IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000596

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	HCG
Date of birth:	15 August 1981
Date of death:	31 January 2021
Cause of death:	1(a) Unascertained
Place of death:	Thomson, Victoria, 3219
Keywords:	Family violence; intimate partner violence; mental ill-health; specialist family violence services; lack of specialist accommodation

INTRODUCTION

1. On 31 January 2021, HCG was 39 years old when she was found deceased at her home in Thomson, Victoria. At the time of her death, HCG lived with her partner, MEK in Thomson, Victoria.

2. At the time of her death, HCG had a (then) 21-year-old daughter, LKM, and six-month-old son, who was in LKM's full-time care.[1] HCG was also about four months pregnant at the time of her passing.

Background – HCG

3. HCG's mother passed away in 2018 from complications of drug and alcohol use and not much is known about HCG's childhood. Her medical history included anxiety/depression, alcohol misuse and asthma.[2] HCG's brother, ADP, noted that she consumed one to one and a half bottles of alcohol per day, she smoked cigarettes and used methylamphetamine.[3] ADP also reported that his sister "*never really had a stable house*".[4]

4. Evidence available to the Court suggests that several of HCG's former male partners perpetrated family violence against her.[5] HCG did not have any criminal convictions, however she was on bail at the time of her passing for alleged offending against her stepfather, with whom she would stay when she needed to escape MEK.[6]

Background – MEK

5. MEK was 42 years old at the time of the fatal incident. Little is known about his childhood or early adulthood; however, he told a psychologist that there were no problems in his family of origin.[7] His medical history included anxiety and depression.[8]

6. MEK had two children with his former wife, who did not have any contact with him at the time of the fatal incident.[9] Evidence available to the Court suggests that MEK perpetrated family violence against his children and three former partners, including his ex-wife. The

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1 Coronial Brief (**CB**), Statement of LKM, 24.
2 First Point Medical Centre records, 104.
3 CB, Statement of ADP, 26.
4 Ibid.
5 Ibid; Matchworks case notes, 12.
6 Victoria Police Family Violence-Related Death Assessment (**FDA**), 23.
7 Hello Bloom/Well Inspired Psychology, records of MEK, 30.
8 East Geelong Medical Centre, Records of MEK, 19-20.
9 CB, Child Protection notes, 166.

alleged abuse included physical assaults, controlling behaviour, property damage, sexual violence, systems abuse and psychological abuse.[10] ADP's former wife detailed similar allegations to the allegations of violence he perpetrated against HCG, including allegedly assaulting her in public, attempting to take her handbag, and multiple Family Violence Intervention Order (**FVIO**) contraventions.[11]

7. MEK had an extensive criminal history including convictions for assault and contravening or persistently contravening FVIOs.[12] The available evidence does not include much information regarding his use of drugs or alcohol, however professionals observed MEK to be substance affected at times[13], HCG suspected he was using drugs, and she believed his substance use made him more aggressive.[14]

8. The available evidence suggests that MEK subscribed to traditional and rigid views about gender equality and violence against women, and these views persisted despite his engagement with Men's Behaviour Change Programs (**MBCPs**). MEK reported that he liked "*the traditional breadwinner type male role model*"[15], he held patriarchal beliefs that "*the man was in control*" and tried to control MBCP sessions, particularly when a female worker was present.[16] He was also observed to have poor impulse and emotional control which "*result[ed] in violent outbursts*".[17] Family violence service providers noted that MEK appeared to be unable or unwilling to acknowledge his use of family violence and lacked insight into his behaviour.[18]

9. From 2017 until the time of the fatal incident, MEK completed one MBCP and commenced (but did not complete) three further MBCPs. He was mandated to complete the MBCPs in the context of Child Protection and/or Community Correctional Services (**CCS**) involvement.[19] These programs did not appear to have any impact on his behaviour, nor improve his insight

[10] Coronial brief, Child Protection notes, 165-6; Victoria Police, FDA , 20; Bethany Community Support, T MEK FV Risk Profile, 1; The Orange Door, Records of HCG, 2.
[11] Victoria Police, FDA for HCG, 20.
[12] CB, Criminal history of MEK, 201-5.
[13] Victoria Police, FDA for HCG, 18.
[14] CB, Police family violence reports, 191; L17 Portal, Records for HCG and MEK, 47-49.
[15] Bethanny Community Support, Summary details for MEK, 44.
[16] Bethany Community Support, MEK Risk Profile, 1.
[17] CB, Child Protection records, 165.
[18] CB, Child Protection records, 166, 175, 176; Bethany Community Support, MEK Risk Profile, 1.
[19] Relationship Matters/Lifeworks, Records of MEK, 8; Bethany Community Services, MEK internal referral, 2; CB, Child protection records, 176; Bethany Community Support, MEK FV Risk Profile, 1.

into same. In late-2020, MEK told a counsellor that he and HCG had a "*healthy relationship*"[20] and alleged that he was subject to "*mild spousal abuse*" from HCG.[21]

Relationship background

10. HCG and MEK commenced their relationship in 2019 which was characterised by frequent separations from that time until the fatal incident.[22] It is not clear if the property in Thomson, was in MEK's name or HCG's name, however it was usually HCG who left the address when the pair argued or MEK was abusive.[23] Furthermore, it was HCG who attempted to secure alternative housing for herself.[24]

11. There is extensive evidence available in the records provided to the Court to suggest that MEK was abusive to HCG throughout their relationship, including:

    a) Frequent physical abuse including pushing, kicking, hitting, causing a black eye, smashing her head against a wall, punching her in the stomach while heavily pregnant and chasing her down the road[25];

    b) Verbal abuse[26];

    c) Emotional abuse including threats[27;]

    d) Financial abuse[28];

    e) Controlling behaviour including obstructing HCG's access to services, taking her phone and breaking it, and making changes to supervised contact with their son without her knowledge[29];

[20] Hello Bloom/Well Inspired Psychology, Records of MEK, 62
[21] Hello Bloom/Well Inspired Psychology, Records of MEK, 30.
[22] CB, Statement of LKM, 23.
[23] Safe Steps, records of HCG, 5; CB, Child Protection records, 172-3; The Orange Door, Records of HCG, 46.
[24] The Orange Door, Records of HCG, 15, 29, 22-3, 46, 121, 127 279; Safe Steps, records of HCG, 2-5; Bethany Community Support, 24.09.2020 – Phone call, HCG; CB, Child Protection notes, 175.
[25] Victoria Police, FDA of HCG, 17; CB, Statement of LKM, 24-5. CB, Child Protection records, 170-172; CB, Statement of JCP, 18.
[26] Victoria Police, FDA of HCG, 12-3, 16; CB, Child Protection records, 167-8; CB, Statement of LKM, 24; CB, Child Protection notes, 175; CB, Statement of JCP, 18.
[27] CB, Child Protection records, 172.
[28] CB, Child Protection records, 172.
[29] Victoria Police, FDA of HCG, 13; CB, Child Protection records, 164, 172-3.

12. MEK reportedly told police that he had chased or restrained HCG for her own safety, including an incident on 1 January 2021, when a member of the public observed him chasing and screaming at HCG.[30]

13. Victoria Police completed nine family violence risk assessments (**FVR L17s**) after attending family violence incidents between MEK and HCG. Police identified HCG as the affected family member (**AFM**) on six of those occasions, and as the respondent on three occasions. There were a further three incidents involving the couple where police attended but did not complete a FVR L17.[31]

14. HCG often escaped MEK violence by attending her stepfather's home.[32] Unfortunately, police often attended her stepfather's home due to allegations that HCG perpetrated family violence against her stepfather.[33] Despite the challenges associated with HCG's attendance at her stepfather's home, she continued to flee MEK to this location as it appeared to be her only alternative option for accommodation.

15. As noted above, HCG and MEK welcomed a baby boy in July 2020. The child was placed in the care of LKM, due to concerns about MEK's violence and HCG's lack of engagement with support services.[34]

16. The available evidence suggests that MEK's behaviour escalated in late-2020. HCG advised Child Protection in October 2020 that she "*needed to gradually leave*" the relationship.[35]

17. On 26 November 2020, following an incident during a supervised visit with her son, HCG contacted Safe Steps and reported that she needed safe accommodation after MEK allegedly assaulted her.[36] Safe Steps directed HCG to The Orange Door (**TOD**), who arranged for three nights' accommodation in a hotel, as well as taxi and supermarket vouchers.[37] It is not clear from TOD records whether HCG accessed the hotel accommodation, and the referral was closed on 16 December 2020 after she did not attend an appointment.[38]

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30 Victoria Police, FDA of HCG, 7.
31 Victoria Police, FDA of HCG, 6.
32 Safe Steps, records of HCG, 5; CB, Child Protection records, 172-3; The Orange Door, Records of HCG 46.
33 L17 portal, Records for HCG and MEK, 69-76, 25; Victoria Police, FDA of HCG, 21, 24.
34 CB, Child Protection records, 165.
35 CB, Child Protection records, 174.
36 Safe Steps, Records for HCG, 2.
37 The Orange Door, Records for HCG, 126.
38 The Orange Door, Records for HCG, 124, 131.

THE CORONIAL INVESTIGATION

18. HCG'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.

19. 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.

20. 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.

21. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of HCG's death. The Coronial 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.

22. This finding draws on the totality of the coronial investigation into the death HCG 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.[39]

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

Circumstances in which the death occurred

23. At 4.00pm on 31 January 2021, a member of the public called Triple Zero to report a female matching HCG's description trying to escape a male matching MEK's description at Ensby

[39] 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.

Street, Thomson. There were no police units available to attend the incident at the time due to a significant incident occurring elsewhere. This is discussed in further detail below.

24. At about 4.30pm, a neighbour heard MEK banging on the door to his home, "*yelling and screaming*" at HCG. He was reportedly shouting at HCG to let him in and about his phone being broken. The neighbour also heard HCG say, "*I'm sorry, I'm sorry*".[40]

25. At 9.30pm that evening, MEK called Triple Zero to report that he had a "*physical…domestic dispute*", that HCG had been bleeding and at the time of the call she was unresponsive and barely breathing.[41] MEK performed cardiopulmonary resuscitation (**CPR**) while on the phone with the Triple Zero call-taker and during this time, said "*I punched her*".[42]

26. Victoria Police members and Ambulance Victoria paramedics arrived on scene at about 9.40pm.[43] They observed HCG naked with blood on her face, arms, hair, hands and legs. Her face was swollen, and the bedroom was covered in wet towels, which were soaked in blood. There were smears of blood on the walls, doors, bedding, sink and toilet, and blood clots and pools of blood inside and outside the house. HCG was not breathing and was cold to touch, and appeared to have been deceased for some time prior to CPR commencing.[44] Paramedics confirmed HCG was deceased at 9.49pm.

