IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000204

AMENDED FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Amended pursuant to section 76 of the Coroners Act 2008 (Vic) on 3 April 2025[1]

Findings of:	Coroner Kate Despot
Deceased:	EDH[2]
Date of birth:	1988
Date of death:	10 January 2021
Cause of death:	1(a) Mixed drug toxicity including phenobarbitone
Place of death:	Warragul, Victoria, 3820
Keywords:	Family violence; gendered violence; overdose; identification of the predominant aggressor

[1] This document is an amended version of the Finding into the death of EDH dated 26 March 2025. Paragraph 86 has been amended pursuant to section 76 of the *Coroners Act 2008* (Vic) as it contained a spelling error.
[2] This finding has been de-identified.

INTRODUCTION

1. On 10 January 2021, EDH was 32 years old when she was found deceased at her sister's home in Warragul, Victoria. EDH is survived by her parents and two sisters.

2. EDH's loved ones described her as an animal lover who dedicated her life to protecting animals. She pursued her dream of working with animals and began studying veterinary nursing in 2012 and was working at the Latrobe Veterinary Hospital in Traralgon as a veterinary nurse.

3. EDH experienced mental health issues starting at a young age. She started self-harming intermittently from the age of 13 or 14 and first attempted suicide at the age of 16. She received several diagnoses including borderline personality disorder (**BPD**), depressive disorder, anxiety, and adjustment disorder. BPD was a consistent diagnosis in the years prior to EDH's passing. She was engaged with a psychiatrist from October 2018 to June 2020, however she missed multiple appointments during that time.

4. EDH was also engaged with a psychologist from October 2018 to October 2019. The psychologist provided cognitive behavioural therapy (**CBT**); however, EDH was poorly engaged at times. EDH later re-engaged with another psychologist from August 2020 until the time of her death, which was a more successful and productive therapeutic relationship.

5. EDH experienced significant family violence and trauma throughout her life. She reportedly experienced family violence and neglect as a child and later experienced several long-term romantic relationships that involved coercion, controlling behaviour and physical violence.

6. In 2011, EDH began a two-year relationship which ended due to her partner's alcohol abuse, jealousy and possessive behaviour. In 2017, another partner coerced EDH into terminating a pregnancy which had a negative impact on her mental health. After this relationship ended, EDH moved back in with her mother, KQT, where her mental health stabilised and she was also able to control her use of alcohol and diazepam. KQT commented that EDH was at "*her happiest and healthiest*" during this time.

7. In 2018, EDH met URE on the online dating application Tinder, and they commenced a relationship in about February 2018. Their relationship continued on a sporadic basis until about February 2020 when it permanently ended. During this relationship, URE allegedly perpetrated family violence against EDH. After commencing a relationship with URE, EDH's

mental health reportedly deteriorated, and she started using increasing amounts of alcohol and diazepam.

8. EDH's family attempted to help her to access mental health supports, however they believed her ability to engage was inhibited due to the ongoing family violence perpetrated against her by URE. They also noted URE would undermine any progress she made and any time she tried to leave the relationship, URE would persistently contact her and threaten suicide or exploit EDH's love of animals, claiming his dog was sick, so that she would return to the relationship.

THE CORONIAL INVESTIGATION

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

10. 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.

11. Victoria Police assigned Detective Senior Constable Jory Coster to be the Coronial Investigator for the investigation of EDH's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

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

[3] Subject to the principles enunciated in *Briginshaw v Briginsh*aw (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.

RELEVANT FAMILY VIOLENCE AND MENTAL HEALTH HISTORY

August 2018

13. On 8 August 2018, EDH disclosed to Victoria Police that she had ended her relationship with URE and that he had perpetrated significant family violence towards her throughout their relationship. She reported that in June 2018, URE sexually assaulted her by placing the tip of a steak knife against her vagina and on another occasion, refused to let her leave the house and grabbed her by the wrists, causing bruising. She also noted that in July 2018, URE followed her in his vehicle and attempted to force her to pull over.

14. Whilst making her report, police observed that URE was 'obsessively' calling EDH and sending her text messages, causing her to be very fearful. Police assessed the risk to EDH as being extreme and applied for a full Family Violence Intervention Order (**FVIO**) in protection of EDH, prohibiting all contact and communication from URE. Police initiated a criminal investigation, and URE was later found guilty of assault with a weapon and use of a carriage service to harass.

