Secretary

Department of Families, Fairness and Housing

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Victoria Cullinan
Coroners Registrar
Coroners Court of Victoria

By email: cpuresponses@coronerscourt.vic.gov.au

Dear Ms Cullinan

I refer to your correspondence of 10 January 2025 attaching a Form 38 issued to the Secretary, Department of Premier and Cabinet, requiring a written response to the recommendations made in Coroner McGregor's Finding into Death Without Inquest (Finding) of [redacted] (ref COR 2021 003935).

I would like to extend my deepest condolences to [redacted] family and loved ones.

The Coroner's recommendations

Coroner McGregor made three recommendations in his Findings. Recommendations 1 and 3 are directed to the Victorian Government:

1. *That the Victorian Government fund further research into the link between family violence and suicide.*

3. *That the Victorian Government resource an expansion of co-responder programs across Victoria.*

These two recommendations refer to matters that primarily sit with the Prevention of Family Violence portfolio in the Department of Families, Fairness and Housing (the department, DFFH), so have been referred to me for my consideration and response.

Recommendation 2 is directed to Austin Health.

Response to recommendation 1: That the Victorian Government fund further research into the link between family violence and suicide.

The Coroner's recommendation is under consideration.

Work is underway across government to understand and provide guidance on the intersection of family violence and suicide, as demonstrated by the following sub sections.

Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)

The department recognises and supports the need for meaningful and reliable data and research to inform the intersection between family violence and suicide prevention and appropriate responses.

Existing MARAM practice guidance recognises the link between family violence and suicide risk. Materials related to the identification, assessment and management of family violence risk also contain clear guidance to support identification of suicide risk and self-harm. DFFH worked with the Suicide Prevention and Response Office (SPARO) in the Department of Health (DH) to develop these materials and ensure they reflect current evidence and best practice.

The adults using family violence-focused MARAM practice guides and training packages[1] cover how to identify and respond to suicide risk, including in the context of homicide risk. This content is based on the practice guidance material developed in collaboration with SPARO.

The independent MARAM 5-year Evidence Review did not specifically identify a need for additional research to explore the link between family violence and suicide. However, the review noted that suicide and self-inflicted injuries are health consequences of intimate partner violence. This review was completed under section 194 of the *Family Violence Protection Act 2008* (Vic) (the Act), which requires periodic reviews[2] of MARAM to ensure it reflects the current evidence base for family violence risk assessment and management.

The Victorian Government is committed to ensuring the MARAM Framework continues to reflect evidence based best practice. In 2024, the Governing Council for the Victorian Social Investment Integrated Data Resource (VSIIDR) approved MARAM risk assessment data from the Tools for Risk Assessment and Management (TRAM) platform to be added to the linked dataset. TRAM is used by The Orange Door and a range of community agencies, including services for victim survivors, adults using family violence, and child and family services, to undertake risk assessment and risk management. The platform collects information on family violence risk factors and the levels of risk present for victim survivors, in addition to risk factor information relating to mental health and suicidality. The addition of family violence risk factor data to VSIIDR will support future data analysis and research relating to the intersections between family violence and suicide risk.

The Victorian Government plans to release the child and young person-focused MARAM practice guides and tools in 2025. These practice guides and tools will include screening/identification of suicide and self-harm risk, with guidance for practitioners on steps

[1] From November 2023, the department has engaged No to Violence (NTV) and Safe and Equal to deliver the MARAM: Adults using Family Violence (AUFV) learning program.
[2] Up to every five years.

to take. The development of the guidance to identify and respond to suicide risk in the practice guides has been informed by:

- The Commission for Children and Young People's *Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection*
- Meyer et al's *Missing figures: The hidden role of domestic and family violence in youth suicide – current state of knowledge report*
- The Australian Institute of Health and Welfare's Suicide and self-harm monitoring data
- Advice from the Suicide Prevention and Response Office, DH.

The practice guides and tools are a mechanism to raise awareness of the intersection between family violence and suicide, specifically related to those under 25 years of age.

From 2026, updates to the MARAM Framework and adult victim survivor-focused MARAM practice guides will seek to strengthen guidance on identifying and responding to suicide risk for victim survivors of family violence. This will align it with the work undertaken since 2019 to recognise the link between suicide and family violence risk in the adults using family violence practice guides and the forthcoming child and young person-focused practice guides. If further research is required to enhance the system response to suicide risk for victim survivors of family violence as part these updates, this will be considered from 2026.

Victorian Suicide Prevention and Response Strategy 2024-2034

In September 2024, in response to recommendation 26 of the Royal Commission into Victoria's Mental Health System, the Victorian Government launched the Victorian Suicide Prevention and Response Strategy 2024-2034 (the strategy). The strategy aims to build a systems-based, evidence-informed, whole-of-government and community-wide approach to suicide prevention and response. It has been developed together with people with a lived or living experience of suicide and was shaped by extensive consultation with clinicians, people who work with people disproportionately impacted by suicide and other experts in the field.

The strategy engages with the substance of the Coroner's recommendations under:

- Priority Area 1: Build and support connected systems, and
- Priority Area 6: Build on and use data and our evidence base in delivery and evaluation.

The first implementation plan 2024-26 includes Initiative 1.7 under Priority Area 1, which is to build an understanding of connections between family violence, sexual offending and suicide to identify key intervention points to support coordinated prevention and response efforts, including opportunities to strengthen referral pathways and service responses. In delivering this initiative, DFFH will work in partnership with DH and Victoria Police. Further, under Priority Area 6, Initiative 6.4 is for DFFH and DH, with input from the Coroners Court of

Victoria, to explore opportunities for linking additional family violence data sets to better identify contributing factors for suicide and points of intervention.

To support implementation, an accountability framework and rolling implementation plan accompany the strategy. This approach will enable the Victorian Government to respond flexibly to emerging issues and new evidence across the life of the strategy, and shift approaches, as required, following evaluations.

Response to recommendation 3: That the Victorian Government resource an expansion of co-responder programs across Victoria.

The Coroner's recommendation is under consideration.

The department supports in principle the intent of the recommendation to achieve greater connection between specialist family violence services and operational policing. This recommendation is similar to State Coroner Judge Cain's recommendations in the inquest into the death of Noeline Dalzell (COR 2020 000670), which is also under consideration by the department. The department will work with Victoria Police to consider options that could address the intent of the recommendation. Implementation of any option will be dependent on appropriate resourcing, prioritisation, and established program guidance and requirements.

Yours sincerely

Peta McCammon
Secretary

11/04/2025