27. Victoria Police spoke to MEK at the scene. He admitted that he punched HCG to the face in the laneway of their street about four or five hours earlier, causing her to bleed from her cheek and inside her mouth.[45] He explained that HCG started to look pale about two hours prior to his Triple Zero call[46] and he "*propped her up*".[47] He reported that HCG slept for a few hours and "*then yeah…It's just happened in the last probably 15 minutes, but it feels like 10*".[48] He also reported that he poured some water on HCG, however she was unresponsive, so he called Triple Zero.[49] He noted that "*there's blood all through the house, which I cleaned up*".[50]

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40 CB, Statement of OWV, 12.
41 CB, 000 call transcript, 118-9.
42 CB, 000 call transcript, 132.
43 CB, Ambulance Victoria (**AV**) records, 113.
44 CB, Statement of JNE, 30-1; CB, Statement of ASO, 34-5; CB, Autopsy MER, 47, 50; CB, photographs, 76- 111; CB, AV records, 113-4.
45 CB, BWC Transcript of Sergeant Paul Howe's (**Sgt Howe**) arrest of TO, 152-3.
46 CB, BWC Transcript of Sgt Howe's arrest of MEK, 153-4.
47 CB, BWC Transcript of Sgt Howe's arrest of MEK, 154.
48 CB, BWC Transcript of Sgt Howe's arrest of MEK, 140-3.
49 CB, BWC Transcript of Sgt Howe's arrest of MEK, 141-2.
50 CB, BWC Transcript of Sgt Howe's arrest of MEK, 159.

28. HCG repeated several times that he did not immediately call Triple Zero to avoid police involvement, as he knew it would lead to an "*L17*" and Child Protection involvement.[51] He provided a 'no comment' interview to police and refused to provide a statement for the coronial brief.[52]

29. Victoria Police later charged MEK with recklessly causing injury, contravening an FVIO, and committing an indictable offence whilst on bail. He was sentenced to five months imprisonment and an 18-month Community Corrections Order (**CCO**).[53]

Identity of the deceased

30. On 2 February 2021, Coroner John Olle formally identified the deceased as HCG, via fingerprint identification.

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

Medical cause of death

32. Director of the Victorian Institute of Forensic Medicine (**VIFM**), Professor Noel Woodford, conducted an autopsy on 1 February 2021 and provided a written report of his findings dated 11 June 2021.

33. Forensic Pathologist, Dr Linda Iles of the VIFM, examined Ms HCG's brain on 5 February 2021 and provided a written report of her findings dated 21 May 2021.

34. At autopsy, Prof Woodford observed multiple, relatively minor, areas of predominantly acute bruising over HCG's body, however the most significant findings related to the face where there was an area of bruising associated with a laceration extending through to the buccal mucosa. Further areas of bruising were present to the lips and right ear. A small amount of blood was present at the nostrils but there was no evidence of nasal bone or facial fracture. There was no blood present in the upper aerodigestive tract.[54]

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51 CB, BWC Transcript of Sgt Howe's arrest of MEK, 148, 160-1.
52 CB, Statement of Sgt Howe, 38.
53 CB, Summary, 3; CB, Prior convictions MEK, 198.
54 CB, Medical Examiner's Report (**MER**), 48.

35. A foetus was present within the uterus showing features in keeping with a gestational age of about 16 weeks. There was a small amount of retroplacental haemorrhage, but no findings at autopsy to indicate haemorrhage within the cervical canal or vagina.[55]

36. Prof Woodford further noted significant natural disease in the form of hepatic cirrhosis and mild pulmonary emphysema.[56]

37. Prof Woodford made observations of the scene where HCG was located and noted significantly dispersed deposition of blood (in the form of drops and staining of bedding and other materials). He explained that the assessment of blood loss at autopsy is problematic and assessment of its possible contribution to the mechanism of death relies on factors such as assessment of skin pallor, visceral pallor, and other findings which are occasionally seen such as subendocardial haemorrhage.[57]

38. Upon her examination of the brain, Dr Iles observed slight pallor of the cerebral cortex.[58]

39. Prof Woodford opined that given the evidence available at the scene and that obtained during the autopsy, it was more likely than not that significant blood loss (likely from the nose and mouth) was a contributory factor in the ultimate mechanism of death. There were no other sites of likely significant haemorrhage and Prof Woodford noted that hepatic cirrhosis may be associated with significant abnormalities of clotting.[59]

40. There was an acute fracture of the right third rib which appeared to have been sustained during resuscitation attempts.[60]

41. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine[61] and its metabolite amphetamine. Ethanol (alcohol) was not detected.[62]

42. Biochemical analysis showed preserved renal function and there were no serological findings to suggest a significant infective or inflammatory process around the time of death.[63]

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55 Ibid.
56 Ibid.
57 Ibid, 49.
58 Ibid.
59 Ibid.
60 Ibid.
61 Methamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline.
62 CB, Toxicology Report, 69.
63 CB, MER, 49.

43. Prof Woodford explained that causes of death with little or nothing in the way of significant findings at autopsy include epileptiform seizure activity and abnormalities of cardiac rhythm, some of which may be genetically inherited.[64]

44. Prof Woodford concluded that the cause of death remained unascertained, despite the performance of a full autopsy and ancillary investigations.[65] He stated:

> *In my opinion, bearing the above comments and caveats in mind, it would be reasonable to conclude from the information available to me at this time that it is more likely than not that blood loss has contributed to the ultimate mechanism of death. However, the quantum of this contribution is not able to be determined.*

45. Prof Woodford provided an opinion that the medical cause of death was 1(a) Unascertained.

46. I accept Prof Woodford's opinion.

REVIEW OF POLICE CONTACT

Victoria Police activity on 31 January 2021

47. Earlier on 31 January 2021, separately to the fatal incident, the Geelong Police Service Area (**PSA**) was involved in a large-scale missing person search. At about 1.00pm, a Triple Zero call was received in relation to a missing 11-year-old girl who lived in Breakwater. Her father stated that she had not been seen since 8.30am that morning and her bedroom window was broken. He noted that she had several medical conditions, her disappearance was out of character, and the family was new to the area so he was unsure where she might have absconded.

48. The search involved a range of Victoria Police units including uniform members, highway patrol members and the police airwing. They patrolled the local primary school, Geelong Racecourse, Barwon River and other popular locations.

49. In addition to this large-scale search, the Bellarine 251 patrol sergeant (**WBR251**) noted at the commencement of their shift that there were "*staffing/rostering issues (ongoing) through PSA*". They further noted that one member was sick at Portarlington and additional members

[64] Ibid.
[65] Ibid, 48.

were sick in the PSA. The WBR251 further noted the Bellarine van required a "*Bio Clean*", likely due to the COVID-19 pandemic that was at its peak at the time.

Triple Zero call at 4.00pm

50. As noted earlier, a member of the public called Triple Zero at 4.00pm to report their concerns about a male chasing a female in Thomson, who are believed to be MEK and HCG, respectively.

51. The member of the public noted:

> *There's a guy and a girl arguing and its comin' out to a domestic violence. He's like chasin' her an shit and she's screaming out an that. And I'm just a bit worried that he's gonna lay hands on her because he's going off his head and she's like trying to get away from him*.[66]

52. The police call-taker (**PCT**) asked the caller if they were in a relationship and the caller said that they appeared to know one another. He was unsure of their relationship status but said he felt compelled to call because "*it's a guy and girl situation…and I just don't wanna see a woman getting laid out by a guy*".[67]

53. The caller confirmed he did not see any physical contact occur between the pair, but he explained that he saw the male chasing the female, and that the female appeared to be trying to escape the male. He reported hearing the male said words to the effect of "*come here ya slut*" and the female said, "*get away from me*". The caller could only provide a basic description of the pair and what they were wearing.

Initial police response

54. At 4.06.45pm, the police dispatcher (**PD**) broadcast the following job on the police D24 radio:

> *But if any unit clear umm Geelong units believed tied up got a dispute Ensby Street, Thomson.*[68]

55. At 4.07.04pm, WBR251 broadcast as follows:

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66 Audio recording of Triple Zero call P2101247756.
67 Ibid.
68 Audio recording of D24 radio broadcast, 31 January 2021

Yeah <indistinct> thanks obviously and I'll go with the dispute.[69]

56. The PD responded:

> *251 that's Ensby Street in Thomson. Complainant wanted to be anonymous but said there was a male and female appeared to be arguing umm, might be known to each other. The male chased the female up the laneway behind Tate Street Primary School umm yelling 'come here' and called her a…some names. Umm didn't know any names, very, very brief description, he didn't want anything to do with it*.[70]

57. At 4.07.41pm, WBR251 responded:

> *251 for any units for information umm, put it on a unit's plate at the lower priority for now let me know if you get anything further and chuck it on hold [badge number].*[71]

58. The PD acknowledged WBR251's response and placed the job on hold for an available unit. As noted above, there was a large-scale search on foot in the Geelong PSA for a vulnerable missing 11-year-old.

59. After broadcasting the job regarding HCG and MEK, additional jobs were broadcast for the Geelong PSA as follows

    a) At 4.08pm, WPA302 (Portarlington 302) was allocated a possible welfare check in Portarlington. At the time they were allocated the task, WPA302 was already at the beach attending to a person trapped in a large hole. Also in attendance were the Country Fire Authority, State Emergency Services and paramedics. At 4.13pm, WPA302 advised that this was going to be a "*lengthy job*".

    A second Triple Zero call for the welfare check was received and PD broadcast same at 4.21pm. WPA302 advised they were still at the beach job. WBR251 advised that this job would either be allocated to a Portarlington or Bellarine unit, whichever one became available first. At 4.41pm, WBR302 advised that they were free and able to attend that job.

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[69] Ibid.
[70] Ibid, 2.00.
[71] Ibid, 2.07.41.

b) Five Triple Zero calls were received for a collision with injuries in Hamlyn Heights at 4.10pm. Corio 302 (**WCO302**) offered to take the job; however, it was later allocated to a Highway Patrol unit, with the assistance of two tow trucks.

c) At 4.15pm, Geelong Police Station advised they were trying to contact a woman about a family violence incident. At 4.30pm, Geelong Police Station confirmed they had spoken to her, and no further action was required.

d) At 4.28pm, a PD requested if any unit was available to attend an erratic driver on Thomson Road, North Geelong. The caller reported seeing a driver using their phone whilst driving, causing them to swerve across lanes. WBR251 advised to put a 'keep a look out for' (**KALOF**) for the vehicle.

60. At 4.44pm, the PD asked WBR251 about the Ensby Street job as follows:

PD: The 303 looks like they're just filtering their jobs now…do you want them to head out when they can or…I don't have any other calls.

WBR251: Did we put them at an address or was it just something heard from an anonymous person and no address?

PD: Yeah anonymous person umm said they were just holding each other up the street, Ensby Street, no other details really. Unable to identify them.

WBR251: Yeah 251, happy for <indistinct> to be included in the patrol later on <indistinct> one off, just let me know <indistinct> a call.

PD: Yeah 251 no worries, will do, thanks

61. Although, with the benefit of hindsight, the decision to close this job might appear unsettling or concerning, I note that at the time, WBR251 was not certain that the incident might have been in relation to family violence. Based on the Triple Zero call alone, there was not enough evidence to conclude that a fatal incident was likely to occur, and it was not confirmed that the parties knew one another.

62. WBR251 clearly articulated her decision-making process in the above extract. There were no further calls received about the incident providing further information about the nature of the incident or the whereabouts of the parties. I also note the significant resourcing issues faced by the PSA due to illness and the search for the vulnerable 11-year-old girl.

63. I am therefore satisfied that despite police not attending the scene, there are no prevention opportunities arising from same.

