IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 2733

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Ms ZT
Date of birth:	16 November 1988
Date of death:	17 June 2016
Cause of death:	1(a) Multiple sharp force injuries
Place of death:	[redacted], Victoria

INTRODUCTION

1. On 17 June 2016, Ms ZT, was 27 years old when she was found deceased in an open grassland adjacent to the [redacted] in Victoria. At the time of her death, Ms ZT was living in Broadmeadows with her husband, Mr BR, and her three young children.

2. Ms ZT was born and raised in Lebanon. Ms ZT grew up as one of ten siblings, five brothers and four sisters who all reside in Lebanon except for a younger sister, NT, who moved to Australia in December 2015.[1]

3. Ms ZT completed her secondary studies in Lebanon and attended a technical institute to train as a tailor. She completed the course and started working in the sewing industry prior to her departure to Australia.[2]

4. Ms ZT visited Australia around 2009 and, during her six months stay on a tourist visa, she met her husband, Mr BR. Mr BR contacted Ms ZT's family and proposed marriage within the first few months of Ms ZT arriving in Australia.[3] Ms ZT's family agreed and Ms ZT married Mr BR before returning to Lebanon. Ms ZT was pregnant with her first child, DR, at this time.

5. Mr BR was born in Melbourne, Australia on [redacted] and had a substantial criminal history prior to meeting Ms ZT:

   (a) Between 1999 and 2007, Mr BR was charged with multiple offences, including theft, intentionally causing injury, criminal damage and serious dangerous driving. These charges resulted in an array of sentences ranging from Community Based Orders to two instances of imprisonment.[4]

   (b) Between 2005 and 2008, Mr BR was held in custody in relation to terrorist related charges but was ultimately acquitted.[5]

6. Mr BR also had a reported history of substance use, particularly methylamphetamines, and was described as using narcotics 'on and off' until the time of the fatal incident.[6]

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[1] *Coronial Brief,* Statement of NT dated 5 July 2016, 540
[2] *Coronial Brief*, Statement of HT dated 9 March 2017, 743.17
[3] Ibid, 743.18
[4] *Coronial Brief*, Criminal Record of Mr BR, 1575-1584.
[5] Ibid; *Coronial Brief*, Northern Health Medical Records of [redacted], 115; Statement of [redacted] dated 28 July 2016, 549
[6] Dr Leon Turnbull, Psychiatric Report of Mr BR dated 12 May 2017, 2

7. Mr BR joined Ms ZT in Lebanon six months after her initial arrival and helped Ms ZT arrange her visa so she could return to Australia permanently.[7]

8. During the period that Mr BR and Ms ZT were in Lebanon, Ms ZT's family reported that Mr BR exercised considerable coercive control over Ms ZT by refusing to allow her to go to public places and attend a family wedding.

9. Mr BR returned to Australia first around December 2009. Ms ZT then returned to Australia with DR around April 2010.[8]

10. Ms ZT spoke very limited English at the time of her arrival in Australia and her English language skills appear to have remained limited until the time of her death.[9]

11. On [redacted] Ms ZT gave birth to their second child, MR. The couple's third child, a daughter, KR, was born on [redacted].[10]

12. During their marriage, Mr BR and Ms ZT lived in several residences within the [redacted] area. At the time of Ms ZT's death, the couple were several months overdue on their rent and eviction proceedings had been commenced against them.[11]

THE CORONIAL INVESTIGATION

13. Ms ZT's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

14. 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.

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[7] *Coronial Brief*, Statement of HT dated 9 March 2017, 743.18
[8] Ibid, 743.19
[9] Ibid, 743.17
[10] Ibid, 743.19-743.20
[11] *Coronial Brief*, Statement of [redacted] dated 14 July 2016, 559-560

15. Under the Act, coroners also have the important functions of helping to prevent deaths and promote 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.

16. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms ZT'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.

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

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

Circumstances in which the death occurred

18. In the early hours of 17 June 2016, Mr BR and Ms ZT were at their home on [redacted] Mr BR attacked Ms ZT in front of their three children with a knife; repeatedly slashing, stabbing and cutting her to her face and body.[13]

19. During the course of the vicious attack on Ms ZT, Mr BR had removed her eye and two of her fingers from Ms ZT's left hand.[14] The children, who witnessed the attack, described the scene as having "*blood everywhere*".[15] Mr BR was reported to have later cleaned up the blood with a mop and water. Later examination of the scene by Police, revealed blood within the premises and the evidence of clean up and diluted blood.[16]

[12] 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.
[13] *Coronial Brief,* VARE interview transcript with DR, 797-798; VARE interview transcript with MR, 866-878
[14] *Coronial Brief,* VARE interview transcript with DR, 817-818
[15] *Coronial Brief,* VARE interview transcript with DR, 803-804; 859-860; VARE interview transcript with MR, 875-876
[16] *Coronial Brief*, Statement of Constable Alexandra Adler dated 5 July 2016, 400-402

20. After murdering Ms ZT, Mr BR placed her body in the boot of his motor vehicle. He then drove to the grassland next to the [redacted].[17] Ms ZT's three children were also present in the car. Mr BR had wrapped Ms ZT's body in a plastic wrap, doona and bound it with electrical tape.

