655-6 (per Tadgell JA).

21. Factors that may be considered in deciding whether to conduct an inquest include:

(a) whether there is such uncertainty or conflict in the evidence as to justify the use of the judicial forensic process;

(b) whether there is a likelihood that an inquest will uncover important systemic defects or risks not already known about;

(c) whether an inquest is likely to assist in maintaining public confidence in the administration of justice or other public agencies;

(d) whether the family or another person has requested the inquest; and/or

(e) to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths.

22. As noted by Justice Keogh of the Supreme Court of Victoria in *Childs v Coroners Court of Victoria:*[17]

> *Matters relied on in support of the request for an inquest must be scrutinized to ensure they amount to more than speculation or suspicion. The interests of justice may require consideration of the desirability of the finality in investigations, the nature and extent to which an issue of public health and safety is engaged, and the interests of the next of kin in being heard in relation to and understanding the findings of a coroner.*

23. In exercising the discretion to hold an inquest, I must also have regard to the scope, purpose and objectives of the Coroners Act, including that:

(a) the purposes of a coronial investigation are to find the causes of death, contribute to the reduction of the number of preventable deaths, and to promote public health and safety and the administration of justice.[18]

[17] [2020] VSC 755, at [65].
[18] Coroners Act, Preamble, s 1(c).

(b) it is the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies, or statutory officers to avoid unnecessary duplication of inquiries and investigations, and to expedite the investigation of deaths and fires.[19]

(c) the death of a family member, friend or community member is distressing, and distressed persons may require referral for professional support or other support. Unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[20]

(d) the coronial system should operate in a fair and efficient manner.[21]

FACTUAL BACKGROUND

24. Before outlining the submissions made by the parties on the Request for Inquest, it is necessary for me to set out certain matters relating to the circumstances of Mr Devlin's death and the investigations which followed, which are relevant to and bear on my determination.

Personal Background

25. Mr Devlin lived in Nurmukah with his wife, Ms Greenwood. He had seven adult children from his first marriage, and three grandchildren. Mr Devlin's family spoke of him as being 'larger than life', funny, smart, passionate, driven and a dedicated father and grandfather.

26. After leaving school, Mr Devlin had joined the Australian Army, where he had risen to the rank of Corporal in the armoured regiment. In the late 1980s, he left the army to focus on raising his family, and secured employment with the Shepparton Shire Council and later with the Moira Shire Council where he worked for more than 15 years. He was promoted within local government over the years, advancing into senior management roles. Many of Mr Devlin's work colleagues reflected on his leadership qualities, strength of character, empathy, and kindness.

27. At the time of his death, Mr Devlin was the Operations Executive Manager at Moira Shire Council. In this role, he managed the portfolios of roads, parks and gardens across the shire and was

[19] Coroners Act, s 7.
[20] Coroners Act, s 8(a), (b).
[21] Coroners Act, s 9.

responsible for about 80 staff across five locations. This included Mr Paterson, a multi-plant operator at the Nathalia depot who had commenced employment with Moira Shire Council in August 2015. While Mr Paterson was one of the staff Mr Devlin was responsible for, he did not directly report to Mr Devlin.

28. Mr Paterson's history is set out in detail in the sentencing remarks of her Honour Justice Jane Dixon. I will not recount his history in full, save that it is relevant to note Mr Paterson ceased work at the Nathalia depot in December 2019 following a workplace incident and did not return.

29. In January 2020, Mr Paterson submitted a WorkCover claim for weekly payments and medical expenses for a psychological injury sustained in the course of his employment which was denied by the WorkCover insurer, Xchanging. A second claim submitted in May 2020 was ultimately accepted following a review by the Workers Compensation Independent Review Service (**WCIRS**) in September 2020. Mr Paterson was subsequently paid weekly payments and medical and like expenses in accordance with the worker's compensation scheme in Victoria, backdated to January 2020.

30. At the time of Mr Devlin's murder, Mr Paterson remained off work, in receipt of weekly payments, and was certified unfit for work by his general practitioner until 20 August 2021.

Circumstances of death

31. On 5 August 2021, Mr Devlin died outside his home in Numurkah from a gunshot wound to the head. The lethal gunshot was fired by Mr Paterson using an unregistered gun, which he was not licensed to possess, in circumstances described by the prosecution as equating to an execution, with *"no warning, no confrontation, or interaction with the deceased"*.[22]

32. The factual circumstances surrounding Mr Devlin's death are set out in detail in the sentencing remarks of her Honour Justice Jane Dixon. I have replicated her Honour's findings in respect of those matters for context:[23]

[22] Statement of Material Facts, CB, pp 42-3.
[23] Sentencing Remarks, [7]-[10], [12]-[23].

Factual background to the offence

…

7. At 8.30pm on 5 August 2021 you drove to Rick Devlin's home where he lived with his wife, Alison. Rick thought that the approaching car in the driveway of his remote rural property must have belonged to a relative and went outside the (sic) greet the visitor. Instead he was confronted by you standing near your car holding a .38 calibre revolver. You fired two shots at Rick Devlin, one of which penetrated his skull and caused his death, while the other shot contacted his chest but did not penetrate below the skin.

8. As soon as you had fired the shots, Alison ran outside to her husband only to find him lying on the ground unresponsive. She phoned 000 at 8.48pm and performed CPR for 28 minutes, all the while fearing that the shooter would return and shoot her.

9. Rick Devlin was found to be deceased by emergency services when they attended at 9.16pm. It was clear that he had died from the gunshot wound to his head. Dr Noel Woodford, a forensic pathologist, confirmed that this was the cause of death when he conducted an autopsy at a later date.

10. Your motive for murdering Rick Devlin was related to a workplace grievance arising out of your employment with Moira Shire Council. Rick Devlin was Chief Executive Operations Manager at the Council. …

12. … When you were working at the Nathalia depot of the Moira Shire, you became involved in a number of workplace disputes with your peers. Tensions escalated between yourself and your peers, leading to you being stood down due to an allegation of theft in November 2019. It would appear that the theft allegation was unfounded, but you never returned to work after November 2019.

13. As a result of ongoing tensions in the workplace, you made allegations of bullying and harassment and demanded that the Council resolve your complaint. At first, the matter was dealt with internally by the Council, but a consultant was later engaged on behalf of Work Safe Victoria. The Australian Services Union provided support to you throughout the dispute. On 15 January 2020, you submitted a claim form for stress-related injuries, citing workplace threats. You remained off work on Work Cover leave, and over the 18 months prior to the murder you became increasingly pre-occupied by your workplace grievance.

14. Your WorkCover claim was rejected on 18 February 2020, leading to a reconsideration. On 12 August 2020, your claim was granted and you received payments in arrears and remained on paid leave.

15. On the one hand, it seems that you were mistreated in the workplace. Your co-workers manufactured allegations against you, hoping to have you relocated or dismissed. On the other hand, you also broke various codes of conduct and at times you were aggressive to your co-workers.

16. By May 2021, your doctor approved your return to work on the proviso that certain conditions were met regarding your work circumstances. In July of that year, a return to work plan was prepared. You were not happy about the plan, which

would have required you to return to work on 9 August 2021. After contact with your union representative, you were advised that your certificate of unfitness lasted until 20 August of that year. That meant you could still go on a camping trip you had planned to take on 9 August 2021 with your friend, 'Bob'.