CPU REVIEW

64. As HCG's death occurred in circumstances where she was experiencing family violence in the lead-up to her passing, I requested that the Coroner's Prevention Unit (**CPU**)[72] examine the circumstances of HCG's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[73]

65. I make observations concerning service engagement with HCG and MEK as they arise from the coronial investigation into HCG's death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and HCG's death.

66. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[74] I make observations about services that had contact with HCG and MEK to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

67. I note that while MEK was sentenced for the assault he perpetrated on HCG on the day of her passing, he was not charged with her homicide. I further note that while this finding contains various alleged family violence offending perpetrated against HCG and other victims, many of these reports were alleged only, and did not result in convictions or findings of guilt on MEK'S behalf.

68. The Court provided MEK with an opportunity to respond to the allegations of family violence. One of the Court's Family Liaison Officers (**FLOs**) contacted MEK via phone while he was in the presence of his support worker and attempted to explain the contents of correspondence that was due to be sent to him. MEK did not wish to engage in the process at the time, however

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[72] 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.

[73] 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.

[74] *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

the FLO was able to confirm his postal address. Formal written correspondence was sent to his address, however it was marked 'return to sender' and sent back to the Court. MEK therefore did not provide any response or comment in relation to the allegations.

Child Protection

69. Child Protection were involved with HCG during her pregnancy with her son and continued until the time of the fatal incident. Child Protection were aware of MEK's perpetration of family violence and attempted to link HCG with family violence and alcohol and other drug supports.[75] Child Protection appropriately shared relevant information with other support services including Bethany Community Support, police and MEK's psychologist.[76] Child Protection also offered HCG separate contact with her son; however, she declined same.[77]

70. Child Protection did not complete a family violence risk assessment or management plan with HCG, despite being required to do so under the Multi-Agency Risk Assessment and Management framework (**MARAM**). I note that in the former State Coroner, Judge Cain's finding into the deaths of four children known to Child Protection, Child Protection advised the Court that their Client Relationship Information Management System (**CRIS**) was redeveloped to reflect the MARAM framework.[78] As a result of these changes, practitioners are now prompted to consider elements of the MARAM when entering information into CRIS and are automatically alerted when mandatory assessments are required. These changes also mean that some determinations made by practitioners must be endorsed before matters can progress through the system.

71. When provided with an opportunity to this concern (that a risk assessment was not performed), the Department of Families, Fairness and Housing (**DFFH**) acknowledged that a risk assessment did not occur. However, DFFH noted that Child Protection identified and otherwise responded to the risk of family violence appropriately, proactively, and in a timely way. DFFH drew my attention to the fact that this case was managed through a Multidisciplinary Centre (**MDC**), which meant that highly experienced Child Protection

[75] CB, Child Protection records, 166, 172-3.
[76] Bethany, 9.10.2020-Call from Child Protection; CB Child Protection records, 167-8, 172; Well Inspired Psychology, Records of MEK, 66.
[77] CB, Child Protection records, 173.
[78] *Finding into death with inquest – Child A, Child B, Child C, Child D, 138,* (COR 4327 2015 et al).

practitioners worked on the case. DFFH further noted that Child Protection also provided a list of other actions and measures undertaken to promote the infant's safety.[79]

72. DFFH submitted that it was unlikely that a MARAM risk assessment or management plan would have led Child Protection to assess the risk of family violence differently, or that a different or otherwise enhanced service response was required.[80]

73. I cannot now conclusively determine that completing a family violence risk assessment or management plan would have prevented the fatal incident and note that while it did not occur, other critical Child Protection interventions *did* occur, consistent with internal policies. I note the significant changes that have occurred at Child Protections since this incident, in part due to Judge Cain's finding (as outlined above) and I am therefore satisfied that I do not need to make any further recommendations.

Victoria Police

74. As identified earlier, Victoria Police completed nine FVR L17s in relation to HCG and MEK, identifying HCG as the respondent in three of those incidents. Following HCG's death, Victoria Police completed a Family Violence-Related Death Assessment (**FDA**), which is a desktop review of all family violence related contacts that police had with HCG and her partner. I note that this desktop review is completed in the absence of the competing priorities and time-pressures faced by members attending family violence related incidents. The main issues identified with respect to Victoria Police's contact are explored further below.

Failure to identify/record family violence

75. There were three occasions in which Victoria Police did not submit a FVR L17.[81] For example, on 29 October 2020, Child Protection contacted police as they had been unable to contact HCG after she made significant disclosures of family violence perpetrated by MEK. MEK had attended a visitation with their son and reportedly said "*if I am here, I have an alibi*".[82] Police attended MEK address, however no-one answered the door. Police did not complete a FVR L17 or take any further action. The FDA relevantly noted:

[79] Child Protection, Letter from Colleen Carey to CCoV, 2 Sept 25.
[80] Ibid.
[81] Victoria Police, FDA for HCG, 9, 12-4, 27.
[82] Victoria Police, FDA for HCG, 8.

*There were opportunities for Supervisors to provide direction to members in relation to this response, including Patrol Supervisors or the supervisor approving the Electronic Patrol Duty Return (**ePDR**). There is no record available to this review that identifies further follow up to satisfy police that HCG was not at risk.*[83]

76. On other occasions, when police *did* complete a FVR L17, they did not always include all relevant information that was available in the Computer-Aided Dispatch (**CAD**) records. For example, on 12 July 2019, witnesses contacted Triple Zero to advise that MEK was reportedly trying to force HCG into a car. This information was recorded in the CAD report, but not the L17, and police labelled the incident as "*emotional*" and "*verbal*" only.[84]

77. On 4 January 2020, a witness contacted Triple Zero after reportedly observing MEK chasing HCG down the street and pushing her. This information was included in the CAD report but was not included in the FVR L17. The FVR L17 noted a verbal altercation and noted that MEK pulled HCG off the road for her own safety.[85]

78. On 15 February 2020, HCG called Triple Zero as she was having an asthma attack. The Triple Zero call-taker noted in the CAD record that there was an aggressive male in the room with HCG, who they heard directing abusive language at HCG. When police and paramedics arrived, HCG had already left, and they were unable to locate her. Police did not include any information about the call-taker's observations in the FVR L17, which only appeared to reflect MEK's version of events. He told police that he and HCG argued about her drinking alcohol and using cannabis while pregnant.[86]

79. On 1 January 2021, a member of the public called police after witnessing MEK allegedly chasing HCG, who was reportedly screaming and distressed. HCG reportedly said, "*we are fucking done*". Police attended the scene and spoke to both parties. MEK told police that HCG "*went off at him*" and tried to rip off his shirt and denied the allegations against him. MEK was observed holding a damaged bag containing perfume, which had been gifted to HCG. He told police that he was holding the perfume to stop HCG from "*glassing him*". HCG minimised the incident and said that she had a "*bit of an argument*" with MEK, and she was merely running on the road to catch a bus.[87]

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83 Victoria Police, FDA for HCG, 10.
84 Victoria Police, FDA for HCG, 19.
85 Victoria Police, FDA for HCG, 17.
86 Victoria Police, FDA for HCG, 16; L17 Portal, Records for HCG and MEK, 54-5.
87 Victoria Police, FDA of HCG, 7.

80. Victoria Police completed a FVR L17, recording MEK as the respondent and HCG as the AFM. The members recorded the incident as a "*verbal argument*" but did not include the witness' information about MEK reportedly chasing HCG, nor about HCG screaming and appearing distressed. The FVR L17 further noted that MEK "*was trying to de-escalate the argument*".[88] At the time of the incident, an FVIO was in place against MEK, to protect HCG. Police did not arrest or charge MEK with a breach of the FVIO, however they arrested HCG as she had an outstanding bench warrant and transported her back to the local police station.[89]

81. The FVR L17 generated a risk rating of 10, so the Geelong Family Violence Investigation Unit (**FVIU**) activated a High-Risk Offender Management Shell for MEK on 3 January 2021.[90] However, there was no High-Risk Management Response Template (**MRT**) attached to the shell created on Interpose, and there were no further FVIU updates recording further actions taken in accordance with the management plan.[91]

82. The FVR L17 generated referrals to TOD for both HCG and MEK. As the FVR L17 did not include the witness' description of the incident, TOD was not aware of the extent of the incident. TOD attempted to contact HCG on 19 and 29 January 2021 unsuccessfully, then closed their referral.[92] TOD noted that Bethany Community Support would address the incident with MEK, however he did not answer their call on 4 January 2021.[93] He also failed to attend the next scheduled MBCP session on 27 January 2021.[94]

83. I note that not completing FVR L17s or completing them with inaccurate/missing information may signify missed opportunities to hold MEK to account for his behaviour and protect HCG from his violence. As noted by the FDA, these deficiencies deny "*an opportunity for cumulative risk assessment, management and referral*".[95] I cannot determine that accurate and comprehensive recording would have prevented the fatal incident, however a lack of accurate information probably inadvertently diluted future police attendances at family violence incidents, as they would not have had the complete picture about the risk MEK posed to HCG.

84. In response to these identified concerns, Victoria Police acknowledged that there were instances where members did not complete a FVR L17 or did not record all available

88 L17 Portal, Records of HCG and MEK, 13-4.
89 L17 Portal, Records of HCG and MEK, 13-4; Victoria Police, FDA of HCG, 7.
90 Victoria Police, FDA of HCG, 7.
91 Victoria Police, FDA of HCG, 8.
92 The Orange Door, Records of HCG, 132.
93 Bethany, Summary details for MEK, 11.
94 Bethany, Summary details for MEK, 8.
95 Victoria Police, FDA HCG, 28.

information.[96] In January 2022, the Victoria Police Manual - Family Violence (**VPM FV**) was updated to include the following:

> *The presence of family violence should be considered at all incidents attended by police, even where family violence was not the initiating report. For example, family violence is commonly seen in mental health, property damage and animal abuse incidents and should be considered during welfare checks.*[97]

85. Additionally, Victoria Police collaborated with Triple Zero Victoria to introduce family violence screening questions and supervisor notifications for welfare checks with potential family violence indicators. This aims to ensure early identification of potential family violence, oversight of these incidents, and compliance with policy. Police training also includes modules on FVR narrative writing to ensure that all relevant information is included.[98]

86. Victoria Police stressed that not all welfare checks where family violence is raised as a potential issue will result in an FVR L17. Victoria Police noted that there are legitimate circumstances where police locate a person and establish there are no concerns for the person's welfare, and no family violence has occurred. The expectation in such a situation is that police will make sufficient enquiries to determine a person's welfare and document their assessment, accordingly, including completing a FVR L17 if required.

Inadequate investigations

87. There were several family violence incidents where police attended but did not comprehensively follow-up or investigate the reports. For example, on 4 March 2020, MEK allegedly assaulted HCG and damaged her property. Following this incident, police did not conduct a field interview with MEK until one month after the incident and submitted a brief of evidence for non-authorisation six months after the incident.[99] MEK reportedly breached his FVIO in protection of HCG on 9 June 2020, 4 September 2020 and 1 January 2021, and these incidents were not fully investigated by police.