15. Following the August 2018 disclosure, police referred URE to Latrobe Community Health Service, however they were unable to make contact with him. Police referred EDH to Quantum Support Services, who commenced a risk assessment with her on 13 August 2018. During this appointment, EDH minimised the family violence that she disclosed to police and stated she was not at risk. Nevertheless, the family violence worker assessed that EDH was at an elevated risk. EDH declined case management from the family violence worker, however had three further phone contacts with the worker before the referral was closed. EDH's mother and sister expressed concerns that the worker was a family friend and that this may have influenced EDH's willingness to engage with the service.

16. EDH's family reported that even after the FVIO was served on URE, he continued to contact EDH by phone and pressured her to "*drop criminal charges against him*". However, EDH refused to report these FVIO breaches to police. On 14 August 2018, the Latrobe Valley Magistrates' Court issued a final FVIO for a period of 12 months. At EDH's request, the Latrobe Valley Magistrates' Court varied the order to permit contact and communication between EDH and URE, provided that he did not commit family violence or damage her property.

February 2019

17. On 10 February 2019, EDH was admitted to Latrobe Regional Hospital (**LRH**) after self-harming and disclosed that URE allegedly physically and sexually assaulted her. EDH underwent a forensic medical examination and spoke to police, however ultimately decided not to make a formal statement and requested that police take no further action. Police applied to vary the FVIO to prohibit URE from contacting or communicating with EDH, which was granted by a court that same day. Police also initiated a criminal investigation and interviewed URE; however, no charges were laid against him.

November 2019

18. On 16 November 2019, EDH told her sister that URE had been allegedly verbally and physically abusive towards her, including physically restraining her from leaving his house. She told her sister that she was able to leave the house and drive away, however she became incredibly angry and turned her car around, drove back to URE's house and began throwing his rubbish bins at his car.

19. URE contacted police and reported that EDH had assaulted him and damaged his car. He told police that he believed EDH suffered from "*undiagnosed mental health issues and abuse[d] Valium*".

20. EDH attended the police station to make a report against URE, however when she arrived, she was arrested and interviewed by police in relation to URE's allegations. Police then served her with a Family Violence Safety Notice (**FVSN**) in protection of URE, after EDH admitted to damaging his car. Police did not charge EDH on this day but advised her that she may be charged on summons. Police later documented that they believed EDH was "*coached by her sister to make counter allegations*" and that she had initially "*attempted to make counter allegations and then admitted to damaging the victims (sic) vehicle*".

21. KQT stated that she spoke to a Sergeant at the police station and asked him to review the family violence history between EDH and URE, and to manage the matter in the context of "*what is known about the cycle of violence*". Police reportedly refused to take EDH's statement in relation to her allegations, took no action to protect her, and completed a family violence risk assessment and risk management report (**VP Form L17**) listing URE as the affected family member (**AFM**) and EDH as the respondent. This triggered specialist family violence referrals for URE as the victim and EDH as the perpetrator.

22. Following the FVSN issued by police, the Latrobe Valley Magistrates' Court issued an interim FVIO in protection of URE on 26 November 2019. This was a limited FVIO that prevented EDH from perpetrating family violence against URE. On the same day, EDH applied for an FVIO directly with the court against URE, which was granted with full conditions. The court's Applicant Practitioner completed a risk assessment with EDH and identified that URE was the predominant aggressor in their relationship, despite EDH being listed as the respondent on the police-initiated FVSN. The Applicant Practitioner completed a safety plan with EDH, made appropriate referrals, and contacted The Orange Door, where police referred EDH as a respondent. The Applicant Practitioner advised The Orange Door that EDH was incorrectly referred to them as a respondent and explained their concerns about EDH being misidentified by police as the predominant aggressor in her relationship with URE. The following day, when The Orange Door contacted EDH, they documented their opinion that EDH was the victim of family violence and was not the predominant aggressor. Unfortunately, The Orange Door was unable to contact EDH again after their first contact.

23. Ultimately, police decided not to charge EDH with any offences after a Sergeant reviewed the criminal brief and the extensive history of family violence perpetrated by URE against her. However, the Sergeant did not explicitly note that EDH was not the predominant aggressor in her relationship with URE, but rather recorded that she had "*acted out of character*". The review of the brief did not occur until March 2020, and it does not appear that there was any action taken to correct police records or to withdraw the FVIO in protection of URE. KQT stated that the manner in which this incident was handled had a significant impact on EDH's "*well-being, mental health and sense of self*".