21. Mr BR removed Ms ZT's body from the car and dumped it on the ground in an open grassland near the [redacted] This location is directly opposite the premises at [redacted].[18]

22. After leaving Ms ZT's body near the [redacted] Mr BR waited a little while to see if Ms ZT's body was moving and then drove to the [redacted] with the children. At approximately 4.04 am, Mr BR purchased pastries for the children using an ANZ Visa Debit card in Ms ZT's name.[19]

23. Later that same day at approximately 1.10pm, Ms ZT's body was discovered by a member of the public. Police were contacted, attended and located her body.[20] Police members found no signs of life and observed multiple lacerations to the head and face of the deceased but due to the extent of her injuries were unable to identify her sex.[21]

24. Mr BR was later arrested and interviewed by Police members on 4 July 2016 initially for child abuse concerns and then later Mr BR was charged with Ms ZT's murder.[22] Police members took Mr BR into custody and Ms ZT's three children were conveyed to the Royal Children's Hospital to treat their injuries. All three children had visible injuries resulting from blunt force trauma, the youngest had burns to her left foot.[23]

25. On 29 March 2018, in the Supreme Court of Victoria, Mr BR was found guilty of the murder of Ms ZT and he was sentenced to life imprisonment with a non-parole period of 30 years.[24]

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[17] *Coronial Brief,* VARE interview transcript with DR, 799-800
[18] *Coronial Brief,* VARE interview transcript with DR, 806
[19] *Coronial Brief*, Statement of [redacted] dated 18 July 2016, 501
[20] *Coronial Brief,* Statement of Senior Sergeant Stephen McIntyre dated 5 September 2016, 447; Statement of [redacted] dated 17 June 2016, 215-216
[21] Ibid
[22] *Coronial Brief*, Statement of Acting Sergeant James Marsden dated 6 July 2016, 393-394
[23] *Coronial Brief*, Statement of DSC Kasey Gibbons dated 21 September 2016, 474
[24] *R v RB* [2018] VSC 142, 15

Identity of the deceased

26. Upon reviewing the available evidence, Coroner Rosemary Carlin completed a Form 8 *Determination by Coroner of Identity of Deceased* dated 7 July 2016, concluding that the identity of the deceased was ZT born 16 November 1988.

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

Medical cause of death

28. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 17 June 2016 and provided a written report of his findings dated 4 October 2016.

29. Dr Bouwer noted the following:

(a) the autopsy revealed multiple sharp force injuries to multiple locations across the body. There were recent incised/chopping type injuries to the face with fractures of the facial bones. There were also multiple stab wounds which appeared to be of varying ages in the torso, upper and lower limbs. Some of these wounds appeared to be several days/weeks old whilst others were well healed and may be many days to weeks old;

(b) the cause of death is likely to be a consequence of the multiple sharp force injuries described above which led to exsanguination or significant blood loss;

(c) the left hand second and third fingers were recently amputated. The severed fingers were located with the deceased inside wrappings discovered at the [redacted] crime scene location; and

(d) the right eye was removed and was absent during the autopsy and at the time of autopsy was not recovered.

30. Precise estimation of the age of the injuries sustained by the deceased is complicated by factors including individual variability in healing responses and limitations inhere in the sampling process. Dr Bouwer commented that the ages of injuries varied and included: peri-mortem (at the time of death), ante-mortem (likely sustained within hours to a day or so prior to death), healing (injuries with advanced healing changes) and headed (showing scarring).

31. Dr Bouwer commented that the sharp force injuries centred in the region of the right eye with associated enucleation of the globes (absent eye), showed haemorrhage without evidence of significant healing and were most likely sustained in antemortem period, whilst many of the

sharp force injuries on the arms, legs, head and torso ranged from well healed scars to scabbed sharp force injuries and were likely sustained days to weeks prior to death. Some of the sharp force injuries were likely sustained around the time of death (peri-mortem), for example the incised injuries on the anterior upper neck below the jaw and pubic region which showed no evidence of healing or haemorrhage.

32. Dr Bouwer found further evidence of blunt force trauma to the ribs with fractures on the left side as well as two older healing rib fractures. There was also bruising in the small bowel mesentery, suggestive of blunt force trauma delivered to the abdominal region.

33. Dr Lyndall Smythe, a Senior Forensic Odontologist, conducted further examinations on the body of the deceased on 20 June 2016. Dr Smythe found additional evidence of trauma to the deceased's teeth with multiple fractures present. Damage to the teeth was recent and most likely occurred around the time of death. Dr Smythe also observed multiple chop indentations in the chin area of the bone and on the right body of the lower jaw, these injuries most likely occurred as a result of multiple severe blows to these areas with a sharp edged object like a hatchet, machete or small axe.

34. Toxicological analysis of post-mortem hair samples identified the presence of amphetamines and methylamphetamine. None of these detected substances were at levels that suggest a connection to the mechanism of death in this case. There was no ethanol or common drugs or poisons found in other port-mortem samples.

35. Dr Bouwer provided an opinion that the medical cause of death was '1(a) Multiple sharp force injuries'.

36. I accept Dr Smythe and Dr Bouwer's opinions.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

37. As Ms ZT's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**)[25] examine the circumstances of Ms ZT's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[26]

38. Ms ZT's relationship with Mr BR met the definition of 'family member' under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).[27] The fatal incident involved a series of fatal assaults by Mr BR towards Ms ZT which meets the definition of 'family violence' in the FVPA, specifically the repeated physical assaults that contributed to her death.

39. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with Mr BR and Ms ZT prior to Ms ZT's death.

Family violence history between Mr BR and Ms ZT

40. The available evidence suggests that Mr BR had a history of perpetrating family violence against current and former partners, in the form of physical assaults, emotional/psychological abuse and threats.[28] During the length of Mr BR and Ms ZT's relationship, Mr BR was severely physically, emotionally and verbally abusive towards Ms ZT and was reportedly very controlling of her and the family's behaviour.[29]

41. Whilst details of the historic violence are not entirely clear, all three children were subject to recent physical violence and were also witnesses to such violence perpetrated by Mr BR against

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[25] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[26] 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.