88. In response to the above identified concerns, Victoria Police acknowledged same and submitted that since these incidents, the organisation has continued to strengthen family

[96] Letter from MinterEllison on behalf of Victoria Police to CCoV dated 20 Oct 25.
[97] Ibid.
[98] Ibid.
[99] Victoria Police, FDA HCG, 15.

violence policy and practice. This includes the review, streamlining, clarification and consolidation of policy into the VPM FV in 2021, and the extensive revision of the *Code of Practice for the Investigation of Family Violence* (**'the Code of Practice'**).[100]

89. Victoria Police noted that further policy updates were published in July 2025 regarding improving identification of the predominant aggressor. The organisation also released a new Predominant Aggressor Practice Guide which clarifies the role of supervisors in providing support to frontline members and reviewing the identification of parties where misidentification is suspected.[101]

90. Victoria Police explained that enhanced supervisory oversight is also being ensured through the development of a new Family Violence Liaison Officer (**FVLO**) training program in 2023. Training of members under this new program commenced in 2025.[102] This training program was developed in collaboration with Monash University.

91. I note that the FDA suggested a possible solution for the issue of inadequate investigation and the non-completion of FVR L17s, namely:

> *That this FDA is disclosed to the Inspector (Emergency Services Telecommunications Authority – ESTA) for review and to consider scope for change to Operational Communication Standard Operating Procedures for checks on a person's wellbeing when there is an identified family violence theme.*
>
> *The police responses to welfare checks when there is information about family violence should result in supervisor notifications to ensure oversight and compliance with the Family Violence Code of Practice.*[103]

92. There appears to be significant merit in the above recommendation which may improve police responses to third-party requests for welfare checks where family violence is mentioned, by improving supervisory oversight to ensure FVR L17s are completed. I note, however, even when police *did* complete FVR L17s in this case, important information was omitted on occasion and/or was not communicated during the call to emergency services. It would

[100] Letter from MinterEllison on behalf of Victoria Police to CCoV dated 20 Oct 25, 2.
[101] Ibid.
[102] Ibid.
[103] Victoria Police, FDA HCG, 28.

therefore be preferrable if the changes suggested above included a system to automatically extract family violence-related information from the CAD record into FVR L17s.

93. If this system were in place during HCG and MEK's interactions with police, key information about MEK's perpetration of family violence would have been included in the FVR L17s. Given that FVR L17s also act as a referral to specialist family violence services, such a system would ensure that all relevant information would have been provided to the specialist family violence services who received the referrals.

94. In relation to the FDA recommendation, Victoria Police advised that in response to a request from Victoria Police, Triple Zero Victoria implemented targeted changes to improve the handling of welfare checks when family violence is a concern. Specifically, call-takers are now required to ask about any known family violence history at the address or with the involved parties during welfare check events, and to record this information where relevant. If it is identified, the call-taker must insert the comment "=== *ADVISE FIELD SUPERVISOR* ===" in the event record, which prompts the dispatcher to notify field supervisors for oversight.[104]

95. The Court sent correspondence to Victoria Police regarding the possibility of creating a system that automatically extracted family violence-related CAD information into FVR L17s. In response, Victoria Police stated that it understood the importance of FVR L17s including accurate and comprehensive information, however suggested there were "*functional limitations*" to my proposed recommendation.[105]

96. Victoria Police explained that members who attend a family violence incident complete the FVR L17 based on evidence gathered at the scene and information from parties/witnesses. The aim of this process is to ensure risk assessments and responses are based on validated information. By contrast, information contained in a CAD narrative is typically unverified or incomplete, as Triple Zero call-takers cannot confirm the accuracy of the details provided.[106]

97. Victoria Police further noted that CAD narratives often include irrelevant, repetitive or sensitive information (such as the caller's identity) which would not be appropriate to include in an FVR L17, noting when a formal referral is generated by the FVR L17, the information becomes accessible to a number of external referral services. The VPM FV already guides

[104] Letter from MinterEllison on behalf of Victoria Police to CCoV dated 20 Oct 25, 3.
[105] Ibid, 4.
[106] Ibid.

police on the details that should be included in the FVR L17 and explains that the parties should be referenced as AFM or respondent. Victoria Police concluded that automatic extraction of CAD narratives was not desirable, and that there is now training delivered by the Centre for Family Violence which includes specific guidance on FVR L17 narrative writing.[107] Furthermore, members have the ability to view CAD data on their IRIS devices.

98. I accept that a verbatim extract of the CAD event details, and the information provided by the Triple Zero to be included in the FVR L17 would not be appropriate in all situations. I further note that Victoria Police have implemented new and improved training, policies and procedures to ensure that FVR L17 narratives are comprehensive. However, my concern remains that members might not appreciate the gravity or importance of details contained within the CAD event and therefore not include it in their narrative.

99. Furthermore, while members might consider the CAD event details, they disregard same without reference to it in their narrative. The context of the original call is important, when considering how to identify the predominant aggressor, amongst other issues. In circumstances where the AFM or respondent has fled the scene prior to police arrival, the narrative provided by the Triple Zero caller might provide valuable contextual information. I note that this is not *verified* information, however it is still important to consider as part of the entire scenario.

100. Furthermore, when a member is attending a new family violence incident and they seek to review the previous family violence incidents prior to attendance, without the CAD event details included in the narrative, they may not have access to important contextual clues about the family violence history. While they could also seek the CAD event details via their IRIS device, this represents an additional step that they must take. In my view, it would be sensible (and simpler) for members to be able to access both the FVR L17 narrative *and* the CAD event data in one place.

101. I am of the view that there is still an opportunity for CAD event data to be included in the FVR L17, potentially in a separate section that is for 'internal use only'. This would ensure that it is not automatically included in the referral to specialist family violence services. However, it would still be present in one place for members to review alongside the narrative, without having to search for the CAD event data via a separate system. This contextual

[107] Ibid.

information might also be useful for internal reviews, intelligence and/or research into family violence related data held by the organisation.

102. I therefore intend to recommend that Victoria Police and Triple Zero Victoria work together to implement a system which automatically extracts family violence-related CAD information into FVR L17s, while excluding it from the subsequent referrals to family violence support services.

Ineffective supervisory interventions

103. I note that when the current processes triggered supervisory oversight due to high-risk ratings, they did not consistently lead to a reduction in risk. The FDA also identified a lack of supervisory oversight or subsequent advice to members within LEAP narratives following attendance at family violence incidents.[108] This included instances where high risk ratings were generated by FVR L17s which should have led to FVIU triage and oversight, but there was no evidence of same.[109] FVIU oversight could have included additional attempts to follow-up with HCG when she was not present at the scene, to better assess the predominant aggressor and otherwise manage and mitigate the risk posed by MEK.[110]

104. Victoria Police acknowledged the issues identified in the FDA, and highlighted the improvements and changes implemented by the organisation (as listed above).

Misidentification of the predominant aggressor

105. Based on the evidence available to the Court, MEK was the predominant aggressor in his relationship with HCG. However, police identified HCG as the respondent in three FVR L17s, effectively labelling her as the predominant aggressor on those occasions.

106. The term predominant aggressor is at times substituted for the term primary aggressor, and:

> *seeks to assist in identifying the actual perpetrator in the relationship, by distinguishing their history and pattern of coercion, power and controlling behaviour, from a victim survivor who may have used force for the purpose of self-defence or violent resistance in an incident or series of incidents. The predominant aggressor is the perpetrator who is using violence and coercive control to dominate, intimidate or cause fear in their partner or family member,*

[108] Victoria Police, FDA HCG, 4, 12.
[109] Victoria Police, FDA HCG, 10.
[110] Victoria Police, FDA HCG, 16, 28.

and for whom, once they have been violent, particularly use of physical or sexual violence, all of their other actions take on the threat of violence[111]

107. The Code of Practice provides the following guidance on identifying the predominant aggressor and lists several indicators for police to consider, including:

    a) Respective injuries

    b) Likelihood or capacity of each party to inflict future injury

    c) Whether either party has defensive injuries

    d) Which party is more fearful

    e) Patterns of coercion, intimidation and/or violence by either party.[112]

108. The Code of Practice advises that when police members are unclear about which party is the predominant aggressor, the AFM should be nominated "*on the basis of which party appears to be the most fearful and in most need of protection*".[113]

109. By way of example, on 4 January 2020, a member of the public called Triple Zero after witnessing MEK allegedly chasing and pushing HCG. When police attended, MEK had HCG's bag and alleged that she took his wallet to purchase alcohol, and he was trying to retrieve it. HCG fled the scene when police arrived. Police recorded this as a verbal altercation but did not include the physical abuse that the witness allegedly observed in the FVR L17. Police did not initiate a criminal investigation or take any steps to follow up with HCG. It appeared that police accepted MEK's version of events and labelled HCG as the respondent.[114] The FDA suggested that misidentification may have occurred on this occasion. I agree with this assessment.

110. TOD subsequently closed their L17 referral "*due to not clear being a FV situation (sic)*".[115]

111. Police misidentification led to MEK being referred to specialist family violence services as the AFM, and on one occasion, being sent an information pack by a victim support agency.[116]

[111] Family Safety Victoria, *MARAM Practice Guides: Foundation Knowledge Guides* (February 2021), 124.
[112] Victoria Police, *Code of Practice for the Investigation of Family Violence* (2019) 3nd Edition V4, 23.
[113] Ibid.
[114] Victoria Police, FDA HCG, 17.
[115] The Orange Door, Records for HCG, 85.
[116] L17 Portal, Records for HCG and MEK, 47.

This may have emboldened MEK to believe there would be no consequences for his family violence perpetration.

112. The FDA stated that misidentification occurred during 2020 "*at a time when less consideration may have been given to misidentification of the person most in need of protection or of police collusion with one of the parties*".[117] The FDA opined that it was unclear whether the misidentification issues canvassed here represented a systemic or organisation-wide issue.

113. Since HCG's passing, Victoria Police has worked to address the issue of police misidentification of the predominant aggressor. This was extensively canvassed in Coroner Despot's finding into the death of EDH.[118] Between October and December 2022, Victoria Police carried out the Predominant Aggressor Identification Trial (**'the Trial'**) in the Northwest Metro Division Five. The aim of the Trial was to examine police risk assessment decisions and identify opportunities for interventions or practice changes that support early recognition and rectification where misidentification has occurred.[119] It also involved the provision of a MARAM-aligned tool to assist supervisors with reviewing these cases.[120] The findings of the Trial noted ongoing problems associated with police misidentification of the predominant aggressor, for example:

a) Supervisory support prior to submission of the FVR L17 was uncommon, possibly due to resourcing issues, meaning police members rarely received support with identifying the predominant aggressor prior to committing their assessment to LEAP and taking further actions such as making family violence referrals and applying for FVIOs.

b) Supervisor case reviews were completed after the completion of FVR L17s in 38.4% of the cases where a female was identified as the predominant aggressor (56 of the 146 instances) but were wholly ineffective in identifying cases of misidentification.

c) There were no documented instances of information sharing with relevant agencies to improve accurate identification of the predominant aggressor. Even uncertainty about the predominant aggressor did not prompt information sharing by police, and the Trial

[117] Victoria Police, FDA HCG, 12.
[118] *Finding into death without inquest – EDH* (COR 2021 0204).
[119] Ibid, 16.
[120] Ibid.

concluded that "*information sharing continues to be under-utilised at the frontline and across the broader systems into Victoria Police*".

d) Following the Trial, a review of the police records relating to the 146 instances where police identified a female predominant aggressor found likely cases of misidentification which were not identified at any stage of the Trial. This is particularly concerning given the additional mechanisms in place aimed at improving accurate identification of the predominant aggressor during the Trial.

e) The Trial found that police continue to take an incident-based approach to assessing predominant aggressors, to "*equate criminal offending with the predominant aggressor at a family violence incident*", and that this has led to instances of misidentification of the predominant aggressor.

f) Which party contacted the police influenced the subsequent direction taken by police - when a male using systems abuse contacted police to make a report about their partner, misidentification was more likely to occur.[121]

114. During the Trial, the only point of review which was effective in identifying instances of misidentification was review by a Family Violence Court Liaison Officer (**FVCLO**). Of the 16 cases subject to a review by a FVCLO, six were confirmed as misidentified, and three others were identified as suspected misidentification. These included cases which had previously been reviewed by a supervisor at a police station.[122]

115. The Trial suggested that one reason for the discrepancy in different types of reviews' efficacy in identifying misidentification may be the differing priorities between police members working in different contexts whereby "*the station focuses on criminality and immediate safety in contrast to the pre-court space, where there is a civil and justice focus*".[123]

116. Following the Trial, Victoria Police have continued their work on addressing misidentification through their Predominant Aggressor Program of Work, which commenced in December 2022. This work includes improving training and guidance and considering amendments to record-keeping systems which promote correct initial identification of the predominant aggressor.