17. You spent the afternoon of 5 August 2021 with Bob, preparing for the camping trip that was to take place the following Monday. Having packed the vehicles in readiness for the Monday departure, you consumed three or four beers at Bob's place at around 4.30pm that afternoon. Bob found your demeanour to be normal that day. However, at around 5.00pm, your wife rang you to advise that the new state-wide COVID-19 restrictions would stop you from being able to go on your camping trip.

18. You drove home from Bob's place and acted out in a drunken and aggressive manner towards your wife. You smashed your mobile phone against a table, threw items around the kitchen (including your dinner) and took your wife's handbag and keys. Your wife fled from the house and drove to Shepparton. After she left, you armed yourself with your .38 revolver and wrote a note for your wife in which you said 'All the best love, sorry, can you give my half to Bob. Sorry, I've had enough. Bye'.

19. It seems that the .38 revolver was given to you by a friend some 20 years earlier, but you were not licensed to possess it and it was not registered. There were other long arms at your home in Caniambo, as you held a Category A and Category B firearms licence.

Police interview

20. The actions you took after leaving the suicide note at your home were described in your police interview after the shooting. You told police that after leaving the note for your wife, you had planned to go to your block of land in Caniambo and kill yourself. Instead of doing that, you drove to Shepparton and bought some alcohol at about 7.36pm. Next, whilst continuing to drink, you drove onward to Numurkah, where you bought more alcohol at a liquor store. From there, you then drove directly to Rick Devlin's house, which was about 8.6 kilometres from the township of Numurkah.

21. You admitted to police that you shot Rick Devlin outside his home. You told police that you were standing about a car length's away from the deceased when you shot him. After the shooting, you returned home and were arrested at 10.20pm that night. Your wife had already notified the police of her concerns about you after finding your note upon her return home from Shepparton.

22. It should be noted that although you and Rick Devlin knew one another, Rick Devlin was not your direct line manager and you did not have day to day contact with him. Nevertheless, you maintained an unshakeable belief that he failed to properly manage your workplace grievance. You believed that he was responsible for orchestrating your removal from the workplace. Your animosity towards Rick Devlin was revealed in different ways during your record of interview. You said: 'If you're running the place, the buck stops with the boss, doesn't it?' This attitude was also reflected in comments you made to others in the lead-up to the shooting.

23. You told police that after the murder, you discarded the firearm in a water channel somewhere between Numurkah and your home. Extensive searches by police failed to locate the revolver. You did not express any remorse for your crime during your record of interview.

33. Her Honour's findings as set out in paragraph [32] above were not disputed by Mr Paterson and are entirely consistent with the evidence contained in the coronial brief.

34. Her Honour also turned her mind to Mr Paterson's subjective perception of his workplace grievance, describing those matters in order to *"expose the workings of your mind at the time you killed Rick Devlin"*. However, her Honour noted that *"from an objective viewpoint, your reasons for acting as you did appear unfathomable"*.[24]

Homicide Investigation and Criminal Prosecution

35. At this juncture, it is necessary for me to provide a brief overview of the system of death investigation in Victoria. The Coroners Court (**Court**) relies upon Victoria Police to assist with the investigation of deaths, recognising their expertise in conducting investigations and evidence gathering. Once a death has been reported to the Court, a member of Victoria Police is appointed the coronial investigator and will assist the coroner with the investigation of the death and undertake inquiries at the direction of the coroner.

36. In cases of suspected homicide, as occurred here, the investigation is conducted by the Victoria Police homicide squad who conduct a criminal investigation in parallel with the coronial investigation. If a person is charged with a criminal offence relating to the death, the coroner will usually suspend the coronial investigation until the criminal proceedings are finalised. This practice ensures there is no prejudice to the accused and avoids unnecessary duplication of inquiries and investigations.[25] At the conclusion of the criminal proceedings, the coronial investigator will provide the coroner with a coronial brief, which is the product of their investigations into the death. The investigating coroner may then give directions for further investigation as required.

[24] Sentencing Remarks, [11].
[25] Consistent with the requirement under s 7 of the Coroners Act that requires a coroner to liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations, and to expedite the investigation of deaths.

37. Victoria Police commenced its investigation of Mr Devlin's death upon attendance at Mr Devlin's home on the evening of 5 August 2021. Within a few hours, Mr Paterson was identified as a potential suspect for the murder, having been arrested at his home at 10.20pm that night in relation to separate alleged firearms offences. Mr Paterson was formally arrested in connection with Mr Devlin's death at 3.54am on 6 August 2021. He was interviewed by homicide detectives later that morning, after receiving legal advice. He made full admissions and was subsequently charged with the murder of Mr Devlin and remanded in custody.

38. The homicide squad detectives conducted a comprehensive and thorough investigation into the death of Mr Devlin to provide evidence to support findings as to his identity, the medical cause of death, and the circumstances of his death. The lines of inquiry pursued by detectives were set out in the prosecution brief of evidence through written statements, audiovisual material, and documentary evidence. This evidence includes:

    (a) the record of interview with Mr Paterson on 6 August 2021;

    (b) body worn camera footage taken by attending police members during their interactions with Mrs Paterson and Mr Paterson on the evening of 5 August 2021;

    (c) statements from Ms Greenwood, Mrs Paterson, Mr Paterson's friend Bob, and police officers and paramedics who attended the scene;

    (d) statements from current and former employees of Moira Shire Council including multi-plant operators and team leaders at the Nathalia Depot, the Superintendent of Works, human resources, union delegates and the Chief Executive Officer;

    (e) statement from a representative from the Australian Services Union (**ASU**) who supported Mr Paterson through his workplace grievances and WorkCover claims;

    (f) forensic investigation reports;

    (g) reports from Mr Paterson's treating medical practitioners and independent medical examiners obtained for the purpose of the criminal proceeding;

(h) Mr Paterson's WorkCover file, full employment records, medical history, firearms licence and registration records, criminal history, banking and phone records; and

(i) records pertaining to disputes, complaints, threats or claims made by Mr Paterson or other members of staff towards Mr Devlin.

39. Mr Paterson entered a plea of guilty to the charge of murder of Mr Devlin on 15 February 2022. He was subsequently convicted and sentenced by her Honour Justice Jane Dixon on 2 December 2022.

40. Following completion of the criminal proceedings, the coronial investigator filed the coronial brief with the Court and the coronial investigation re-commenced. This matter was initially with my colleague, Coroner Leveasque Peterson. I assumed carriage of the investigation in July 2023.

WorkSafe Investigation

41. In parallel with the homicide investigation, WorkSafe Victoria (**WorkSafe**) undertook its own investigation into Mr Devlin's death.

42. WorkSafe is tasked with, amongst other matters, monitoring and enforcing compliance with the *Occupational Health and Safety Act 2004* (Vic) (**OHS Act**) and relevant regulations,[26] and monitoring the operation of measures taken and arrangements put in place to ensure occupational health, safety and welfare.[27]

43. The OHS Act sets out the obligations and duties of employers to provide and maintain a safe workplace. Relevantly, under section 21 of the OHS Act, employers are required to, so far as is reasonably practicable, provide and maintain for employers of the employer a working environment that is safe and without risks to health.[28]

44. WorkSafe's role in investigating Mr Devlin's death was to determine whether there had been any breaches of the OHS Act.[29] WorkSafe was notified of Mr Devlin's death on 10 August 2021, via the WorkSafe Advisory Centre.[30] Subsequently, on 12 August 2021, WorkSafe Inspectors attended the

[26] *Occupational Health and Safety Act 2004* (Vic) (**OHS Act**), s 7(c).
[27] OHS Act, s 7(l).
[28] OHS Act, s 21(1).
[29] Submissions of WorkSafe Victoria dated 18 April 2024, [41].
[30] Documents – WorkSafe Attendances_Clean, Case: 01715581, pp 20-26.