[27] Section 8(1)(a) of the *Family Violence Protection Act 2008*

[28] *Coronial brief*, Statement of [redacted] dated 3 March 2018, 50, 53-55; Statement of [redacted] dated 7 March 2018, 86-87, 90; Appendix G – Transcript of Audio Recording, 232-233, 244, 247

[29] *Coronial Brief*, Statement of HT dated 9 March 2017, 743.17-743.25; Coronial Brief, Statement of NT, 545-547; Coronial Brief, Victorian Forensic Paediatric Medical Service Medical Report of DR, 115-136; Coronial Brief, Victorian Forensic Paediatric Medical Service Medical Report of MR, 137-154; Coronial Brief, Victorian Forensic Paediatric Medical Service Medical Report of KR, 155-173; Coronial Brief, Appendix A- Table of Disclosures, 493-500.

Ms ZT in the lead up to the fatal incident.[30] Since the fatal incident, all three children have made disclosures of violence witnessed against their mother and perpetrated against themselves.[31]

42. The available evidence provided to the Court indicates that Ms ZT's in-laws observed changes to Ms ZT's behaviour and held suspicions that Mr BR was being violent towards her. Mr BR's sister, Ms [redacted], noted, that '*about a year after the birth of their first child things changed between them. There was suddenly a feeling of coldness'*.[32] Ms ZT was described as becoming '*very quiet and distant. She lost her bubbly personality'*.[33] Ms [redacted] further advised that she became '*suspicious that* [redacted] *might be hitting [Ms ZT] because she started all of a sudden wearing makeup which she never did before*'[34] and did not respond when asked why. Ms ZT's mother-in-law also witnessed Ms ZT with a black eye, and when she made enquiries about the injury, Ms ZT was unable to recall the details of how she had obtained it.[35]

43. Ms ZT was also reportedly restricted from having contact with friends and family and had limited and supervised conversations with her parents and siblings. Mr BR was described as being extremely jealous and would become agitated if Ms ZT was in contact with men.[36]

44. During Ms ZT's antenatal treatment for her second child, Mr BR was identified as aggressive to staff and controlling of Ms ZT. Mr BR initially refused to allow an interpreter to be present to interpret for Ms ZT and was unwilling to leave Ms ZT alone with medical staff.[37] Following the birth of MR, Mr BR demand that Ms ZT be discharged from hospital six hours after giving birth so that she could return home to care for the other children and clean the house.[38]

45. In 2011, Mr BR and Ms ZT met with Ms AR. Several days after this meeting, Mr BR and Ms AR were married and Mr BR, Ms ZT and their children began residing with Ms AR and her son.[39]

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[30] *Coronial Brief*, Statement of HT dated 9 March 2017, 743.17-743.25
[31] Coronial Brief- Attachment Material 3, Statement of HT, 743.17-743.25; Coronial Brief, Appendix I- Exhibit 103- Transcript of VARE DR, 790-864; Coronial Brief, Appendix J- Exhibit 1035 Transcript of VARE MR, 865-879; Coronial Brief, Statement of NT, 545-547; Coronial Brief, Victorian Forensic Paediatric Medical Service Medical Report of DR, 115-136; Coronial Brief, Victorian Forensic Paediatric Medical Service Medical Report of MR, 137-154; Coronial Brief, Victorian Forensic Paediatric Medical Service Medical Report of KR, 155-173; Coronial Brief, Appendix A- Table of Disclosures, 493-500.
[32] Coronial Brief, Statement of M [redacted] 727.
[33] Ibid.
[34] Ibid.
[35] Ibid, 728.
[36] Coronial Brief- Attachment Material 3, Statement of HT, 743.17-743.25; Coronial Brief, Statement of TA, 534-539; Coronial Brief, Statement of NT, 542.
[37] Coronial Brief- Attachment Material 3, Statement of C Fletcher, 743.9-743.10.
[38] Coronial Brief, Maternal and Child Health Records of MR, 1007.
[39] Coronial Brief, Statement of AR, 526.

46. Ms AR made a statement following the fatal incident, detailing the abuse she was subject to whilst residing with the family. Ms AR's statement describes extremely controlling and violent behaviour perpetrated by Mr BR towards Ms ZT and Ms AR.[40] Ms AR ended the marriage one month after its commencement and was pregnant at the time of their separation. Ms AR was instructed by Mr BR to have a termination.[41]

47. Mr BR did not let his children attend school or socialize with other children, and only allowed them to speak in Arabic and learn the Koran.[42] Mr BR also expressed a desire to teach the children about guns, swords, war and Jihad.[43]

48. The available evidence suggests that Mr BR ascribed to strict Islamic customs and forced Ms ZT to wear a Burka[44] and stand behind him at all times. Mr BR disclosed to his brother-in-law that he '*wanted to go to Syria to fight for ISIS*'[45] and did not let his wife '*leave the house*'.[46] Mr BR advised that when Ms ZT had objected to him fighting for Jihad, he had '*grabbed her hand and he sliced it with a knife*'.[47]

49. Mr BR did not approve of Ms ZT remaining in contact with her family and in April 2016, Ms ZT spoke with her sister, Ms NT, who came to Australia recently and was asked to check in with Ms ZT by her family. Ms ZT advised her sister she was not allowed to talk to anyone and that she would never see her again.[48]

[40] Ibid, 529.
[41] Ibid, 530.
[42] Coronial Brief, Statement of NT, 541.
[43] Ibid; Coronial Brief, Statement of TA, 536.
[44] Coronial Brief, Statement of [redacted], 550; Coronial Brief, Statement of [redacted], 581; Coronial Brief, Statement of TA, 536.
[45] Coronial Brief, Statement of TA, 534.
[46] Ibid.
[47] Ibid, 535.
[48] Coronial Brief, Statement of NT, 545-546.