[121] Ibid, 17-18.
[122] Ibid.
[123] Ibid.

117. Victoria Police further noted its release of the new Predominant Aggressor Practice Guide in July 2025, which provides clear direction on the factors that members should consider when determining parties and how to respond to uncertainty to ensure accurate identification of parties in the first instance. It also includes guidance on when and how a review of the initial determination of parties should be undertaken, and rectification steps when misidentification is confirmed. It has also developed complementary guidance for external stakeholders on raising suspected misidentification with Victoria Police, alongside updates to the Victoria Police website to improve transparency and accessibility.[124]

Possible solutions/recommendations

118. I acknowledge the work undertaken by Victoria Police in this space; however, I am of the view that more can be done. Additional strategies can be implemented to prevent misidentification from occurring in the first place and to increase the likelihood that it is identified as early as possible when it does occur. Some strategies to address this issue are explored below:

a) Expansion of co-responder programs

b) Specialist family violence sector review of Victoria Police FVR L17s

c) Reviews of cases where police have attended multiple family violence incidents

Expansion of co-responder programs

119. In my finding into the death of CM, I recommended "*That the Victorian Government resource an expansion of co-responder programs across Victoria"*.[125] Former State Coroner, Judge Cain, similarly made the following recommendation in his Honour's finding into the passing of Noeline Dalzell:

> *Victoria Police and The Orange Door in two regions as a pilot collaborate to embed advanced family violence practitioners within each FVIU to assess, jointly respond to and manage repeat and/or high-risk family violence matters and improve proactive victim/AFM engagement. I note the complexity of placing a Family Violence Practitioner within the structure of a statutory organisation such as Victoria Police and acknowledge that this will need to be a senior worker with extensive experience*

[124] Letter from MinterEllison on behalf of Victoria Police to CCoV dated 20 Oct 25, 3.
[125] *Finding into death without inquest – CM* (COR 2021 3935).

and provided with supervision by a specialist family violence service. An independent evaluation of the pilot program should be completed within two years of commencing operation in each of the two regions selected.[126]

120. The response from the Department of Families, Fairness and Housing (**DFFH**) in both cases indicated that further funding would be required to implement the recommendation. Victoria Police (in the Dalzell matter) indicated that it also required external funding for same.

121. Judge Cain reiterated the recommendation from Dalzell in his Honour's finding into the death of Jessica Geddes and recommended that funding be provided to achieve same.[127] As DFFH and Victoria Police have not yet responded to that finding, I will direct a copy of this finding be provided to both organisations for consideration as part of their response to the Jessica Geddes finding.

Specialist family violence sector reviews of Victoria Police FVRs

122. The Family Violence Reform Implementation Monitor's (**FVRIM**) report, *Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor* (**'FVRIM Report'**) made recommendations in relation to improving accurate police identification of the predominant aggressor, which former State Coroner, Judge Cain endorsed in his finding into the death of Michael Power.[128] Victoria Police noted that they are undertaking a program of work designed to address the intent of all FVRIM recommendations, however this does not include FVRIM Recommendation 5 which states that Victoria Police:

> *Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possibly for other targeted cohorts) before it is committed to Victoria Police's LEAP database.*[129]

123. Victoria Police advised that the Trial (referenced above) acquitted Recommendation Five of the FVRIM report and thus they were fully compliant with all recommendations. In Judge Cain's finding into the death of FCP, his Honour recommended

> *That Victoria Police fully implement recommendation 5 of the FVRIM December 2021 report, Monitoring Victoria's family violence reforms: Accurate identification of the*

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126 *Finding into passing with inquest - Noeline Dalzell* (COR 2020 0670), 79.
127 *Finding into death without inquest – Jessica Geddes* (COR 2020 6055), 23.
128 *Finding into death without inquest – Michael Power* (COR 2016 5556), 24.
129 FVRIM, *Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor* (Report, December 2021), 6.

> *predominant aggressor, specifically to "Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possibly for other targeted cohorts) before it is committed to Victoria Police's LEAP database." The review of Family Violence Reports should occur by police and members of the specialist family violence sector together.*[130]

124. This recommendation was endorsed by Coroner Despot in her Honour's finding into the death of EDH,[131] and by Coroner Giles in her Honour's findings into the deaths of Ms KSQ[132] and Tracey Knowles.[133]

125. In response to Judge Cain's recommendation in the FCP finding, Victoria Police advised that it had concerns about the recommendation due to "*potential safety risks associated with any delays in information being committed to LEAP…noting resourcing constraints across the sector which may impact the timely review of FVRs/L17s*". It further submitted that trials and reforms should be "*developed and implemented in a whole of government setting to determine the best solutions and avoid unintended consequences*".[134]

126. In Judge Cain's recent finding into the death of DCF, his Honour reflected upon Victoria Police's response to the FCP finding. His Honour noted:

> *Victoria Police's rejection of the recommendation on the basis that it requires stakeholder consultation is disingenuous.*[135]

127. Judge Cain therefore recommended that Victoria Police fully implement recommendation 5 of the FVRIM December 2021 report and recommended that Victoria Police work with Family Safety Victoria to implement same.[136]

128. As Victoria Police and Family Safety Victoria are yet to respond to this recommendation, I intend to direct a copy of this finding be provided to both organisations, to consider as part of their response to his Honour's recommendation.

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[130] *Finding into death without inquest – FCP* (COR 2020 1981), 19.
[131] *Finding into death without inquest – EDH* (COR 2021 0204).
[132] *Finding into death without inquest – Ms KSQ* (COR 2023 2596).
[133] *Finding into death without inquest – Tracey Knowles* (COR 2021 3811).
[134] Victoria Police, Statement of Chief Commissioner R Hill dated 16 May 2025, 3.
[135] *Finding into death without inquest – DCF* (COR 2022 2405), 17.
[136] Ibid, 21.

Review of cases where Victoria Police have attended multiple family violence incidents

129. In Judge Cain's recent finding into the death of Jessica Geddes,[137] Victoria Police advised the Court that the Family Violence Command developed an analytical tool using Triple Zero Victoria (**TZV**) CAD data to identify repeat reporting trends to a particular geographical area, address or involving specific people to allow for assessment and tasking to police stations or specialist units in response to the increased repeat reporting. It would seem prudent that where two parties in a relationship are repeatedly identified as the predominant aggressor, that this should trigger a review to ensure that Victoria Police consider all available information across time to determine the true predominant aggressor. This analytical tool might be of assistance in setting up such a trigger for review.

130. I therefore intend to recommend that Victoria Police implement a mechanism which triggers a review of the predominant aggressor in a relationship when police attend several family violence incidents and label both parties as the predominant aggressor on more than one occasion.

Systemic issues – perpetrator interventions

Background

131. Perpetrator interventions in Victoria consist of two key intervention types - behaviour change interventions (mostly MBCPs) and legal/policing interventions.[138]

132. MEK completed a 13-session MBCP run by LifeWorks in 2017 and partially completed three further MBCPs run by Bethany Community Support (**'Bethany'**) from 2019 to 2021.[139] His engagement with MBCPs occurred in the context of Child Protection involvement and CCO conditions requiring completion of same.[140] At the time of the fatal incident, MEK had completed four sessions of his fourth MBCP at Bethany. In MEK's Bethany records, Bethany staff noted that MEK:

[137] *Finding into death without inquest – Jessica Geddes* (COR 2020 6055).
[138] Bell, C., & Coates, D., ANROWS, *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews* (2022) 4.
[139] Bethany, MEK FV Risk Profile, 1.
[140] Relationship Matters/Lifeworks, Records of MEK, 8; Bethany, MEK internal referral, 2; CB, Child Protection notes, 176; Bethany, MEK FV Risk Profile, 1; Geelong Medical Centre, 9.

a) "*[P]resented as aggressive, loud and argumentative*" in MBCP sessions that occurred via phone during the COVID-19 lockdowns.[141]

b) Attempted to control and dominate any sessions he attended with his former partner.[142]

c) Was "*often demeaning, dismissive and disrespectful*".

d) "*Did not hide his controlling ways towards his partners when workers were present*"

e) "*Held strong and rigid gender based patriarchal beliefs that the man was in control*"

f) "*Only engaged with the system when he was forced to but then abandoned service engagement*"

g) "*Had a disrespect for orders and service involvement*"[143]

h) Was dismissive and showed no insight into his behaviour when spoken to about an L17 Bethany received with respect to an alleged incident involving HCG.[144]

133. Bethany staff recorded MEK's family violence risk level as "*elevated*".[145] They also attempted to engage HCG in support during their involvement with MEK.[146]

134. MEK was referred to case management at Bethany, and several referrals were sent via FVR L17s to TOD in relation to his use of family violence. However, MEK did not engage with these services, due to several reasons, namely, he was uncontactable, he had not consented to the referral, or because he was already engaged with a MBCP.[147]

135. Bethany staff prepared non-completion reports for each MBCP that MEK failed to complete. They marked his performance in the groups as unsatisfactory by almost every measure in 2020 and 2021.[148] Despite his attendance at MBCPs over several years, in the months prior to the fatal incident, MEK told his psychologist that he believed his relationship with HCG was healthy[149] and he did not or could not identify his relationship was unhealthy.

[141] Bethanny, Summary details MEK, 24.
[142] Bethany, MEK FV Risk Profile, 1.
[143] Bethany, MEK FV Risk Profile, 2.
[144] Bethanny Summary details MEK, 59, 61.
[145] Bethany, MEKFV Risk Profile, 2; Bethanny Summary details for MEK, 60.
[146] Bethany, MEK FV Risk Profile, 2; Bethany, Summary details HCG, 3-7
[147]The Orange Door, records of HCG, 85, 94, 103-4; L17 portal, records of HCG and MEK, 24, 38, 62.
[148] Bethany, Non-completion report 3/2/21, 1-2; Bethany, MEK non completion report 21 5 2020, 1-2.
[149] Well Inspired Psychology, 62.