Moira Shire Council office and issued a notice requiring the Council to produce relevant documents pertaining to:

(a) complaints, grievances, issues or concerns raised by, or in relation to, Mr Paterson;

(b) enquiries made or actions taken by Moira Shire Council in response to such matters, including any investigation reports, safety reports, audits and other documents; and

(c) the policies, procedures and systems of work in place to prevent, respond to and investigate inappropriate workplace behaviours[31] (**Production Notice**).

45. Records were duly produced in response to the Production Notice and considered by WorkSafe.

46. In its submissions, WorkSafe referred me to relevant case law on the duty of employers to prevent harm to another from the criminal conduct of a third party. As a general rule, the law does not impose a duty to prevent harm to another from the criminal conduct of a third party over whom an employer has no control, even if the risk of such harm is foreseeable. While there may be situations in which there is a duty of care to warn or take positive steps to protect another against harm from third parties, a duty of care of that kind will usually only arise because of a special vulnerability and special knowledge, an assumption of a responsibility, or both.[32]

47. In considering whether or not Moira Shire Council could be held criminally liable for a breach of the OHS Act in relation to Mr Devlin's death, WorkSafe determined that the actions of Mr Paterson were too distant from the workplace and could not be reasonably foreseeable. While there was evidence that Mr Paterson had made verbal threats to others in the workplace, there had never been any demonstration of physical violence by Mr Paterson. Further, in circumstances where the criminal act occurred away from the workplace and out of hours, there was an insufficient connection to the workplace to hold the Council responsible for failing to provide a safe workplace.[33]

48. Accordingly, no prosecution was commenced under the OHS Act in connection to the death.[34]

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[31] Documents – WorkSafe Attendances_Clean, Inspection Report DHR-16582, p 2.
[32] Submissions of WorkSafe Victoria dated 18 April 2024, [42]-[47], referring to *Modbury Triangle Shopping Centre Pty Ltd v Anzil* [2002] HCA 61, at [29] per Gleeson CJ, and *Smith v Littlewoods Organisation* [1987] AC 241 at [272-274].
[33] Submissions of WorkSafe Victoria dated 18 April 2024, [44], [48-49].
[34] Submissions of WorkSafe Victoria dated 18 April 2024, [49].

49. WorkSafe further informed me that in February and March 2022, six months after Mr Devlin's death, it received four requests under s 131 of the OHS Act to investigate alleged bullying at Moira Shire Council.[35] These requests were investigated by WorkSafe in accordance with the OHS Act.

50. As part of those investigations, WorkSafe obtained detailed witness statements, training records and relevant organizational policies and procedures. Based on the material available to investigators at that time, it was determined that there was insufficient evidence to support any breach of the OHS Act to the required criminal standard, and no prosecution has been brought in relation to those matters.[36]

51. In addition to these investigations, WorkSafe has conducted a number of visits to Moira Shire Council in relation to occupational health and safety matters. Of relevance, WorkSafe has issued four improvement notices[37] to Moira Shire Council in relation to psychosocial harms between 30 November 2022 and 1 August 2023. These related to:

    (a) a failure to provide an adequate system of work for responding to inappropriate behaviours.

    (b) a failure to maintain a consistent system of work in relation to incident reporting and investigation.

    (c) obligations to provide training to managers and employees respectively in relation to the reviewed system of work (issued in two separate improvement notices).[38]

[35] Section 131 of the OHS Act provides that, if a person considers that the occurrence of an act, matter or thing, constitutes an offence against the OHS Act or the regulations, and no prosecution has been brought in respect of that matter within 6 months of the occurrence, the person may write to WorkSafe to request they bring a prosecution. Within 3 months of receiving a request under this provision, WorkSafe is required to investigate the matter, and following the investigation advise the person in writing whether a prosecution has been or will be brought, or give reasons why a prosecution will not be brought unless WorkSafe considers that giving such advice or reasons will prejudice the current investigation of an indictable offence.
[36] Submissions of WorkSafe Victoria dated 18 April 2024, [51]-[58].
[37] WorkSafe Inspectors may issue a person an improvement notice pursuant to s 111 of the OHS Act if they reasonably believe that a person is contravening a provision of the OHS Act or the Regulations, or has contravened such a provision in circumstances that make it likely that the contravention will be continued or be repeated. A person in receipt of the improvement notice must remedy the contravention or likely contravention by the date specified in the notice. A failure to comply with the notice is an indictable offence.
[38] Submissions of WorkSafe Victoria dated 18 April 2024, [60].

52. WorkSafe has informed me that all four improvement notices have now been complied with. In addition, WorkSafe Inspectors are currently involved in ensuring Moira Shire Council develop and implement a Psychosocial Risk Management Plan.[39]

53. Further, as a result of reviewing the coronial brief, WorkSafe became aware of certain documents included in the coronial brief, and other materials provided to the Commission of Inquiry (detailed further below), which had not been disclosed to WorkSafe Victoria either through its own inquiries or in response to its Production Notice. WorkSafe is currently considering this material to determine whether further investigation is required in respect to potential breaches of the OHS Act.[40]

Inquiries into Moira Shire Council

Municipal Monitor

54. On 22 April 2022, Margaret Allan (**Ms Allan**) was appointed to the role of Municipal Monitor for the Moira Shire Council. Ms Allan was tasked with monitoring the governance processes and functioning of the council.

55. On 7 October 2022, Ms Allan provided a confidential report to the Minister for Local Government (which is set out at Appendix A of the Commission of Inquiry's report), in which she noted:

    (a) concerns raised by staff about the Council's poor human resources practices and failure to afford staff with procedural fairness and natural justice;

    (b) the ongoing impacts of Mr Devlin's murder on the organization;

    (c) ongoing investigations by WorkSafe into the Council; and

    (d) governance issues at the Council, some of which had been referred to the Local Government Inspectorate for investigation.

56. Ms Allan recommended further intervention beyond the appointment of a Monitor was warranted to establish a culture of good governance. At around this time, the Australian Services Union (**ASU**)

[39] Submissions of WorkSafe Victoria dated 18 April 2024, [60].
[40] Submissions of WorkSafe Victoria dated 18 April 2024, [4-5].

separately wrote to the Minister for Local Government to raise concerns about workplace issues at the Council and sought intervention by the State Government to ensure the safety of the workplace.

Commission of Inquiry

57. On 17 October 2022, in response to the findings of the Municipal Monitor, the Minister for Local Government appointed a Commission of Inquiry into the Moira Shire Council (**Commission**) pursuant to section 200 of the *Local Government Act 2020* (Vic) (**LG Act**). The Commission was established to inquire into the affairs of the Council, including the Council administration's performance and human resource practices.