COMMENTS

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

Third party reporting of family violence

50. The available evidence suggests that several of Ms ZT's immediate family and her in-laws were aware of or suspected that Mr BR was perpetrating violence against Ms ZT prior to her death. Despite this knowledge, none of Ms ZT's family members made further enquiries or sought support for Ms ZT. When Ms ZT ceased contact with the family just prior to her death, concerns for her safety also do not appear to have been considered.

51. It should also be noted that the cultural background of both Ms ZT, her sister, brother in law and in-laws may have played a role in their identification and knowledge of family violence. The Royal Commission into Family Violence (**The Royal Commission**) found that '*factors influencing attitudes to family violence in CALD communities include broader social norms relating to both gender and violence*.'[49] The 2013 National Community Attitudes toward Violence Against Women Survey also found that '*people born in a country in which the main language is not English are **less likely** than the Australian-born to have a:*

- *high level of understanding of violence against women*
- *low level of endorsement of violence-supportive attitudes*
- *high level of support for gender equality*.'[50]

52. There are a multitude of factors influencing these results, including broader social norms relating to both gender relations and to violence. Whilst the evidence is not conclusive as to whether Ms ZT's relatives held these beliefs, it is possible that the cultural norms played a role in their response to signs that Ms ZT was experiencing family violence.[51]

53. In an effort to address the barriers that third parties face in obtaining access to information about family violence and providing information and assistance to victims of family violence, the Royal Commission reviewed the available resources for third parties.

54. At its conclusion, predominantly by way of recommendations 10 and 37, the Royal Commission encouraged the adoption of a model whereby third parties (as well as victims and perpetrators

[49] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 5, 106
[50] VicHealth, Victorian Health promotion Foundation (2014), *Australians' attitudes to violence against women. Findings from the 2013 National Community Attitudes Towards Violence Against Women Survey,* 77.
[51] Ibid.

of family violence) can access information via a website to assist in recognising family violence and how to seek help, both in the crisis period and during longer term recovery.[52]

55. This Court is advised that the Victorian Government has selected the Orange Door[53] website as the most suitable existing site with the capacity to develop into a space for the delivery of accessible information for those experiencing, witnessing and being affected by family violence. The Court is also informed that, in line with the Royal Commission's recommendation, the website is now currently in operation.[54]

56. In light of the comprehensive nature of the Royal Commission's work in this regard, I support the recommendations put forward, specifically in this case as they relate to the issue of assisting third parties to educate and assist both perpetrators and victims of family violence.

57. In Ms ZT's case, education and information via a website, such as the Orange Door website, may have provided an initial avenue for family members and friends to assist her, while the Orange Doors may have provided an opportunity to report concerns and create more tangible opportunities for intervention and prevention. The challenge for informal supporters assisting persons affected by family violence is often knowing what information and services are available and how to access these supports.

Campbell Page Employment Services

58. Campbell Page Employment Services (Campbell Page) is a not for profit organisation funded by the federal Department of Human Services (DHS), to support individuals who are receiving Centrelink benefits to engage in and find employment. Mr BR was referred by Centrelink to Campbell Page in 2014 and was an intermittent client of Campbell Page's Disability Employment Services until the time of the fatal incident.[55]

59. On 10 June 2016, Mr BR attended Campbell Page seeking assistance in finding employment. During this appointment, Mr BR was accompanied by his eldest child, noting that his wife was sick and unable to look after the child.[56] Mr BR was observed to have injuries to his hands and advised that these were from gardening. Mr BR was also noted as acting aggressively towards

[52] Victoria, Royal Commission into Family Violence, Recommendation 10
[53] http://orangedoor.vic.gov.au
[54] http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=12>; *The Lookout* website can be found at http://www.thelookout.org.au
[55] Coronial Brief, Statement of P Konnolou, 716.
[56] Coronial Brief, Statement of I Bilgili, 706.

staff and at one point, '*turned to his child and started shouting at him*'[57] in Arabic, causing the child to become scared and turn away.[58]

60. Another employee who witnessed the encounter and spoke Arabic provided a translation to Mr BR's employment consultant following the appointment. This employee advised that Mr BR had told his son that he was '*like a dog and like that [the employment consultant] and that [DR] need [sic] to behave as the little kid knows what would happen at home*'.[59] Following the appointment, the employment consultant advised her manager that she was '*scared*'[60] of Mr BR '*and did not feel safe*'[61] and it was arranged that Mr BR would meet with the manager at the subsequent appointment.

61. On 14 June 2016, Mr BR met with his employment manager and was accompanied by his three children. During this appointment, Mr BR and his children were observed to be dirty and '*their clothes appeared to have long term dirt in them and they were unwashed and unclean and running around*.'[62]

62. On 23 June 2016, Mr BR met with his usual employment consultant and was accompanied by all three of his children. Mr BR was questioned about the children's schooling during this appointment and he advised that '*his wife was from Lebanon and teaching the children the Koran'*.[63] All three children were again observed to be dirty and Mr BR was also recorded as noting that '*he would go to Syria to fight the Jihad. He said he would not be in Australia long as he was going to Syria for Jihad*'[64] and that his employment consultant did not need to find him employment.

