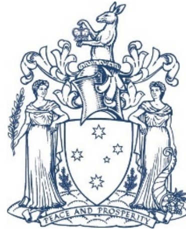

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 007046

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Mathew Edward Moroney

Delivered On:	6 July 2022
Delivered At:	Coroner's Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing Dates:	6 July 2022
Findings of:	Judge John Cain, State Coroner
Counsel Assisting the Coroner	Nicholas Ngai, Family Violence Senior Solicitor
Catchwords:	Family violence; homicide; mandatory inquest; murder-suicide

INTRODUCTION

1. Mathew Edwards Moroney was forty-six years old at the time of his death. Mr Moroney was fatally shot at his friend's residence at 5 Dryden Place in Sale, Victoria on 25 December 2019.

2. Mr Moroney was born and raised in Moe, Victoria along with his older brother and younger sister. He struggled in school and was expelled from secondary school. Mr Moroney spent most of his working life in the construction industry and working at the Hazelwood Power Station.

3. Mr Moroney had four children with four separate partners but due to his substance abuse issues, he never had full time care of any of his children.

4. Mr Moroney was reported by family to have suffered from lifelong substance abuse issues with both drugs and alcohol. This had a significant detrimental affect on Mr Moroney's mental health and contributed to his extensive criminal offending from adolescence to adulthood.

5. Mr Moroney met Kirsty Pavich a few months prior to the fatal incident and Ms Pavich offered Mr Moroney a room to stay in her residence at 5 Dryden Place in Sale. Mr Moroney wanted a place that had some stability because his transient lifestyle had impacted on his ability to spend more time with his youngest daughter. Mr Moroney shared care with the child's mother, whom he was separated from.

6. Ms Pavich met Jake Wills at a pokies venue a week prior to the fatal incident and they commenced an intimate relationship.

THE CORONIAL INVESTIGATION

7. Mr Moroney's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Mr Moroney ordinarily resided in Victoria[1] and the death appears to have been unexpected and violent.[2]

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[1] Section 4 *Coroners Act 2008*
[2] Section 4(2)(a) *Coroners Act 2008*

8. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Moroney'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.

12. This finding draws on the totality of the coronial investigation into the death of Mr Moroney including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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[3] 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.

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

Circumstances in which the death occurred

13. On the evening of 24 December 2019, Ms Pavich had several guests staying at her residence including Mr Moroney. Ms Pavich went out with Mr Moroney to another associates' house on Patten Street in Sale. Both Ms Pavich and Mr Moroney returned to the Dryden Place residence in the early morning of 25 December 2019.[4] Ms Pavich received a text message from Mr Wills stating that he needed his push bike back.

14. Ms Pavich rode to Mr Wills address at 34 McLaughlin Place. Mr Wills accused Ms Pavich of being unfaithful to him and being intimate with Mr Moroney and alleged that Mr Moroney had been stealing money from Mr Wills's bank account.[5] Mr Wills made numerous threatening comments to Ms Pavich and about what he would do to Mr Moroney.[6] Mr Wills left the McLaughlin Place address shortly after and arrived at the Dryden Place residence seeking out Mr Moroney at around 9:00am.[7]

15. Mr Moroney heard banging at the front door and went to open it to see who was making all the commotion outside. Mr Moroney opened the front door and Mr Wills stepped inside and discharged his firearm towards Mr Moroney's neck. Mr Moroney fell to the floor and was bleeding heavily from the neck.

16. Mr Wills left immediately and rode back to the McLaughlin Place address and spoke shortly with Ms Pavich before briefly leaving the address to speak to his neighbour. He then returned to the McLaughlin Place address and continued arguing with Ms Pavich.[8]

17. At approximately 9.38am, Ms Pavich fled to the front yard of the McLaughlin Place address in fear for her life and Mr Wills walked to the side driveway with his firearm and shot himself in the head.[9]

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[4] *Coronial Brief*, Statement of Kirsty Pavich dated 31 December 2019, 25
[5] *Coronial Brief*, Statement of Bradley Snowden dated 25 December 2019, 57; Statement of Kirsty Pavich dated 31 December 2019, 29-32
[6] *Coronial Brief*, Statement of Kirsty Pavich dated 31 December 2019, 14-16
[7] *Coronial Brief*, Statement of Lynette Hills dated 25 December 2019, 80
[8] *Coronial Brief*, Statement of Rachelle Wittingslow dated 25 December 2019, 61
[9] *Coronial Brief*, Statement of Bradley Snowden dated 25 December 2019, 58; Statement of Kirsty Pavich dated 31 December 2019, 37

18. Emergency services first arrived at the Dryden Place residence at 9.30am.[10] Attending ambulance paramedics declared Mr Moroney deceased at 9.55am. Separate ambulance paramedics arrived at the McLaughlin Place address at 9.43am and Mr Wills was declared deceased onsite.[11]

Identity of the deceased

19. On 25 December 2019, Mathew Edward Moroney born 2 May 1973, was visually identified by his friend, Aimmy Davies.

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

Medical cause of death

21. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 26 December 2019 and provided a written report of her findings dated 28 April 2020.

22. Dr Glengarry noted the following from her post-mortem examination:

    a) There was a pathological distance range entrance wound of the anterior neck associated with a wound track that was directed from front to back, towards the right and horizontally without an exit wound;

    b) Multiple grey metal pellets were retrieved along the wound track; and

    c) Some natural disease was identified along with hepatitis and liver scarring but none had any bearing on the cause of death;

23. Toxicological analysis of post-mortem samples identified the presence of heroin, methylamphetamine, benzodiazepines and cannabis. The concentration levels detected were not significant enough to have an effect on the cause of death.

24. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) Shotgun wound to the neck.

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[10] *Coronial Brief*, Statement of Anthony Mead dated 1 January 2020, 109-110
[11] *Coronial Brief*, Statement of Nicole Blackwell dated 9 January 2020, 112

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

25. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr Wills and Ms Pavich was one that fell within the definition of '*family member'*[12] under that Act. Moreover, Mr Wills's actions in fatally shooting Mr Moroney shortly after threatening and verbally abusing Ms Pavich constitutes '*family violence'*.[13]

26. In light of Mr Moroney's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[14] examine the circumstances of Mr Moroney's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[15]

27. Whilst both Mr Wills and Mr Moroney had a substantive criminal history, neither was subject to a community corrections order or parole conditions in the lead up to the fatal incident.

28. I confirm that a thorough review of all the available evidence did not reveal any missed opportunities for intervention or prevention in the circumstances of Mr Moroney's death.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mathew Edward Moroney, born 2 May 1973;

    b) the death occurred on 25 December 2019 at 5 Dryden Place, Sale, Victoria, from a shotgun wound to the neck; and

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[12] Family Violence Protection Act 2008, section 8(1)(b)

[13] Family Violence Protection Act 2008, section 9

[14] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

[15] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

c) the death occurred in the circumstances described above.

31. I convey my sincere condolences to Mr Moroney's family for their loss.

32. Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Mr Corey Peatey, Senior Next of Kin

Ms Kylie Moroney

Ms Elizabeth Shackleton

Detective Senior Constable Gregory Cogan, Coroner's Investigator

Signature:

Judge John Cain
STATE CORONER
Date: 6.07.2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.