58. In accordance with the LG Act, a Commission of Inquiry may conduct its inquiry in any manner that it considers appropriate, subject to the instrument of appointment, the requirements of procedural fairness, and applicable legislation.[41] It may inform itself in any manner it sees fit, and is not bound by the rules of evidence, or any practices or procedures applicable to courts of record.[42] It may also give or disclose information, documents or things to any person or body if it considers that information, document or thing is relevant to the functions of that person or body and that it is appropriate to do so.[43]

59. In undertaking its inquiry, the Commission interviewed all current and some former Councillors, the current and immediate past Chief Executive Officers and some employees of the Moira Shire Council, and invited contributions from the community via private interviews, written submissions and community consultations. It also reviewed documentary evidence produced to the Commission by Moira Shire Council and witnesses, and considered submissions from persons about whom an adverse finding was proposed to be made.[44]

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[41] *Local Government Act 2020*, s 204.
[42] *Local Government Act 2020*, s 205.
[43] *Local Government Act 2020*, s 219. However, pursuant to s 216 of the LG Act, any answer, information, document or other thing given or produced to a Commission of Inquiry by a person, and the fact that an answer, information, document or other things was given or produced, is not admissible in evidence, or otherwise able to be used against the person in any other proceedings except for an offence against the LG Act or against sections 254 or 314 of the *Crimes Act 1958* in relation to the Commission of Inquiry.
[44] Commission of Inquiry Report, p 5.

60. On 26 February 2023, the Commission completed its Inquiry into Moira Shire Council Report (**Report**). The Report was tabled in the Victorian Parliament on 7 March 2023, together with the confidential advices provided by the Municipal Monitor and ASU.

61. The Commission made wide ranging findings concerning governance issues identified at the Council prior to and following Mr Devlin's murder. It found (amongst other matters) that:

    (a) the depot environment was fundamentally unsafe;[45]

    (b) there was a governance failure;[46]

    (c) the Council's administration had failed to ensure a safe and healthy environment in the depots and for the outdoors workforce;

    (d) the Council had not put in place any plan or process to bring about cultural and behavioural changes required following Mr Devlin's murder;[47] and

    (e) the Council and its administration had repeatedly failed to meet their obligations under sections 21 and 22 of the OHS Act to provide and maintain a safe place of work and to monitor that workplace.[48]

62. The Commission made nine recommendations to the Minister for Local Government. The recommendations were directed to restoring good governance, with the intention of providing a stable foundation for building effective leadership, project delivery, community engagement and a positive culture within the Council.[49] This included recommendations that:

    (a) the Council be dismissed and an interim Administrator or Administrators be appointed to ensure the restoration of good governance to the Shire in accordance with the LG Act.

[45] Commission of Inquiry Report, p 12, [8].
[46] Commission of Inquiry Report, p 12, [10].
[47] Commission of Inquiry Report, p 13, [14].
[48] Commission of Inquiry Report, p 22-23, [53]-[59].
[49] Commission of Inquiry Report, p 5.

(b) the Administrators overhaul the Council's Corporate, Governance and Performance Division, giving priority attention to the governance and human resources functions including the use of disciplinary processes.

(c) the Moira Shire Council Employee Code of Conduct and the Recruitment, Selection Policy and Procedures documents be rewritten comprehensively.[50]

63. The Minister for Local Government accepted the Commission's recommendation to dismiss the Council and appoint an interim Administrator. The Victoria Parliament subsequently passed legislation to dismiss the Moira Shire Council and appointed a panel of administrators for the purpose of ensuring the restoration of good governance at the Council.[51]

Reforms to Moira Shire Council

64. On 9 March 2023, John Tanner AM was appointed as interim Independent Administrator for the Moira Shire Council. A Panel of Administrators was subsequently appointed on 6 June 2023, comprising John Tanner AM (Chair), Dr Graeme Emonson PSM and Suzanna Sheed.[52]

65. In its submissions on the Request for Inquest, Moira Shire Council provided an update on the implementation of the Commission's recommendations and the work currently underway by the Council to promote positive change in the organization.[53]

66. Moira Shire Council has undergone considerable leadership changes since the Commission's Report was tabled. On 18 December 2023, Matthew Morgan was appointed as Chief Executive Officer of Moira Shire Council for a four-year term commencing 22 January 2024. The Council is recruiting into leadership roles across the organisation to create stability and increase capacity. The Council has also undergone an organisational restructure, with assistance of independent human resources advisors, to address the Commission's recommendations and improve service delivery and culture.[54]

[50] Commission of Inquiry Report, p 27.
[51] *Local Government (Moira Shire Council) Act 2023*.
[52] Mr Tanner's tenure as Administrator concluded on 9 June 2024. The current Panel comprises Dr Emonson (Chair) and Suzanna Sheed.
[53] Submissions of Moira Shire Council dated 19 April 2024,
[54] Submissions of Moira Shire Council dated 19 April 2024, [24]-[25].

67. Of the nine recommendations made by the Commission, six have been fully implemented. Work is well underway in implementing the remaining three recommendations, with a timeline for completion set for these recommendations to be completed within the next two years.[55]

68. Further, Moira Shire Council has introduced a range of measures to reform its workplace culture and ensure the safety of the workplace. These reforms are extensive, and include:

    (a) a 12-month program of work in conjunction with the ASU to review all of the Council's People and Culture policies and procedures, due to be completed by 31 December 2024.

    (b) an independent review and maturity assessment of its OHS framework which has led to the development of OHS Action Plans to enhance the robustness of its safety framework.

    (c) development of an organisation-wide Psychological Risk Management Plan in consultation with WorkSafe to address matters raised through a staff Psychological Hazards Survey.

    (d) rollout of a Preventative Wellbeing Program supported by the Healthy Minds Institute, which includes training for leaders and staff in managing psychosocial hazards, supporting wellbeing and creating a strong focus on all round wellbeing of the Council's workforce.

    (e) working with an organizational psychologist to plan and conduct interventions aimed at addressing psychosocial hazards within identified teams.[56]

69. This program of works is ongoing, with a view to promoting change in the organisation and building the maturity of the Council's systems, processes and people to ensure and maintain a safe working environment.

Further investigations by the Court

70. Following completion of its report, the Commission referred certain information and documents to the Court which it considered may be relevant to the investigation of Mr Devlin's death. This included copies of Mr Devlin's work diaries which had been produced to the Commission in the course of its inquiry, as well as contact details of six potential witnesses.

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[55] Submissions of Moira Shire Council dated 19 April 2024, [21]-[23].
[56] Submissions of Moira Shire Council dated 19 April 2024, [25]-[27].

71. At the direction of Coroner Peterson, who then had carriage of the investigation, the coronial investigator, Detective Sergeant Simon Quinnell (**D/Sgt Quinnell**) reviewed the material provided by the Commission and provided a further statement to the Court.[57]

72. D/Sgt Quinnell identified two documents of relevance within the diaries. However, he noted these documents did not provide any information that was not already known to investigators, outlined in the criminal proceedings and later touched upon in the plea hearing and sentencing remarks.[58] I agree with this assessment. The documents, or the substance of them, were already known to homicide investigators and are contained within relevant Council and Xchanging records that formed part of the prosecution and coronial briefs of evidence. The diaries do not provide any further insight into interactions between Mr Paterson and Mr Devlin, or the circumstances of Mr Devlin's murder which are not already known.