63. Given that Mr BR's employment consultant was alarmed enough by Mr BR's behaviour that she requested the Manager take future appointments, it is concerning that no consideration was given to the welfare of the children in his care. Had Campbell Page reported these concerns to Child Protection, it is possible that services may have contacted Mr BR and that further enquiries may have uncovered some of the abuse occurring in the home. This was a missed opportunity for intervention.

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[57] Ibid.
[58] Ibid.
[59] Ibid.
[60] Ibid, 707.
[61] Ibid.
[62] Coronial Brief, Statement of P Konnolou, 717.
[63] Coronial Brief, Statement of I Bilgili, 707.
[64] Ibid, 708.

64. Campbell Page advised that in 2016 and at present they do 'not have a specific child welfare policy attached to this program'[65] but cited two organisation wide policies that '*ensure safe environments for vulnerable clients including children and an incident reporting and monitoring framework'*.[66] Campbell Page advised that a '*specific child welfare and safety policy' has not been introduced 'as the vulnerable persons policy continues to cover this'*.[67]

65. The Campbell Page Vulnerable Persons policy advised that staff;

> *…may engage an external Child Safety Officer to provide expert advice and support to children, parents, employees and volunteers regarding the safety and well-being of children utilising our services…Where an employee suspects child abuse or neglect they should refer to the requirement of the State and then discuss immediately with their Manager. With Manager approval the worker may call the relevant State Authority.*[68]

66. Whilst this policy does provide some instruction for employees concerned about child abuse, it makes specific reference to actions relating to 'children utilizing' the services of Campbell Page. Furthermore, the policy provides no specific guidance as to what constitutes suspected child abuse or neglect and the signs that staff should remain alert too. It is also unclear what level of training staff receive in relation to these obligations.

67. Campbell Page advised that in 2014 their South Australian division introduced the Child Safe Policy.[69] This policy '*details workers obligations into [sic] reporting child abuse and neglect'*.[70] This policy advises that '*employees and volunteers have an obligation to notify the Child Abuse Report Line…. as soon as practicable if they have a reasonable suspicion that a child has been, or is being, abused or neglected*.'[71] The document also details incidents of abuse or neglect but fails to provide practical information regarding the signs and symptoms of neglect or abuse.

68. Developing the capacity of workforces engaged with vulnerable communities to recognise the signs and symptoms of child abuse and how to respond is vital to promoting community safety and wellbeing. Staff employed in services such as Campbell Page come into contact with vulnerable populations on a daily basis and are in a unique position to refer families to additional support if they identify concerns.

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[65] Ibid, 2.
[66] Ibid.
[67] Ibid.
[68] Campbell Page, *Vulnerable Persons policy*, 4.
[69] Campbell Page, Statement of Natalie Turmine, 1.
[70] Campbell Page, Child Safe Policy South Australia, 1.
[71] Ibid, 4

69. The available evidence suggests that Campbell Page staff were preoccupied with their own safety and did not consider the risks posed to the children in Mr BR's care. This indicates that staff may be unaware or ill equipped to identify and respond to these issues, and policies and procedures appear to provide little support to staff in these instances.

70. Campbell Page provided a further response to the Court noting that they are currently:[72]

(a) Adopting their Child Safety Policy across all States and Contracts. This Policy is tailored to each State's specific requirements, and will cover child clients as well as children of clients, and whilst most staff are not mandatory reporters this will provide greater guidance to staff to identify and respond to signs and symptoms of child abuse and neglect.

(b) They will roll out staff training, Q&A sessions and FAQs for staff to understand their requirements under the policy and to recognise child abuse and neglect and how to respond in these instances.

(c) The policy will cover their responsibilities, to identify and respond to signs of abuse or neglect, including how to appropriately escalate any concerns.

(d) They will include specific Child Safety policy training into their staff induction and training.

(e) They are also in the final stages of obtaining our White Ribbon Accreditation. Campbell Page have worked in partnership with White Ribbon Australia to update their policies and training for staff to identify the risk factors indicating the presence of family violence.

Maternal Child Health Services engagement with Ms ZT

71. Ms ZT and Mr BR attended appointments at Maternal and Child Health (MCH) services in Hume City Council in relation to her two oldest children. Entries indicate that Mr BR provided interpreting services for Ms ZT during some of these appointments.[73]

72. In September 2011, MCH staff were notified by Northern Health that Mr BR had previously displayed dominating and aggressive behaviour towards hospital staff[74] and were made aware of 'indicators of the husband's controlling behaviour'[75] towards Ms ZT.

[72] Correspondence from Campbell Page - Natalie Turmine dated 17 July 2020, 1-2
[73] Coronial Brief, Maternal and Child Health Records, 1004, 1005, 1006 and 1012
[74] Coronial Brief, Maternal and Child Health Records, 1007
[75] Correspondence received from Hume City Council Maternal Child Services dated 18 October 2018, 2

73. A review of the MCH records indicate that Ms ZT was asked by MCH staff on 12 occasions between 13 September 2011 and 5 November 2014 whether she was experiencing or had previously experienced family violence.[76] In all instances, Ms ZT denied experiencing family violence, however, MCH were unable to confirm their presumption that Mr BR had left the room when these enquiries were made.[77] MCH services also advised the Court that Ms ZT had presented to appointments wearing a Niqab[78], which had meant that staff were not able to '*observe any physical indicators of abuse'*.[79]

74. It should be noted that Ms ZT's sister-in-law was a MCH nurse and undertook the 18 month Key Ages and Stages assessment of [redacted] on 5 March 2013. The Court has been informed that management were made aware of this at the time of the appointment and that the '*staff member was subsequently counselled about the requirement of professional practice as a MCHN and all staff were informed of the Code of Ethics concerning professional boundaries'*.[80] The placement of Ms ZT's sister-in-law as a MCH nurse may have impacted on Ms ZT's willingness to disclose any experiences of family violence during this appointment and throughout her engagement with the service.