Analysis

136. Based on the available evidence, MEK was a high-risk perpetrator of family violence at the time of his relationship with HCG. As noted earlier, he allegedly perpetrated family violence against HCG and at least three other former partners (including his ex-wife) and his children.[150] As of September 2020 MEK was listed as a respondent on 28 FVR L17s.

137. In 2017, a forensic psychologist assessment opined that MEK "*required a more intensive offence-specific treatment to challenge his views on male prerogative and use of violence to solve interpersonal conflicts, than what would be offered through the nominated [MBCP]*". At the time, MEK did not identify the need to change his behaviour.[151] This attitude appears to have persisted until the time of the fatal incident.[152]

138. According to Australia's National Research Organisation for Women's Safety (**ANROWS**), Australia is yet to adequately invest in behaviour change work with perpetrators of family violence.[153] Effective intervention with high-risk perpetrators of family violence is a particular challenge for the service sector,[154] and the Expert Advisory Committee on Perpetrator Interventions (**the Committee**) found that there is "*an urgent need for a more intensive intervention in the community to respond to higher risk perpetrators*", particularly those found unsuitable for a MBCP, and those recently released from prison whose sentence was too short to allow for participation in perpetrator intervention.[155] The Royal Commission into Family Violence (**RCFV**) made a similar finding.[156] The Committee therefore recommended the development of "*a family violence intervention in the community for high risk perpetrators who are unsuitable for participation in an MBCP*".[157]

[150] CB, Child Protection notes, 165-6; Victoria Police, FVA for HCG, 20; Bethany Community Support, MEK FV Risk Profile, 1; The Orange Door, Records of HCG, 2.
[151] CB, Child Protection notes, 176.
[152] CB, Child Protection notes, 166, 176; Bethanny, Summary details MEK; Bethany, MEK FV Risk Profile.
[153] Helps, N., Bell, C., Schulze, C., Vlais, R., Clark, O., Seamer, J., & Buys, R. *The role of men's behaviour change programs in addressing men's use of domestic, family and sexual violence: An evidence brief* (February 2025). ANROWS 23
[154] State of Victoria, Expert Advisory Committee on Perpetrator Interventions, *Final Report* (2018) 67.
[155] State of Victoria, Expert Advisory Committee on Perpetrator Interventions, *Final Report* (2018) 70.
[156] Family Safety Victoria, *Changing Ways: Intensive interventions for serious-risk adults using family violence – Program requirements* (March 2024) 6.
[157] State of Victoria, Expert Advisory Committee on Perpetrator Interventions, *Final Report* (2018) 7.

139. ANROWS has reviewed the evidence available on the effectiveness of MBCPs.[158] Their findings reflect that MBCPs are worthwhile, cost-effective interventions,[159] but that "*behavioural changes produced through men's participation in a single MBCP are incremental*",[160] and while some MBCP evaluations report promising results, most report mixed findings. Of the 29 reviews of behaviour change interventions considered by ANROWS in a 2022 report, only three reviews reported on the impact of the programs on victim/survivors and their children. These found some improvements in their quality of life and experiences of safety and empowerment.[161]

140. ANROWS additionally found that the evidence base of the effectiveness of MBCPs in Australia is generally of poor methodological quality.[162] It made several recommendations aimed at improving the quality of research into perpetrator interventions,[163] for example, the use of high-quality randomised controlled trials with larger sample sizes.[164]

141. I note the relevance of Recommendations 1 and 2 of *Engaging in change: A Victorian study of perpetrator program attrition and participant engagement in men's behaviour change programs* (**'Engaging in Change'**):

> *Recommendation 1: This study reveals significant gaps and challenges in data quality and consistency. There is a need to explore how data could be better collected, linked and utilised state-wide to support improved understandings of how people who use violence move through different points of the system, and to support effective intervention.*
>
> *Recommendation 2: There is a need to explore longer-term participant trajectories following program exit. This requires improvements in collecting, linking and utilising*

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[158] Bell, C., & Coates, D., ANROWS, *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews* (2022); Helps, N., Bell, C., Schulze, C., Vlais, R., Clark, O., Seamer, J., & Buys, R. (2025). *The role of men's behaviour change programs in addressing men's use of domestic, family and sexual violence: An evidence brief* (ANROWS Insights, 01/2025). ANROWS.

[159] Helps, N., Bell, C., Schulze, C., Vlais, R., Clark, O., Seamer, J., & Buys, R. *The role of men's behaviour change programs in addressing men's use of domestic, family and sexual violence: An evidence brief* (February 2025). ANROWS 23.

[160] Bell, C., & Coates, D., ANROWS, *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews* (2022) 13.

[161] Ibid, 9.

[162] Bell, C., & Coates, D., ANROWS, *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews* (2022) 9; Helps, N., Bell, C., Schulze, C., Vlais, R., Clark, O., Seamer, J., & Buys, R. (2025). *The role of men's behaviour change programs in addressing men's use of domestic, family and sexual violence: An evidence brief* (ANROWS Insights, 01/2025). ANROWS 15.

[163] Bell, C., & Coates, D., ANROWS, *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews* (2022) 3.

[164] Ibid, 33.

data on the uptake of referral pathways, transitions to one-on-one case management work, entry into another program, and engagement with other points of the perpetration intervention and justice system. This data can also be used to support program design to better engage diverse cohorts of people who use violence.[165]

142. ANROWS further noted that MBCPs can be enhanced or undermined by the broader environment in which the person using violence is situated.[166] MBCPs therefore require ongoing development, evaluation, and better funding to provide tailored, holistic and timely services alongside other services within the family violence sector.[167] While financial pressures create an incentive to fund cheap interventions,[168] short-term perpetrator interventions "*do not seem effective and should be replaced or augmented with programs that include wraparound and holistic supports*".[169]

143. In March 2024, Family Safety Victoria finalised the program requirements for a pilot program called *Changing Ways: Intensive interventions for serious-risk adults using family violence* (**'Changing Ways'**). The pilot commenced in April 2024 and will run for two years. It targets serious-risk adults using family violence with an intensive, coordinated response based on their level of risk. The service model includes leading and coordinating multi-agency risk assessment and management, advocacy for victim survivors, and where appropriate, responsive, individual readiness for change and behaviour change work.[170]

144. The Changing Ways pilot may have been beneficial to HCG's safety. Such a program may have improved multi-agency coordination, including cross-sector risk assessment and systematic sharing of more fulsome risk information. This may have improved police responses to HCG, including through supporting accurate identification of the predominant aggressor.

145. While the Changing Ways pilot is still underway, I will direct a copy of this finding be provided to Family Safety Victoria so that learnings from HCG'S death can be incorporated

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[165] Fitz-Gibbon, K., McGowan, J., Helps, N. & Ralph, B. (2024) *Engaging in Change: A Victorian study of perpetrator program attrition and participant engagement in men's behaviour change programs. Monash University, Victoria, Australia*. 8.

[166] Helps, N., Bell, C., Schulze, C., Vlais, R., Clark, O., Seamer, J., & Buys, R. (2025). *The role of men's behaviour change programs in addressing men's use of domestic, family and sexual violence: An evidence brief* (ANROWS Insights, 01/2025). ANROWS 6.

[167] Ibid, 26.

[168] Ibid.

[169] Bell, C., & Coates, D., ANROWS, *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews* (2022) 3.

[170] Family Safety Victoria, *Changing Ways: Intensive interventions for serious-risk adults using family violence – Program requirements* (March 2024) 28.

into their work on the pilot, including how they work with Victoria Police in circumstances of high-risk family violence perpetrators.

146. Research indicates that while a court mandate may increase the likelihood of program completion, it also correlates with low levels of program readiness and behaviour change, and higher rates of disengagement once the mandate is no longer in place.[171] Therefore, ensuring court-mandated participants engage in meaningful behaviour change work is a particular challenge.[172] As a result, the Engaging in Change report suggests there "*is a need to better understand whether mandated program attendees do effectively engage in MBCPs, or whether alternative interventions are required that better meet their needs, ensure continued risk visibility, and more effectively hold their behaviours to account*."[173]

147. I therefore note and endorse Recommendations 4 and 5 of the Engaging in Change report, namely:

> *Recommendation 4: Given the varied results from international studies examining the impact of court mandates on MBCP completion, there is a need to better understand whether mandated program attendees do effectively engage with MBCPs, or whether alternate interventions are required that better meet their needs, including their stage or readiness to change, ensure continued risk visibility, and more effectively hold their behaviours to account.*
>
> *Recommendation 5: For court-mandated program participants, the program provider should provide a completion report to the court at the point of program completion or exit. This report should inform future court decision making in matters involving the participant.*[174]

148. Finally, the available evidence suggests that funding models for MBCPs and related interventions are currently unsustainable, leaving services to rely on philanthropic funding, and to stretch beyond their resource limits, to provide valuable services. I therefore note and endorse Recommendation 3 of the Engaging in Change report, namely:

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[171] Family Safety Victoria, *Changing Ways: Intensive interventions for serious-risk adults using family violence – Program requirements* (March 2024) 28, 36, 37, 42.
[172] Ibid, 78.
[173] Ibid, 38.
[174] Ibid, 8.

Recommendation 3: Short- and long-term funding models used for men's behaviour change programs should be reviewed to address the concerns raised by practitioners in this study. This includes ensuring funding models encompass the full breadth of work required to effectively deliver the intervention, including to support participant attendance, engagement, and completion. This requires adequate resourcing of program readiness work and family safety contact work as core components of MBCP delivery.[175]

Systemic issues – gendered violence and primary prevention

Background

149. As noted earlier, HCG experienced gendered and family violence throughout much of her life, almost exclusively perpetrated by men. Similarly, MEK allegedly perpetrated family violence against at least three former partners and his children. He reportedly "*learned from a young age that violence led to power and respect*" and "*he had used violence over many years to enforce his position of authority or to maintain respect when he felt he was being undermined*".[176] He also appeared to be rigidly attached to problematic attitudes regarding gender equality and violence against women, and these attitudes persisted despite his engagement with MBCPs.[177]

150. Based on the available evidence, it also appears that some of the professionals that HCG encountered did not have a sufficient understanding of the gendered nature of family violence.

Analysis

151. In Australia, violence against women is 'staggeringly common', and is overwhelmingly perpetrated by men.[178] Although attitudes regarding violence against women are slowly improving, problematic attitudes in relation to gender equality and violence against women, including attitudes which reinforce rigid gender roles, persist for a concerning minority of

[175] Fitz-Gibbon, K., McGowan, J., Helps, N. & Ralph, B. (2024) *Engaging in Change: A Victorian study of perpetrator program attrition and participant engagement in men's behaviour change programs*. Monash University, Victoria, Australia. 8.
[176] CB, Child Protection notes, 175.
[177] Bethanny Summary details for MEK, 44
[178] Our Watch, *Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia* (2nd ed, 2021) 12; Australian Bureau of Statistics, *Personal Safety Survey – Physical Violence* (2023) < Physical violence, 2021-22 financial year | Australian Bureau of Statistics (abs.gov.au)>; Australian Bureau of Statistics, *Personal Safety Survey – Partner Violence* (2023) <Partner violence, 2021-22 financial year | Australian Bureau of Statistics (abs.gov.au).>.