73. In respect of the six potential witnesses identified by the Commission, four had provided statements to homicide investigators in the criminal investigation which formed part of the prosecution brief of evidence and the coronial brief. The remaining two witnesses had been interviewed by the Commission during its inquiry. I have had the benefit of reviewing these transcripts and considering the information provided by these witnesses.[59] The concerns raised by these witnesses before the Commission related to human resource management practices affecting other employees of the Council, and incidents occurring after Mr Devlin's death. None of the matters raised were closely or causally connected to Mr Devlin's murder, and fall outside the bounds of a coronial inquiry, which must be restricted to issues sufficiently connected with the death being investigated.[60]

74. Nonetheless, the concerns raised by the witnesses, and the findings of the Commission do give rise to substantial public health and safety concerns regarding the Council's compliance with obligations under the OHS Act to provide and maintain a safe place of work. Those issues are appropriately a matter for WorkSafe as the workplace health and safety regulator. Having regard to the requirement

[57] Statement of Detective Sergeant Simon Quinnell dated 21 September 2023, CB 992-7.
[58] Ibid, [9], [16], CB, p 993-4.
[59] Section 216 of the LG Act provides that any answer, information, document or other thing given or produced to a Commission of Inquiry appointed under the LG Act is not admissible in evidence, and may not be able to be used against the person in any other proceedings, unless the document or thing was obtained or could have been obtained, independently of its production to the Commission of Inquiry.
[60] *Harmsworth v The State Coroner* (1989) VR 989 at 995-6, per Nathan J.

for Coroners to liaise with other investigative authorities,[61] I directed Court staff to write to WorkSafe to draw their attention to relevant findings made by the Commission in their Report and make enquiries as to whether WorkSafe had, or intended to, investigate those concerns. WorkSafe's response to those matters is set out at paragraphs [44] to [53] above.

SUBMISSIONS OF INTERESTED PARTIES

75. As outlined above, the interested parties were invited to provide written submissions on the Request for Inquest after they had reviewed the coronial brief.

Submissions of Ms Greenwood

76. Ms Greenwood filed submissions and reply submissions in support of the Request for Inquest on 19 April 2024 and 10 May 2024.

77. In summary, Ms Greenwood submitted that I should exercise my discretion to hold an inquest in relation to Mr Devlin's death as:

    (a) previous proceedings and investigations in respect of the circumstances surrounding the murder of Mr Devlin had not, due to their nature and scope, fully explored all factors which may have contributed to his death. If an inquest were not held, there existed a *"real likelihood"* that the broader factors which gave rise to the context in which Mr Devlin was murdered would never be fully and properly investigated.[62]

    (b) an inquest is necessary to fully investigate those factors, and for findings to be made as to whether Mr Devlin's death was preventable and what steps ought to be taken in the future to prevent a re-occurrence of similar circumstances.

    (c) the holding of an inquest would be consistent with the objectives of the Act, and in particular the objective of promoting public health and safety, noting that an inquest has the potential to reduce potential risks to thousands of Victorians working in local government.[63]

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[61] Coroners Act, s 7.
[62] Submissions of Ms Greenwood dated 19 April 2024, [30].
[63] Submissions of Ms Greenwood dated 19 April 2024, [33-34].

(d) there are inconsistencies in respect of critical issues in written statements contained in the Coronial Brief, including in respect of incidents occurring in the workplace in November 2018 and August 2019 concerning Mr Paterson's potential for violence. An inquest is necessary for relevant witnesses to give evidence and for that evidence to be tested and findings of fact made in respect of those matters.[64] Further, there were suggestions of a *"lack of transparency"* from certain witnesses, including in respect of the production of Mr Devlin's work diaries which may shed light on the circumstances in which the death occurred.[65]

78. It was conceded that by reason of the criminal proceedings, an inquest is not required to determine the cause of Mr Devlin's death, nor the *"immediate perpetrator*" of the murder. However, it was submitted that the criminal proceedings did not address relevant issues regarding the circumstances of Mr Devlin's murder as Mr Paterson had pleaded guilty and so a contested hearing did not take place. It was submitted that, at the plea hearing, oral evidence was limited to matters relating to Mr Paterson's mental health. No employees gave evidence, and none were cross examined in respect to factors which might have contributed to the murder having occurred.[66]

79. Ms Greenwood further submitted that no findings were made in the criminal proceedings against Mr Paterson as to:

(a) the culpability of others involved in the factual matrix (including, for example, those in positions of influence at Moira Shire Council);

(b) what steps might have been taken to prevent the murder;

(c) whether systemic or cultural factors within the Council may have contributed to the murder occurring;

(d) whether there remains a risk of persons being injured or killed at the Council, and whether any such risk has a general application, for example to other local government bodies; and

(e) whether any recommendations ought to be made in relation to Mr Devlin's death.[67]

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[64] Submissions of Ms Greenwood dated 19 April 2024, [43-49].
[65] Reply Submissions of Ms Greenwood dated 10 May 2024, [8].
[66] Submissions of Ms Greenwood dated 19 April 2024, [13-14].
[67] Submissions of Ms Greenwood dated 19 April 2024, [13-14].

80. It was further submitted that, while WorkSafe has powers to investigate work related deaths pursuant to Part 9 of the *Occupational Health and Safety Act 2004* (Vic) (**OHS Act**), the exercise of such powers would not be a suitable alternative to an inquest as:

(a) a WorkSafe investigation would be confined in scope by virtue of its statutory purpose and framework, and does not have the same prevention focus as a coronial inquest, nor the same scope of powers available to a coroner to compel a witness to answer questions;

(b) there is no guarantee that any investigation by WorkSafe would result in a prosecution;

(c) in any event, a prosecution would not be an adequate substitute for a coronial inquest in terms of a full examination of the circumstances leading to Mr Devlin's death, noting that:

i. a prosecution would be focused on the culpability of the individuals or entities charged, rather than on broader prevention opportunities;

ii. the court in a prosecution would take a passive role in respect of evidence presented;

iii. interested parties, including next of kin, are unable to cross-examine witnesses and test evidence in a prosecution, as they are able to do in an inquest; and

iv. evidence may be limited if the prosecution proceeded by way of a guilty plea, and it is possible that no oral evidence would be given at all.[68]

81. Specific reliance was placed on comments made by the Commission of Inquiry into Moira Shire Council (**Commission**) in its final report,[69] that it considered that Mr Devlin's death *"may well have been preventable"*, and that it had referred evidence it had gathered in the course of its inquiry to the State Coroner *"for further examination"*.[70] In her reply submissions, Ms Greenwood submitted that it can be concluded from the Commission's referral of evidence to the State Coroner that it had formed the view that *"there had not been sufficient Inquiry in respect to the circumstances*

[68] Submissions of Ms Greenwood dated 19 April 2024, [20-21].
[69] Moira Commission of Inquiry, 'Commission of Inquiry into Moira Shire Council' Report dated 26 February 2023 (**Commission's Report**).
[70] Submissions of Ms Greenwood dated 19 April 2024, [15-19].

surrounding Mr Devlin's Death", and that the State Coroner was best placed to further investigate those circumstances.[71]

82. As to the proposed scope of inquest, Ms Greenwood submitted that this could be limited to:

(a) the circumstances in which the death occurred;

(b) what factors contributed to the death of Mr Devlin, including whether there were systemic and/or cultural factors, which existed at Moira Shire Council which contributed to the death of Mr Devlin;

(c) whether Mr Devlin's death was preventable; and

(d) if applicable, what recommendations should be made to any Minister or public statutory authority or entity on any matter connected with Mr Devlin's death, including any recommendations directed to preventing such an occurrence arising again in the future.