75. Practice guidelines in place at the time of Ms ZT's engagement with MCH services indicate that questions regarding a woman's experience of family violence must be asked during the four-week Key Ages and Stages Consultation and may be asked at any appointment if professional judgement warrants it.[81] These guidelines did not, however, stipulate conditions in which these questions should be asked and made no reference to the need to ensure that the partner was absent when making these enquiries.

76. *Maternal and Child Health Service guidelines* introduced in 2019 and the *Maternal and Child Health Services practice guidelines 2009*, reissued in 2019, do not provide any further clarification on this and do not indicate that these questions must be asked whilst the mother is alone as a matter of standard practice.

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[76] Ibid, 1
[77] Ibid, 2.
[78] A Niqab is a veil that covers the face, leaving only the area around the eyes visible. Some women may choose to accompany this with an eye veil.
[79] Hume City Council, Statement of Maternal and Child Health Services, 2.
[80] Ibid, 1.
[81] Department of Education and Early Childhood Development, Victorian Government (2009) *Maternal and Child Health Service: Practice Guidelines 2009*; Department of Education and Early Childhood Development, Victorian Government (March 2009) *Maternal and Child Health Service: Key Ages and Stages Framework.*

77. Mr BR had previously demonstrated a willingness to accept direction from medical staff if the request was explained as being a part of standard procedure.[82] Given this, it is possible that Mr BR may have permitted Ms ZT to meet with MCH staff alone had this or similar explanations been given. In the absence of guidance available to MCH, the success of isolating a mother to make these enquiries is reliant on the ingenuity of the attending MCH nurse.

78. In 2018, the Victorian Government introduced the use of 'family violence consultations'.[83] The *Additional Family Violence Consultation- Practice Note for Maternal and Child Health Nurses* (Practice Note) advises that MCH nurses may consider having a family violence consultation if:

- *the MCH nurse was unable to complete the family violence questions because the partner or other family members were present; or*
- *family violence has been disclosed or identified and more time is required for discussion or to complete a safety plan; or*
- *the MCH nurses suspects the family is experiencing family violence and requires additional time for exploration and discussion; or*
- *the MCH nurse or family member/s require a joint consultation with a specialist family violence practitioner*.[84]

79. Whilst the Court welcomes the introduction of these consultations, it is worth noting that the Practice Note fails to provide MCH staff with guidance as to how they may safely engage a woman without their partner being present for the purposes of arranging the consultation or conducting it. The Practice Note also fails to provide any suggestion as to how MCH may manage situations where a suspected perpetrator refuses to allow their partner to be left alone.

80. Given the lack of direction provided in the *Maternal and Child Health Service guidelines, Maternal and Child Health Services practice guidelines 2009* and the *Additional Family Violence Consultation- Practice Note for Maternal and Child Health Nurses*, I have made recommendations below that these documents be updated to indicate that family violence enquiries must be asked whilst the mother is alone as a matter of standard practice. It is also suggested that these documents be updated to provide staff with guidance on how to arrange family violence consultations with a mother, to manage instances in which the partner declines

[82] Coronial Brief- Attachment Material 3, Statement of C Fletcher, 743.9-743.10; Coronial Brief- Attachment Material 3, Statement of C Barca, 743.14.
[83] Department of Health and Human Services, Victorian Government (2019) *Maternal and Child Health Service guidelines,* 10; Department of Health and Human Services, Victorian Government (2018) *Additional family violence consultation- practice note for maternal and child health nurses*.
[84] Department of Health and Human Services, Victorian Government (2018) *Additional family violence consultation- practice note for maternal and child health nurses*, 6.

to leave the mother alone and how to manage suspected perpetrators of violence. Maternal Child Health staff will also require additional training to support the implementation of these updated guidelines.

Use of Interpreters in health care settings

81. MCH records confirm that one of MCH nurse's seen by the family was multilingual and spoke Arabic, however, it is unclear how many appointments were attended with this nurse and Mr BR is documented as interpreting for Ms ZT during several appointments.[85] MCH also acknowledge this in their statement to the Court and note that 'there were indicators of the husband's controlling behaviour such as attending all KAS assessments and interpreting for Ms ZT'.[86]

82. Historic and current MCH guidelines do not provide advice on the use of family members as interpreters for women visiting MCH services. Instead, employees are referred to the Department of Health and Human Service's *Language Services Policy* which stipulates that:

> *Family members should not be used as interpreters…In situations of suspected or actual family violence, using perpetrators, children or any other family members as interpreters presents an unacceptable risk and should not be undertaken. Every reasonable effort must be made to use an accredited interpreter before a family member or friend of the client asked [sic] to assist.*[87]

83. This policy guidance does not appear to have been adhered to during Ms ZT's engagement with MCH services and the available evidence indicates that these considerations were not considered in current iterations of the policies and procedures governing the practice of MCH staff. Given that MCH were aware that Mr BR had demonstrated controlling and aggressive behaviours and that there was some concern regarding their relationship, it would have been prudent for staff to insist on using an interpreter. MCH staff could also have considered consulting with a family violence specialist service to get advice about engaging with Ms ZT without further endangering her relationship with Mr BR

84. Given that Mr BR is documented as having previously agreed to using an interpreting service during Ms ZT's antenatal care[88] and for some of Ms ZT's MCH appointments[89], this should

[85] Ibid; Coronial Brief, Maternal and Child Health Records, 1004, 1005, 1006 and 1012.
[86] Hume City Council, Statement of Maternal and Child Health Services, 2.
[87] Department of Health and Human Services, Victorian Government (2017) *Language services policy*, 16.
[88] Coronial Brief- Attachment Material 3, Statement of C Fletcher, 743.9-743.10; Coronial Brief- Attachment Material 3, Statement of C Barca, 743.14.
[89] Coronial Brief, Maternal and Child Health records, 1006.

have been employed in all subsequent appointments. More generally, this should be standard practice for all MCH appointments in order to avoid instances in which perpetrators of violence are providing interpreting services for victims, and to ensure that parents and caregivers are provided with the information necessary to make informed decisions regarding their children's health.