Australians.[179] To address gender-based violence, more must be done to challenge dominant forms of masculinity, and the harm they do to people of all genders at an individual, group and society level.[180]

152. Primary prevention aims "*to change the underlying social conditions that produce and drive violence against women*" to prevent it from occurring in the first place.[181] This involves working on actions to address the gendered drivers of violence against women to create generational, cultural and attitudinal change.[182] These drivers are evident in the attitudes expressed by MEK according to his MBCP records, and include:

    a) Condoning violence against women.

    b) Men's control of decision-making and limits to women's independence in public and private life.

    c) Rigid gender stereotyping and dominant forms of masculinity.

    d) Male peer relations and cultures of masculinity that emphasise aggression, dominance, and control.[183]

153. Primary prevention also involves addressing other factors which play a role in influencing the occurrence or dynamics of men's violence against women, including:

    a) The condoning of violence in general.

    b) Experience of, and exposure to, violence.

    c) Factors that weaken prosocial behaviour (such as neighbourhood-level poverty, disadvantage and isolation, and substance misuse).

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[179] Christine Coumarelos et al, ANROWS, *Attitudes Matter: The 2021 National Community Attitudes Towards Violence against Women Survey (NCAS) Findings for Australia* (Report, 2023) 22-4.

[180] Respect Victoria, *Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament* (Report, September 2022) 113 <Three-Yearly Report - Respect Victoria - 2022.PDF>.

[181] Our Watch, *Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia* (2nd ed, 2021) 12.

[182] Victorian Government, *Free from Violence: Victoria's Strategy to Prevent Family Violence and all Forms of Violence Against Women - Second Action 2022-2025* (December 2021) 4 <Free-from-violence-second-action-plan-2022-2025.pdf (content.vic.gov.au)>.

[183] Our Watch, *Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia* (2nd ed, 2021) 36.

d) Backlash and resistance to prevention and gender equality.[184]

154. Primary prevention uses a range of mutually reinforcing strategies across a wide range of settings/areas including education, workplaces, sports clubs, health and community services and the media industry.[185] As it takes a whole of population approach, primary prevention can play a role in positively shifting the attitudes not just of those who use and experience family violence in the community, but of professionals who respond to it. For example, by improving community understanding of the gendered drivers of violence against women, primary prevention can support more objective assessment of family violence incidents by police and reduce misidentification of the predominant aggressor which results from bias based on whether women adhere to gender stereotypes which make them ideal victims.[186]

155. In recent years, Victoria has made progress in building an effective primary prevention system. Respect Victoria was established in 2018 in response to a recommendation by the Royal Commission into Family Violence, becoming the first agency dedicated to the primary prevention of family violence and all forms of violence against women in Victoria.[187] Under Victoria's *Free from Violence* strategy, several primary prevention initiatives have been funded and rolled out across education, public sector workplaces, local government and sport settings.[188] One prominent example of a primary prevention initiative is Respectful Relationships Education (**RRE**) in Victorian Schools, which has had positive outcomes thus far but requires stronger, ongoing investment to sustain and embed it within schools over the long term.[189] Further examples include initiatives focused on the primary prevention of sexual violence, which is currently a priority area for Respect Victoria, including consent education in schools.[190]

156. Achieving lasting change of the underlying social conditions which produce and drive family violence through primary prevention will require large-scale, persistent efforts over an extended period. Current state and federal funding for primary prevention is not sufficient to

[184] Our Watch, *Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia* (2nd ed, 2021) 48, 51; Shaoling Zhong, Ronggin Yu, and Seena Fazel, 'Drug Use Disorders and Violence: Associations with Individual Drug Categories' (2020) 42(1) Epidemiologic Reviews.
[185] Respect Victoria, *Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament* (Report, September 2022) 6, 114.
[186] FVRIM, *Monitoring Victoria's Family Violence Reforms: Accurate Identification of the Predominant Aggressor* (Report, December 2021) 39 <FVRIM Predominant Aggressor December 2021_0.pdf (content.vic.gov.au)>.
[187] Respect Victoria, *Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament* (Report, September 2022), 4.
[188] Ibid.
[189] Ibid, 52-3.
[190] Ibid, 28.

meet this goal and has predominantly been for relatively short-term activity targeting fairly small cohorts.[191]

157. I note and endorse Judge Cain's recommendations in his Honour's finding into the death of Thi Nguyen:

> *Recommendation 1: The Victorian Government urgently increase the total quantum of primary prevention funding, and prioritise longer term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria.*
>
> *Recommendation 2: The Federal Government commit to long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch in Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia. These include:*
>
> a. *Our Watch (to provide independent national leadership on primary prevention)*
> b. *Australia's National Research Organisation for Women's Safety (ANROWS) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)*
> c. *Australian Bureau of Statistics (to deliver the Personal Safety Survey)*
> d. *Workplace Gender Equality Agency.*[192]

Systemic issues – specialist family violence services and emergency housing for people experiencing family violence

Background

[191] Ibid 16; Our Watch, *Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia* (2nd ed, 2021) 109; FVRIM, *Monitoring Victoria's family violence reforms Primary prevention system architecture* (Report, 2022) 38-40.

[192] *Finding into death without inquest – Thi Minh Phuong Nguyen* (COR 2021 0964), 13-14.

158. Based on evidence available to the Court, HCG appeared to experience housing instability and referred to herself as "*homeless*" and "*couch surfing*" at times.[193] She regularly escaped to her stepfather's home after being allegedly assaulted by MEK, however while she was there, police were contacted several times due to alleged family violence that she perpetrated against her stepfather. Despite the persistent issues arising from HCG fleeing to her stepfather's house, this appeared to be her only option for alternative accommodation.

159. Services were aware that HCG remained in a relationship with MEK "*due to a lack of resources, especially secure housing".*[194] Although services were often unable to contact HCG following referrals,[195] in the year prior to the fatal incident HCG contacted various services requesting support, primarily with housing:

    a) On 22 October 2019, HCG contacted TOD requesting support with housing. They provided her with the contact details for a housing service and advised her of the 'refuge option'. HCG advised that she might visit a TOD, but did not appear to visit same.[196]

    b) On 16 January 2020, HCG contacted TOD and said she wanted to leave her relationship with MEK due to escalating violence. She reported that she was staying with her stepfather but needed to leave the following day. She planned to visit TOD the next day, however, did not attend.[197]

    c) On 23 January 2020, HCG contacted TOD and again requested support with accommodation, accessing new identification and a new phone.[198]

    d) On 24 January 2020, HCG contacted TOD again for support with housing. TOD advised that they were unable to provide housing support and suggested that she contact a housing service. HCG reportedly said, "*what the hell and I (sic) blooding wasting my time for"* and ended the call.

    e) On 27 March 2020, HCG contacted Safe Steps and reported she was homeless due to family violence and needed emergency accommodation. She reportedly "*requested to*

[193] Matchworks, case notes for HCG, 3; CB, Child protection notes, 163.
[194] The Orange Door, Records of HCG, 278.
[195] L17 portal, Records for HCG and MEK, 54, 61, 69; The Orange Door, Records of HCG, 85, 132; CB, Child Protection notes, 166.
[196] The Orange Door, Records of HCG, 15.
[197] The Orange Door, Records of HCG, 20.
[198] The Orange Door, Records of HCG, 22-3.

know if we could help her or if writer was wasting her time" then terminated the call after the worker explained the available service options and that they needed to understand her risk level.[199]

f) On 3 June 2020, HCG contacted Safe Steps and reported she had been assaulted that day and had bruises and broken ribs. The worker commenced an assessment, however HCG "*became agitated stating she didn't want to answer questions and she just needed accommodation*" before terminating the call.[200] Safe Steps contacted a housing service and asked them to contact HCG.[201]

g) On 24 September 2020, HCG contacted Bethany "*[l]ooking for support options with residential rehab for alcohol and securing her own housing so that she could live with her son*".[202]

h) On 19 November 2020, HCG called TOD and reported that Child Protection advised her to call them for housing support. TOD provided her with a number of a housing service so she could book a housing assessment. HCG booked an appointment for an assessment on 8 December 2020, however, did not attend.[203]

i) On 26 November 2020, HCG called Child Protection and advised she was afraid for her life, and that MEK reportedly broke into her stepfather's home and verbally abused her.[204] That same day she also called Safe Steps seeking help with safe accommodation after MEK allegedly assaulted her that day. Safe Steps redirected her to TOD[205], who arranged three nights' accommodation in a hotel, and taxi/supermarket vouchers.[206] It is not clear if she accessed this accommodation.

Analysis

160. HCG appeared to struggle with maintaining contact with services, likely due to the family violence she was experiencing, and intersecting issues related to poverty, substance misuse, mental health and homelessness. A co-responder program, as described above, with assertive outreach may have increased the ability of services to effectively engage HCG. I note that a

[199] Safe Steps, records of HCG, 5.
[200] Safe Steps, records of HCG, 4.
[201] Safe Steps, records of HCG, 3.
[202] Bethany, 24.09.2020 – Phone call, HCG, 1.
[203] The Orange Door, Records for HCG, 46, 121.
[204] CB, Child Protection notes, 175.
[205] The Orange Door, Records for HCG, 127.
[206] The Orange Door, Records for HCG, 126.

co-responder program may also increase engagement of perpetrators and victims of family violence with specialist family violence services and can significantly reduce the risk levels of both parties.[207]

161. It appears that the lack of emergency housing options inhibited services' ability to adequately support HCG at times when she was motivated to access support. There were many instances (as noted above) where HCG proactively sought assistance from a service, however, was redirected elsewhere. HCG may have benefited significantly from housing with intensive, wrap-around support for her other intersecting needs.

162. Safe Steps report that every night in Victoria, there are as many as 300 people in hotels fleeing family violence. However, using hotels as emergency accommodation is expensive, potentially harmful and can lead to poor results, with 35% of people leaving in an 'unsafe' manner, for example, returning to the perpetrator.[208] Hotel accommodation is also unlikely to be suitable for victim survivors who have intersecting and complex needs, such as HCG. HCG required tailored support, which could not be provided in hotel accommodation. Given the significant intersection of family violence victimisation, mental health diagnoses[209] and substance misuse issues,[210] emergency accommodation must be equipped to support women and gender diverse people with comprehensive wrap-around support.