Submissions of Moira Shire Council

83. Moira Shire Council provided an overview of the relevant legal principles under the Coroners Act applicable to the exercise of the discretion to hold an inquest, including:

(a) the requirement to avoid unnecessary duplication of investigations under section 7 of the Coroners Act;[72]

(b) the factors to be considered in conducting a coronial investigation,[73] including:

i. that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by a death;

ii. the desirability of promoting public health and safety and the administration of justice;

iii. the principle that the coronial system should operate in a fair and efficient manner;

[71] Reply Submissions of Ms Greenwood dated 10 May 2024, [4].
[72] Submissions of Moira Shire Council dated 19 April 2024, [11].
[73] Submissions of Moira Shire Council dated 19 April 2024, [11].

(c) the limitations of the coroner's powers of investigation, including that enquiries must be relevant, in the legal sense to the death,[74] and that a coroner is not permitted to inquire for the sole or dominant reason of making a comment or investigation;[75] and

(d) the balancing exercise required in considering the relative costs of holding an inquest, and doing without one, weighing the benefits which the inquest might produced against the disadvantages with an investigation short of an inquest may entail.[76]

84. The Council also provided the Court with an update on the implementation of recommendations arising from the Commission's Report and additional measures it has undertaken to improve workplace safety and culture, as described in paragraphs [64] to [69] above.

85. The Council did not seek to take a position on whether an inquest should be held, noting this is ultimately a discretionary matter for the coroner. However, the Council drew my attention to relevant matters that may have a bearing on that determination, namely:

(a) the circumstances of Mr Devlin's death had been thoroughly investigated by Victoria Police and the Commission of Inquiry. The criminal investigation, prosecution and Supreme Court plea had exposed, with detail, the circumstances leading to Mr Devlin's death. The Commission of Inquiry had also conducted a thorough and wide-ranging inquiry of Moira Shire Council and had made relevant findings and recommendations.

(b) whether Mr Devlin's death was preventable is a matter that can be considered based on the voluminous materials available in the coronial brief and Commission of Inquiry's Report, without the need for oral evidence at inquest.

(c) there is unlikely to be any new material that could be examined in an inquest that may uncover systemic defects or risks not currently known, noting the police investigation into the murder, subsequent conviction of the offender, and the Commission of Inquiry's in-depth examination of Council management and processes.[77]

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[74] *Harmsworth v State Coroner* [1989] VR 989 at 995.
[75] Submissions of Moira Shire Council dated 19 April 2024, [11]-[13].
[76] Submissions of Moira Shire Council dated 19 April 2024, [14].
[77] Submissions of Moira Shire Council dated 19 April 2024, [6], [19].

(d) the material currently available would allow the Coroner to make the required findings pursuant to section 67(1) of the Coroners Act – namely the identity of the deceased, the medical cause of death, and the circumstances in which the death occurred.[78]

Submissions of WorkSafe Victoria

86. WorkSafe submitted that, in its view, it is unnecessary to hold an inquest into Mr Devlin's death as an inquest is unlikely to elicit any further information which has not already been gathered in investigations undertaken by Victoria Police, WorkSafe Victoria and the Commission of Inquiry, and would likely duplicate previous investigations.[79] It was submitted that all the issues surrounding Mr Devlin's murder have been well ventilated in the course of numerous investigations, and that an inquest at this point would result in a significant duplication of investigative resources.[80]

87. Relevantly, WorkSafe submitted that:

(a) there is no dispute that Mr Devlin was murdered by Mr Paterson;

(b) there was insufficient nexus between the murder and the workplace for WorkSafe to initiate a prosecution against Moira Shire Council;

(c) there is little dispute that Moira Shire Council, including the Nathalia Depot where Mr Paterson worked, was a workplace in which multiple people conducted themselves inappropriately prior to Mr Devlin's murder, including instances of bullying. Those issues have been documented by all of the investigating agencies;

(d) since Mr Devlin's death, as a result of the Commission of Inquiry, the Moira Shire Council has been replaced with administrators, until after the Council election due in 2028, and a new CEO has been appointed;

(e) WorkSafe has conducted numerous site visits to the Moira Shire Council between 2017 and to date including in relation to psychosocial risks, and continue to work directly with the

[78] Submissions of Moira Shire Council dated 19 April 2024, [8]-[9].
[79] Submissions of WorkSafe Victoria dated 18 April 2024, [6].
[80] Submissions of WorkSafe Victoria dated 18 April 2024, [12], [69]-[70].

Council to provide guidance and direction to ensure it is complying with its duties under the OHS Act.[81]

CONSIDERATION

88. The Request for Inquest relied upon three grounds in support of the need to hold an inquest:

    (a) significant aspects of the background circumstances of Mr Devlin's murder, including events at Moira Shire Council in the lead up to the death had not been considered in previous proceedings and investigations.

    (b) the question of whether Mr Devlin's death was preventable is an open question and a matter of significant public interest in the context of a local government workplace.

    (c) an inquest may uncover systemic defects or risks not currently known which may prevent similar deaths occurring in the future.

Are any of the circumstances leading to the death of Mr Devlin unclear?

89. The circumstances of Mr Devlin's death have been the subject of a comprehensive criminal investigation. That investigation forensically examined the immediate circumstances of the murder, as well as events at the Council which may have had a bearing on Mr Paterson's motive and actions. Evidence of those matters is detailed in:

    (a) the record of interview with Mr Paterson on 6 August 2021, in which he made full disclosures regarding the events of 5 August 2021 and his motivations.

    (b) detailed statements from current and former Council employees and family and friends of Mr Devlin and Mr Paterson regarding events at the Council and in the lead up to the death.

    (c) relevant records from the Council, the WorkCover insurer Xchanging, the ASU and Mr Paterson's treating practitioners.

90. There is no factual dispute as to the identity of the deceased, the medical cause of death, or the circumstances connected with the death, which are detailed in full in the sentencing remarks. I am

[81] Submissions of WorkSafe Victoria dated 18 April 2024, [7]-[11].

satisfied that the criminal investigation and subsequent prosecution, have exposed, with detail, the circumstances leading to Mr Devlin's death. I consider that all appropriate lines of inquiry have been pursued by investigators in this matter, and that there is no substantive gap or lacuna in the investigation that warrants further coronial investigation. Insofar as it is submitted that further investigation of the circumstances of the death is necessary to determine the 'culpability of others involved in the factual matrix', I note that it is not the role of the Coroner to lay or apportion blame.

91. Where conflicting statements in the coronial brief have been identified about incidents occurring in the workplace in November 2018 and August 2019 concerning Mr Paterson's potential for violence, I am not satisfied that the resolution of these issues justifies the use of the judicial forensic process in circumstances where:

(a) there is no evidence of any direct threat of violence being made towards Mr Devlin by Mr Paterson in these incidents;

(b) these events occurred over 18 months prior to the murder of Mr Devlin and cannot be considered to be sufficiently proximate to or causally relevant to Mr Devlin's death such that they fall within the scope of the coronial inquiry; and

(c) the passage of time is likely to substantially diminish the forensic utility of any examination of the witnesses to these events.