85. Ms ZT was a victim of violence perpetrated by Mr BR, the use of Mr BR as her interpreter placed Ms ZT's welfare at risk and provided Mr BR with a further opportunity to exercise control over Ms ZT's access to information and support.

Ms ZT's children and concerns regarding their non-attendance at school

86. At the time of the fatal incident, Ms ZT and Mr BR's eldest child, DR, was aged six and a half years and was not enrolled in and had never attended school or kindergarten. Attending school plays an important role in monitoring the safety and wellbeing of children and their families within their community. When a child is not enrolled in school, they remain isolated from the broader community, allowing for welfare and wellbeing issues to go undetected.

87. Examinations of DR following the fatal incident found that DR had most likely been exposed to '*many incidents of violence and abuse*'[90] which had resulted in him presenting with '*post traumatic symptoms, behaviours and disrupted emotional and psychological development*'.[91] Upon removal from the family home, DR's '*communication was limited*'[92] and he had developmental delays. In addition, DR displayed behaviours symptomatic of significant and long term exposure to abuse.

88. Had DR been engaged in school, it is likely that these behaviours or other signs of abuse would have come to the attention of staff and would have led to statutory or non-statutory interventions. These interventions would have engaged Ms ZT and may have reduced the likelihood of her and the children remaining in the home.

89. The Court sought clarification from the Department of Education and Training (DET) who advised that under the *Education Training and Reform Act 2006 'parents and carers have an obligation to enrol children of compulsory school age (6 to 17 years old, inclusive) in a registered school or to register them in home schooling'*.[93] In order to monitor compliance with

[90] Coronial Brief 2, Victim Impact Statement- DR, 164.
[91] Ibid.
[92] Ibid.
[93] Correspondence received from Department of Education and Training, Lucy Toovey dated 6 February 2019, 1

these obligations, DET has access to several databases including the Victorian Student Register and has information sharing protocols in place with kindergartens across the State.

90. DET only become alerted to school aged children who are not enrolled in education, when the child has previously been enrolled in school and transfers or disengages from education, or when the child has attended kindergarten and then fails to proceed to school.[94] Outside of these monitoring systems, DET advised that members of the public and service providers may also report the non-attendance of a child at school.[95]

91. DET have advised that the Child Information Sharing Scheme (CISS) will assist in increasing efforts to monitor the identification of school aged children who have never been engaged with education.[96] As noted in their statement, the CISS allows authorized agencies to share information pertaining to a child's safety or wellbeing. Phase Two of this scheme came into effect in 2020 and encompasses universal services into the scheme.[97] As a part of this work, the Child Link digital register is also anticipated to be operation in 2022 and will '*produce a single child profile for every Victorian child displaying factual data about a child's enrolment and participation in government services*'[98] by drawing '*together information from existing government information management systems that hold information relevant to child wellbeing and safety'*.[99] This presumably includes services such as Maternal and Child Health Services and will result in children becoming known in the Child Link system from an early age.

92. Given that Ms ZT's youngest children were engaged in Maternal and Child Health Services, had the tool been in existence in the period proximate to the fatal incident, it may have alerted DET that DR was not enrolled in school. This in turn, may have also prompted further investigations and statutory interventions.

93. DET have further confirmed Child Link will be a web-based platform that will display consolidated information about Victorian Children from birth to 18 years of age to authorised professionals known as Child Link users.[100] The information displayed is legislated and includes key identifying facts about a child and their family and information about the child's participation in a range of government funded services including Maternal and Child Health,

[94] Ibid, 1-3.
[95] Ibid, 3.
[96] Ibid, 6.
[97] Ibid.
[98] Ibid, 7.
[99] Office of the Victorian Information Commissioner (2019, *Child information sharing scheme and privacy law in Victoria- frequently asked questions*, 9.
[100] Correspondence received from Department of Education and Training, Lisa Gandolfo dated 13 July 2020, 1

supported playgroup, kindergarten, government and non-government schools and home school. Child Link will also indicate whether there has been any child protection orders in place associated with the child or a sibling, including whether the order places the child in out of home care and whether the child identifies, or has been identified as, Aboriginal and/or Torres Straight Islander.[101]

94. The majority of authorised Child Link users will be able to view information about children in their own service, whilst some key roles in departments and commissions will have a boarder view. Child Link will become operational by December 2021, with Child Link users progressively onboarded from December 2021 and through 2022. Child Link will draw Maternal and Child Health, supported playgroup and Child Protection data provided by Department of Families, Fairness and Housing (DFFH), as well as kindergarten and school enrolment data from the Department of Education and Training (DET) and its associated authorities.[102]

95. DET confirm that through Child Link, they will be able to identify school-aged children who are not enrolled with an education provider. Child Link will receive information including the date of birth of the child and information in relation to registered schools or home schooling that the child has accessed, enrolled in, or registered for.[103]

Victoria Police welfare checks

96. Victoria Police attended the residences of Mr BR and Ms ZT multiple times between 2011 and the fatal incident.[104] Victoria Police records provided to the Court confirm that there were 25 events that were reported to 000 and that the police did not attend every single reported event.