163. In October 2023, Safe Steps launched a pilot of the Sanctuary model of emergency accommodation, which provides a trauma-informed alternative to hotel emergency accommodation with 24/7 on-site family violence specialist support, and access to wrap-around services.[211] Safe Steps also provides a part-time nurse on-site, as well as a child support worker and in-reach from a range of other support services.[212] Pets can be accommodated (with some restrictions) and participants stay for an average of three weeks. The Sanctuary

[207] Hamilton, G et al, *Updated Evaluation of the Alexis Family Violence Response Model* (2024) RMIT University, 5, 19, 28, 33.
[208] Wendy Tuhoy, 'New high-security shelters for women in crisis to sit empty during family violence epidemic', *The Age* (29 May 2025).
[209] Maher, J. Met al., *Women, disability and violence: Barriers to accessing justice: Final report* (ANROWS Horizons, 02/2018), 1.
[210] Family Safety Victoria, *MARAM Practice Guides Foundation Knowledge Guide: Guidance for Professionals Working with Child or Adult Victim Survivors, and Adults Using Family Violence* (2021) 62.
[211] Safe Steps submission to the Strong Foundations: Building on Victoria's work to end family violence online consultation February 2024 - Safe-Steps-response-to-Strong-Foundations-Consultation-Feb-24.pdf 6; Safe Steps, Statement dated 12 March 2025, 3.
[212] Urbis, Sanctuary Pilot Program Evaluation (Final report, 18 December 2024), 17.

model was funded through a mixture of Commonwealth Government and philanthropic funding.[213] Evaluations of the Sanctury model show:

a) Victim survivors were overwhelmingly happy with their experience, and reported positive outcomes including improved health and wellbeing, increased financial stability, and greater social inclusion.[214]

b) Children were able to continue to engage in education while at Sanctuary and thereafter, which itself is a protective factor against adverse childhood events.[215]

c) 97% of adults who exited Sanctuary made safe transitions including to refuges, the homes of friends/family and other safe accommodation, including private rentals. This is a drastic improvement on hotel emergency accommodation safe exit rates of 60-70%.[216]

d) Victim survivors reported feeling safe and secure in their subsequent housing, indicating improved housing pathways.[217]

e) It is cheaper to provide than hotel emergency accommodation,[218] and is estimated to have saved the government between $1.9 to $4.6 million due, for example, to avoided medical and mental health costs, avoided return to the perpetrator, reduced impact on children and avoided homelessness costs.[219]

164. The Sanctuary model can accommodate victim-survivors with certain intersecting needs, including mental health and substance misuse issues, however there are some limitations. For example, the Sanctuary model cannot accommodate victim-survivors who are experiencing an acute mental health episode or those whose drug use is not being medically managed by a medical clinician.

165. Demand for family violence emergency accommodation significantly outstrips the capacity of the Sanctuary program. While Safe Steps secured federal capital funding to expand the

[213] Safe Steps, Sanctuary Expansion Operating Funding Budget Submission FY 25-26, 3.
[214] Safe Steps, Sanctuary Expansion Operating Funding Budget Submission FY 25-26, 7; Urbis, Sanctuary Pilot Program Evaluation (Final report, 18 December 2024), 7.
[215] Ibid.
[216] Ibid, 20.
[217] Safe Steps, Sanctuary Expansion Operating Funding Budget Submission FY 25-26, 7.
[218] Safe Steps, Sanctuary pilot initial funding submission, 4, 8; Safe Steps, Sanctuary Expansion Operating Funding Budget Submission FY 25-26, 3, 4; Urbis, Sanctuary Pilot Program Evaluation (Final report, 18 December 2024), 8.
[219] Urbis, Sanctuary Pilot Program Evaluation (Final report, 18 December 2024), 8.

number of Sanctuary apartments from seven to 35,[220] the Victorian Government did not provide Safe Steps with the $3.9 million of required operational funding for the 2025-2026 financial year, nor the $9.6 million of ongoing funding it requested.[221] Consequently, Safe Steps advised that the additional 28 units that are under construction will sit empty. If completed, they can house more than 1000 woman and children per year.[222]

166. If the Sanctuary accommodation model was available to HCG, it is likely that it would have been of significant benefit as she would have been able to access support for her diverse but intersecting needs. Therefore, I intend to recommend that the Victorian Government provide Safe Steps with the requested funding, and that it scales long-term investment in supported accommodation projects like Sanctuary to replace the hotel model.

Systemic issues – abandonment as an act of family violence

167. I note that this case is not the only case before the Court where a previously identified family violence perpetrator has failed to act to assist a previously identified victim of family violence in need of urgent medical assistance.[223] In the cases identified, there was a significant delay in calling Triple Zero where an overdose was suspected, or the previously identified perpetrator assaulted the victim, did not promptly call Triple Zero and the person subsequently died. In all the cases before the Court, the perpetrator of family violence either faced no criminal charges or was only charged with summary offences.

168. In the present case, the medical evidence could only partially attribute HCG's death to the assault by MEK, despite his admission to police that he punched her to the face. HCG's blood loss was so significant during the four to five hours after the assault that despite MEK's assertion that her cleaned up the blood, there were pools of blood inside and outside the house, blood clots and smears of blood throughout the house, blood-soaked towels and pillows, and blood on HCG's face and body.[224] MEK alleged that HCG refused medical care, then repeatedly told police that he did not contact emergency services earlier as he was fearful of police and Child Protection intervention.[225]

[220] Urbis, Sanctuary Pilot Program Evaluation (Final report, 18 December 2024), 6.
[221] Safe Steps, Sanctuary Expansion Operating Funding Budget Submission FY 25-26, 11.
[222] Wendy Tuhoy, 'New high-security shelters for women in crisis to sit empty during family violence epidemic', *The Age* (29 May 2025).
[223] See, for example, *Finding into death without inquest – Narelle Simmons* (COR 2021 5579).
[224] CB, Ambulance Victoria records, 113; CB, Photographs, 76- 111; CB, Statement of ASO, 34.
[225] CB, Howe's BWC Transcript of MEK arrest, 148-9, 160-1.

169. I note in Judge Sanger's recent finding into the death of Narelle Simmons,[226] her Honour explored a similar issue in which Ms Simmons was assaulted by her partner, her partner did not immediately call for help and Ms Simmons later passed away, in part due to the injuries she sustained. Her Honour recommended:

> *That the Attorney-General consider making a referral to the Victorian Law Reform Commission to:*
>
> *a) consider the creation of a new offence (abandoning a victim in medial need); and/or*
>
> *b) amending the Family Violence Protect Act 2008 (Vic) to include abandonment of a victim in medical need as an example of family violence; and*
>
> c) *to consider how family violence perpetrators can be held to account in circumstances where a charge of criminal negligence is not available.*[227]

170. Given the tragic circumstances of HCG's death in circumstances where she did not receive immediate medical attention, I see significant merit in Judge Sanger's recommendation and intend to endorse same. I will direct a copy of this finding be provided to the Attorney-General to assist with their response in the matter of Narelle Simmons.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was HCG, born 1981;

b) the death occurred on 31 January 2021 in Thomson, Victoria, 3219, from unascertained causes; and

c) the death occurred in the circumstances described above.

[226] *Finding into death without inquest – Narelle Simmons* (COR 2021 5579).
[227] Ibid, 23.

172. While HCG's cause of death remains medically unascertained, noting the available evidence and Prof Woodford's opinion, I am satisfied on the balance of probabilities that the assault by MEK contributed to her death. The precise (numerical) contribution of the assault to HCG's death cannot be quantified, however it is most unlikely that she would have died were she not assaulted, as there were no other injuries or illnesses identified at post-mortem that could have caused the death. Furthermore, were it not for the assault, it is unlikely that HCG would have died in circumstances where she was probably afraid, in pain, and in dire need of medical attention.

COMMENTS

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

173. I endorse Recommendations 1 - 5 of *Engaging in change: A Victorian study of perpetrator program attrition and participant engagement in men's behaviour change programs*:

> *Recommendation 1: This study reveals significant gaps and challenges in data quality and consistency. There is a need to explore how data could be better collected, linked and utilised state-wide to support improved understandings of how people who use violence move through different points of the system, and to support effective intervention.*
>
> *Recommendation 2: There is a need to explore longer-term participant trajectories following program exit. This requires improvements in collecting, linking and utilising data on the uptake of referral pathways, transitions to one-on-one case management work, entry into another program, and engagement with other points of the perpetration intervention and justice system. This data can also be used to support program design to better engage diverse cohorts of people who use violence.*
>
> *Recommendation 3: Short- and long-term funding models used for men's behaviour change programs should be reviewed to address the concerns raised by practitioners in this study. This includes ensuring funding models encompass the full breadth of work required to effectively deliver the intervention, including to support participant attendance, engagement, and completion. This requires adequate resourcing of program readiness work and family safety contact work as core components of MBCP delivery.*

Recommendation 4: Given the varied results from international studies examining the impact of court mandates on MBCP completion, there is a need to better understand whether mandated program attendees do effectively engage with MBCPs, or whether alternate interventions are required that better meet their needs, including their stage or readiness to change, ensure continued risk visibility, and more effectively hold their behaviours to account.

Recommendation 5: For court-mandated program participants, the program provider should provide a completion report to the court at the point of program completion or exit. This report should inform future court decision making in matters involving the participant.

174. I endorse Judge Cain's recent recommendations in his Honour's finding into the death of Thi Nguyen:

Recommendation 1: The Victorian Government urgently increase the total quantum of primary prevention funding, and prioritise longer term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria.

Recommendation 2: The Federal Government commit to long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch in Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia. These include:

e. Our Watch (to provide independent national leadership on primary prevention)
f. Australia's National Research Organisation for Women's Safety (ANROWS) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)
g. Australian Bureau of Statistics (to deliver the Personal Safety Survey)
h. Workplace Gender Equality Agency.

175. I endorse Recommendation 1 in Judge Sanger's recent finding into the death of Narelle Simmons:

That the Attorney-General consider making a referral to the Victorian Law Reform Commission to:

a) consider the creation of a new offence (abandoning a victim in medial need); and/or

b) amending the Family Violence Protect Act 2008 (Vic) to include abandonment of a victim in medical need as an example of family violence; and

c) *to consider how family violence perpetrators can be held to account in circumstances where a charge of criminal negligence is not available.*

176. I endorse Recommendation 1 in Judge's Cain's finding into the death of DCF:

That Victoria Police fully implement recommendation 5 of the FVRIM December 2021 report, Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor, specifically to "Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possible for other targeted cohorts) before it is committed to Victoria Police's LEAP database." The review of Family Violence Reports should occur by police and members of the specialist family violence sector together. Victoria Police should work with Family Safety Victoria to implement this recommendation.

RECOMMENDATIONS

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

1. That **Victoria Police** and **Triple Zero Victoria** work together to implement a system which automatically extracts family violence-related CAD information into FVR L17s, while excluding it from the subsequent referrals to family violence services.

2. That **Victoria Police** implement a mechanism which triggers a review of the predominant aggressor in a relationship when police attend several family violence incidents and label both parties the predominant aggressor on more than one occasion. This trigger should be automated and should not depend on members reading and complying with a new practice guide. The review process should involve specialist family violence services, and should consider information recorded across time, including in FVR L17s.

3. That the **Department of Families, Fairness and Housing** provide Safe Steps with the funding requested for the Sanctuary accommodation model in their 2025-26 budget bid, noting that this aligns with the March 2021 Legal and Social Issues Committee *Inquiry into Homelessness in Victoria*.

4. That the **Department of Families, Fairness and Housing** consult with **Safe Steps** on further expansion of the Sanctuary model to provide a range of Sanctuary facilities across metropolitan and regional communities, including provision of specialist Sanctuary facilities to accommodate people with complex needs.

5. That the **Department of Families, Fairness and Housing** scale up long-term investment in supported accommodation projects like the Sanctuary to replace the hotel model.

I convey my sincere condolences to HCG's family for their loss.

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.

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

LKM, Senior Next of Kin

Department of Families, Fairness and Housing

Family Safety Victoria

Safe Steps

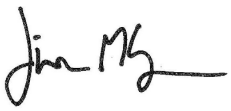
The Hon. Sonya Kilkenny, Attorney-General of Victoria

Triple Zero Victoria

Victoria Police

Detective Sergeant Paul Howe, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 28 October 2025

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.