92. Further, in respect of the submission that there were suggestions of a *"lack of transparency"* from certain witnesses, including in respect of the production of Mr Devlin's work diaries, I note that:

(a) matters to be relied upon in support of a request for inquest must amount to more than speculation or suspicion;[82] and

(b) concerns raised regarding the late production of the work diaries were investigated by the coronial investigator who was satisfied that the conduct was in no way dishonest, nor done with the intention of impacting the investigation. I accept this advice and do not consider any

[82] Per *Childs v Coroners Court of Victoria* [2020] VSC 755, at [65].

further investigation of those issues is warranted, noting the diaries contained no information relevant to the death that was unknown to investigators.

93. I am satisfied that the circumstances of Mr Devlin's death have been thoroughly investigated in the criminal proceedings, and the facts concerning the death have been appropriately recorded in the sentencing remarks, sufficient to meet community expectations. Having regard to the obligation under the Coroners Act to avoid unnecessary duplication of inquiries and investigations, I do not consider any further investigation of the circumstances of Mr Devlin's death by way of inquest is necessary or appropriate.

Was Mr Devlin's death preventable?

94. The question of whether Mr Devlin's death was preventable featured prominently in both the submissions of Ms Greenwood and the Commission's Report. To some degree, the puttage of this inclined to me to appear to absolve Mr Paterson of full responsibility for his actions, and drew an implied inference that Mr Devlin, as a senior executive in a position of influence at the Council, may have had responsibility, in part, for the circumstances leading to his own murder. I do not accept that proposition.

95. The Supreme Court has made it clear that the cause of Mr Devlin's death lies solely with Mr Paterson and that the choice to use lethal violence in response to a workplace grievance was his alone. As the sentencing remarks of Justice Jane Dixon state:

(a) Mr Paterson acted consciously and voluntarily, and in full knowledge of the wrongfulness of his actions, when he armed himself with a revolver he was not legally entitled to have and went to Mr Devlin's home on the evening of 5 August 2021.[83]

(b) Places of employment commonly result in workplace grievances against those working in managerial roles. A workplace grievance does not justify the enacting of violent revenge as Mr Paterson chose to do.[84]

[83] Sentencing Remarks, [71]-[72].
[84] Sentencing Remarks, [73].

(c) The action taken by Mr Paterson, in shooting an unarmed man at his home, as he came outside to greet a late night visitor, was *"a ghastly and cowardly act"*,[85] which warranted a term of imprisonment of more than the standard sentence for murder.[86]

96. Having so considered, it is arguably unnecessary for me to consider the issue further. However, for completeness, and given the focus on the issue of the preventability of Mr Devlin's death in Ms Greenwood's submissions and the final report of the Commission of Inquiry, and of the centrality of the prevention function in the coronial jurisdiction, I will address the issue in brief.

97. In undertaking this retrospective evaluation, there is an implicit danger for courts and other investigative bodies, of viewing events through the 'distorting prism of hindsight'. That is, it can be tempting to conclude that what occurred was always going to occur, and from that conclusion to view the actions or inactions of those involved more critically and as if the outcome was obvious and should have been foreseen. As noted by her Honour Coroner Hawkins, as she then was, in the Finding with Inquest into the 2017 Bourke Street Incident,[87]

> *the temptation to use hindsight is particularly pronounced in the context of considering issues of causation and whether if other action has been taken, or if opportunities for apprehension were missed, that another and better outcome would or might have ensued*.[88]

98. I have borne this in mind when approaching the question of whether an Inquest is warranted on the basis that Mr Devlin's murder could be considered preventable, having regard to what was known to persons at the relevant time.

99. It is evident that there were longstanding and unresolved workplace issues at Nathalia Depot and across the Moira Shire Council at the time of Mr Devlin's murder, as noted in the sentencing remarks and identified in the Commission's Report. However, there is insufficient evidence to support the

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[85] Sentencing Remarks, [69].
[86] Sentencing Remarks, [80].
[87] Finding into Deaths with Inquest of Matthew Poh Chuan Si, Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel dated 19 November 2020.
[88] Ibid, at [1.43], referring to various authorities on this point. See: *Brodie v Singleton Shire Council* (2001) 206 CLR 512, [320]; *Hawthorne v Hillcoat* [2008] NSWCA 340, [47]; *Vairy v Wyong Shire Council* (2005) 223 CLR 422, [443]; *Neindorf v Junkovic* (2005) 222 ALR 631, [93] per Hayne J; *Roads and Traffic Authority (NSW) v Dederer* (2007) 24 CLR 330, [65]-[66] per Gummow J; *DPP v Hicks* (No 1) (2014) 240 A Crim R 171, [74]-[75].

proposition that Mr Paterson had expressed any direct physical threats or homicidal ideation towards Mr Devlin proximate to the murder, that may have given rise to a foreshadowing of subsequent events such that preventative action could have been taken by the Council or other authorities.

100. Relevantly, in the record of interview with Mr Paterson, in which he gave a frank and comprehensive account of his actions, Mr Paterson expressly denied having made any threats towards Mr Devlin prior to the murder.[89] This is consistent with the evidence of Mr Paterson's treating practitioners and ASU representative with whom he had developed a strong rapport, and who had assisted him from the time he ceased work in December 2019.[90]

101. When working for Moira Shire Council, there is evidence to indicate that Mr Paterson talked frequently about his firearms, made comments that he would engage lawyers from a particular law firm to *"take the house"* of people in senior management at the Council, including Mr Devlin, and at times behaved aggressively towards his co-workers, including one incident in November 2018 where he was alleged to have threatened a co-worker, for which he received a first and final warning.

102. Further, in November 2019 in the course of a telephone call between Mr Devlin and Mr Paterson in relation to the investigation of the alleged theft (which was of kerosene), Mr Paterson offered to drop the kerosene off at Mr Devlin's home. Although no direct threat was made, Mr Devlin did raise the concern in a subsequent email to HR that he believed this comment *"is some kind of threat to say he knows where I live"*. However, the meaning or purpose of Mr Paterson's comment in the context of this conversation is unclear. There is no evidence Mr Paterson made any explicit threat towards Mr Devlin following this conversation; indeed, this pre-dated the fatal incident by over 18 months.

103. It is clear from the evidence before me that Mr Paterson frequently made antagonistic remarks in the workplace. However, in the context of a workplace with ongoing tensions and disputes, the

[89] Record of Interview with Mr Paterson on 6 March 2024, [266], [496-9], [503], [511-2], [516-9].

[90] Mr Paterson's medical records confirm that while stressed and anxious due to the workplace issues, he expressly denied any death wishes, suicidal ideas, plan or intent, and found cognitive behavioural therapy strategies of assistance in coping with his anxiety and depression. In his last conversation with Mr Paterson on 3 August 2021, the ASU representative observed that Mr Paterson's demeanour was positive. While Mr Paterson was frustrated at times due to the WorkCover process, the ASU representative stated that Mr Paterson never made any direct threats towards himself or any persons from Moira Shire Council (including Mr Devlin) during their interactions.

remarks might simply have been attributable to mere bluster or braggadocio and do not necessarily prefigure acts of violence.