97. Whilst there are some events recorded which are of concern, particularly 20 February 2012 - AV reported witnessing a man punching a woman in a vehicle[105] and 2 February 2016 - neighbours hears ranting and raving in Arabic and being loud and aggressive, these events were isolated and police members determined that the circumstances did not warrant a welfare check.

98. Victoria Police provided a response to the Court confirming that there is no policy or procedure within the Victoria Police Manual (**VPM**) which directly relates to the subject of welfare checks

[101] Ibid
[102] Ibid, 2
[103] Ibid
[104] Victoria Police records provided to the Court dated 14 August 2020
[105] Victoria Police notes record that they called back the Ambulance paramedics who did not recall the incident reported.

or prescribes how a welfare check is to be conducted.[106] The VPM does not attempt to prescribe responses because of the very broad range of circumstances which may be encountered by police members when responding to a particular call or job.

99. Victoria Police further clarified that:

(a) In response to recommendations arising from the investigations into the deaths of Rachel Mihail[107] and Janet Foster[108], Victoria Police Corporate Policy commenced a review of those chapters within the VPM which may relate, albeit indirectly, to the issue of welfare checks. This review involved input from Crime Command, State Emergencies and Support Command, and the Centre for Law and Operational Development within People Development Command. Corporate Policy concluded that the VPM provides adequate direction, when coupled with their training, for police members to undertake their general duties, including the processes and responsibilities involved in responding to a request for a welfare check.

(b) The manner in which police members respond to calls which may involve a request or a need for a welfare check is guided by the risk assessment applied by the members to that particular set of circumstances. All police members receive foundational training in the processes of information gathering and risk assessment. In addition, they receive 'on the job' training and guidance in respect of all aspects of general duties patrol response including the conduct of welfare checks.

(c) Police members are expected to draw upon their training and experience (which includes the experience of colleagues) to guide their response. When police members are in doubt or require further guidance, they are expected to seek direction from the patrol supervisor or other appropriate senior members. In this way the police response should be appropriate to the circumstances, demonstrate sound judgement and reflect contemporary organisational and community expectations.

[106] Victoria Police response dated 4 September 2020
[107] COR 2017 5903
[108] COR 2016 2544

RECOMMENDATIONS PERSUANT TO SECTION 72(2) OF THE ACT

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

Recommendation One:

That the **Department of Health** update the *Maternal and Child Health Service guidelines* and the *Additional Family Violence Consultation- Practice Note for Maternal and Child Health Nurses* to indicate that family violence enquiries must be asked whilst the mother is alone as a matter of standard procedure and what strategies are best adopted to achieve this. Appropriate training must also be provided to staff performing these tasks.

Recommendation Two:

That the **Department of Health** also review the *Maternal and Child Health Service guidelines, Maternal and Child Health Services practice guidelines 2009* and the *Additional Family Violence Consultation- Practice Note for Maternal and Child Health Nurses* with a view to update these guidelines to provide staff with guidance on how to arrange a family violence consultation with a mother, to manage instances in which the partner declines to leave the mother alone and how to manage suspected perpetrators of violence.

Recommendation Three:

That the **Department of Health** update the current policies and procedures governing the practice of MCH staff to reflect the guidelines provided in the Department of Families, Fairness and Housing's *Language Services Policy*, specifically that family members are not to be used as interpreters in a health service setting.

Recommendation Four:

That **Services Australia** consider requiring all contractors who provide social services funded programs adopt a Child Safety Policy across all locations that they operate. This policy should be State specific, refer to child clients as well as children of clients, and provide greater guidance to staff on the signs and symptoms of child abuse and neglect. This should be supported by training for staff in recognising child abuse and neglect and how to staff may respond in these instances.

Recommendation Five:

That **Victoria Police** consider updating guidance to indicate that police members should consider undertaking a welfare check on residents in instances where there are repeated incidents reported to emergency services requesting police attendance and where incidents are described as "*violent or possibly family violence related*". This should also be considered as part of the training and guidance for police members when assessing whether a welfare check is required or not.

Recommendation Six:

I reiterate my previous recommendation in the coronial findings in the cases of the deaths of Mrs FS[109] and Mrs K.[110] I recommend that the **Victoria Government** and **Family Safety Victoria** develop a research-based strategy, in consultation with victim survivors, informal supporters and priority communities, to provide targeted information and services to informal supporters assisting persons affected by family violence.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was ZT, born 23 March 1982;

(b) the death occurred on 17 June 2016 at [redacted] Victoria from 1(a) Multiple sharp force injuries; and

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

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

103. I convey my sincere condolences to Ms ZT's family for their loss.

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

[109] COR 2017 2423
[110] COR 2017 1889

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

Ms NT, Senior Next of Kin

Ms Natalie Turmine, Chief Executive Officer, Campbell Page

Ms Jenna Atta, Secretary, Department of Education and Training

Professor Euan Wallace, Secretary, Department of Health

Department of Premier and Cabinet Family Violence and Service Delivery Reform Unit

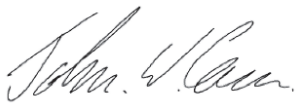
The Honourable Linda Reynolds, Minister for Government Services, Services Australia, Australian Government

Ms Eleri Butler, Chief Executive Officer, Family Safety Victoria

Ms Lauren Callaway, Assistant Commissioner, Family Violence Command, Victoria Police

Detective Senior Constable Miranda Stubbs, Coroner's Investigator

Signature:



JUDGE JOHN CAIN

STATE CORONER

Date: 15 May 2021

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