104. In this connection, and as noted above, the alleged threats made by Mr Patterson were made over 18 months prior to the murder. Mr Paterson had not been at the workplace since mid-December 2019 and he murdered Mr Devlin on 5 August 2021. While there was an ongoing dispute regarding the proposed return-to-work plan for Mr Paterson due to concerns about how Moira Shire Council would make the return to work safe, the evidence indicates that Mr Paterson was managing these issues positively and with the support of his treating practitioners and ASU representative.[91]

105. Accordingly, for the purposes of deciding whether there were concrete prevention opportunities that warrant further exploration at Inquest, I am not satisfied that the alleged threats made by Mr Paterson in the workplace between 2018 and 2019 could reasonably be considered predictive of his subsequent decision to kill Mr Devlin in August 2021. Rather, it appears Mr Paterson acted impulsively, while in a heightened emotional state exacerbated by alcohol use. There was no prior warning of his intended actions. As noted by Justice Jane Dixon, the reasons Mr Paterson took the actions he did, from an objective viewpoint, remain unfathomable.[92]

106. In these circumstances, I do not consider that an Inquest is warranted to explore these issues further.

107. Further, and for completeness, while acknowledging and expressing deep appreciation for the evidence provided by the Commission of Inquiry to assist in the present investigation, I note that the Commission does not have any specific power to direct or 'refer' specific questions to the Coroners Court regarding the investigation of a reportable death (including as to the preventability of a death). Such questions form part of the analysis the Court undertakes in the usual course of investigating a reportable death, pursuant to its obligations under the Coroners Act, as is the case here.

[91] CB, pp 403; 420-1; Exhibit 73 - Xchanging Records, Workcover 2 – Claim 08190061917, p 8.
[92] Sentencing Remarks, [11].

Are there any systemic defects or risks not currently known?

108. Mr Paterson attributed his motive for the murder of Mr Devlin to his perception that Mr Devlin had failed to properly manage his workplace grievance.

109. The Commission of Inquiry was established in response to broader concerns raised about the Council's governance and human resource management practices. The Commission had a wide-ranging scope of inquiry, which enabled it to scrutinize and carefully examine the Council's governance, procedures and practices. Its inquiry went well beyond the limits of a coronial inquiry, which must be confined to those enquiries which are relevant to the death in the legal sense. Relevantly, a coroner is not permitted to conduct an open-ended inquiry into the merits or otherwise of the performance of government agencies.[93]

110. The Commission identified a number of longstanding systemic governance failings and made nine recommendations to the Minister for Local Government targeted to restoring good governance and to better ensuring the safety and wellbeing of Council staff. The recommendations have been accepted in full and I am satisfied that they have been appropriately actioned, with work completed or underway in response to all recommendations. The Panel of Administrators is providing ongoing assurance and oversight of the Council's management to ensure good governance is restored.

111. I am also satisfied that the reforms made to the Council's human resource management practices will ensure the Council is better able to effectively respond to safety concerns raised by staff in the future.

112. I agree with and accept the submissions of WorkSafe and Moira Shire Council that there is unlikely to be any new material that could be examined in an inquest that may uncover systemic defects or risks not currently known, which have not already been uncovered through WorkSafe's investigations and the Commission of Inquiry's comprehensive inquiry into the Council.

[93] *Harmsworth v The State Coroner* (1989) VR 989 at 995-6, per Nathan J.

DETERMINATION ON REQUEST FOR INQUEST

113. In determining whether to exercise my discretion to hold an inquest into the death of Mr Devlin, I have carefully reviewed the submissions filed by Ms Greenwood and the interested parties, as well as the evidence contained in the coronial brief, and the sentencing remarks of Justice Jane Dixon. I have also had regard to the scope, purpose and objectives of the Coroners Act.

114. Having considered this material, I have decided that it is not necessary or desirable in the interests of justice to hold an inquest into the death of Mr Devlin for the following reasons:

    (a) the identity of the deceased, the medical cause of death, and the circumstances in which the death occurred have been established in the criminal proceedings following a competent and thorough investigation. Those facts are set out in the public record in the sentencing remarks of Justice Jane Dixon in a manner that is comprehensive and wholly sufficient to meet community expectations.

    (b) there are no circumstances surrounding the death of Mr Devlin that are unclear or which require further examination in an inquest.

    (c) it is unlikely an inquest will uncover any systemic defects or risks that have not been uncovered through the comprehensive investigations undertaken by WorkSafe, the Municipal Monitor and the Commission of Inquiry. Those investigations have resulted in significant reforms to the administration and governance of the Moira Shire Council, and I am satisfied that, to the extent this has any relevance to my present task, appropriate steps have been undertaken to address the concerns identified in governance and workplace safety at the Council.

    (d) the Court does not have the resources, nor would it be in the public interest, for an inquest to be held, with witnesses summonsed and lawyers potentially engaged, in every coronial investigation. There must be a sound basis upon which the decision to proceed to inquest is taken. I have not identified a legitimate coronial purpose or public interest that is likely to be served by holding a public hearing in this matter in circumstances where:

i. Mr Paterson has been convicted of Mr Devlin's murder, and the circumstances giving rise to the death are set out in detail in the relevant sentencing remarks; and

ii. a thorough and wide-ranging public inquiry has been held into Moira Shire Council which has exposed in detail deficiencies in governance, culture and workplace safety. The findings of that inquiry are set out in the comprehensive and detailed Report of the Commission, which has made relevant recommendations to address those matters.

ACKNOWLEDGMENTS

115. I convey my deepest sympathy to Mr Devlin's family, friends and the community in which he lived and worked. I acknowledge the sudden and traumatic circumstances in which Mr Devlin's death occurred, and the grief and devastation that his loved ones and colleagues have endured as a result of this loss. I also acknowledge the complex emotions – including disappointment and the unfurling of further grief – that may follow the present determination. In the course of preparing this determination, I have taken the opportunity to consider evidence regarding the man that Mr Devlin was in life, and how he was regarded by his friends and loved ones. Their loss is immeasurable.

116. To the extent relevant to the present determination, I acknowledge the significant reforms being undertaken by Moira Shire Council to address the systemic workplace health and safety and governance issues identified by the Commission. I am encouraged by the program of works underway at the Council to establish and maintain a safe working environment for all staff, and which have been developed in consultation with current employees, ASU, WorkSafe, and independent experts. I am satisfied there is a genuine commitment by the Council to reform its systems and processes to ensure the wellbeing of its staff now and into the future, and that there is ongoing and continued oversight by its Panel of Administrators to provide assurance to government throughout the period of administration.

117. I thank Ms Greenwood and her legal representatives, as well as the counsel and solicitors who represented the interested parties for their comprehensive and detailed submissions on this matter. I also acknowledge and thank D/Sgt Quinnell and D/Sgt Meneilly for their dedicated assistance during the investigation, as well as to Ms Elizabeth Morris, the Court's Senior Legal Counsel.

ORDERS AND DIRECTIONS

118. I order that a copy of this ruling be published on the Coroners Court of Victoria website in accordance with rule 69 of the *Coroners Court Rules 2019* (Vic).

119. I direct that a copy of this determination be provided to the following:

Ms Alison Greenwood, Senior Next of Kin, c/ Dawes & Vary Riordan Lawyers
Mrs Sandra Devlin and the Devlin Family, c/ Shine Lawyers
Ms Kirsten Hughes, Lead Lawyer, Public Law, WorkSafe Victoria
Mr Matthew Morgan, Chief Executive Officer, Moira Shire Council
Detective Senior Sergeant Simon Quinnell, Coroner's Investigator

Signature:

Ingrid Giles
CORONER

Date: 9 August 2024

NOTE: Under section 82 of the **Coroners Act 2008** (the Act) if a coroner determines not to hold an inquest into a death, the person who requested the coroner to hold an inquest into the death may appeal against the coroner's determination to the Trial Division of the Supreme Court within 3 months after the day on which the determination of the coroner is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.