Early-2020

24. On 20 January 2020, the FVIOs against URE and EDH were finalised in Court for a period of 12 months. The order against URE was a full, no-contact order and prevented him from contacting or communicating with EDH, going to her home or workplace, stalking her or keeping her under surveillance, damaging her property and committing family violence against her. The order against EDH prevented her from committing family violence or damaging URE's property. Both orders were due to expire on 19 January 2021.

25. It appears that the relationship between EDH and URE also ended around this time. Following the end of her relationship, EDH moved into a house in Traralgon with her friend. EDH's sister noted that EDH was "*feeling extremely unsafe physically and emotionally*", regularly

had nightmares, and felt like she "*was always on high alert, looking out for [URE]*". EDH's friend made similar observations and noted that EDH felt unsafe in the local area as URE lived nearby and she stopped walking her dogs as she was worried about seeing him.

July-August 2020

26. In July 2020, URE contacted EDH by phone and asked her how she was "*as he had not been seeing her car at work for a while*". EDH's sister, VYM, noted that EDH was significantly distressed by this contact as she felt "*she would never escape him*" and it impacted her sense of safety, knowing that he was monitoring her whereabouts. VYM noted that EDH contacted police about this FVIO breach, however she was told to make an appointment to make a statement later in the week as the incident was "*not serious*". EDH changed her phone number, however, did not follow through with making a formal statement "*as the police officer made her feel like it wasn't important*". EDH similarly told her friend that she felt the police officer "*talked down*" to her.

27. In July and August 2020, EDH had two brief episodes of treatment with the Latrobe Mental Health Service. The first treatment was initiated after she presented to the LRH emergency department (**ED**) with superficial cuts to her arms. She was reviewed by a psychiatrist, had adjustments made to her medication regime and was discharged for follow-up with her general practitioner (**GP**) and her private psychologist. The second brief episode of treatment occurred in August 2020, following a call by KQT to the service. EDH received a call from the service and a plan was made for follow-up with her GP and private psychologist.

28. During this time, EDH missed several shifts at work and told her employer that she needed some time off to "*sort herself out*". She subsequently experienced financial stress due to reduced hours at work, which further exacerbated her poor mental health.

29. EDH started seeing psychologist LJD in August 2020. Her reason for engagement with LJD was to address the impact of family violence on her mental health. LJD recorded that EDH presented with severe post-traumatic stress disorder (**PTSD**), depression, anxiety, and stress. EDH noted her history of depression, however explained that her mental health and self-esteem had been particularly damaged during her relationship with URE. At her first appointment with LJD, EDH reported that if she "*had stayed with [URE] [she] would have ended up killing [herself]*".

30. During EDH's September and October 2020 appointments with LJD, she noted that although the family violence she experienced was still affecting her, her mental health was improving, particularly due to the fact that URE was 'distanced' from her.

December 2020

31. On 16 December 2020, EDH attended her GP and reported that she had overdosed on quetiapine. Her GP advised her to present to a hospital ED, so EDH attended the LRH ED. At the LRH ED, EDH was assessed by a mental health clinician and reported that the overdose was an impulsive decision in the context of URE contacting her via email as well as other FVIO breaches, which intimidated and threatened her. EDH was concerned about the FVIO expiring and did not know what she could do to extend the order.

32. EDH further disclosed that a housemate's friend had recently sexually assaulted her and that a result of the assault, she was afraid of socialising, and she was afraid of exercising at the gym in front of men. She told clinicians that she was deliberately putting on weight to make herself less appealing to men.

33. The clinician noted EDH's chronic suicidal ideation, that her immediate distress had abated and that she was suitable for discharge with follow-up in the community. A follow-up appointment with the Acute Community Intervention Service (**ACIS**) was scheduled for 18 December 2020.

34. On 18 December 2020, EDH was reviewed by a psychiatry registrar. She told the registrar that URE had contacted her, allegedly in breach of the FVIO, causing her to feel threatened and intimidated. She again disclosed the assault by her housemate's friend and explained that she was using the strategies she previously learned in therapy to manage her distress. She agreed to increase the frequency of her appointments with LJD and agreed to increase her antidepressant medication. A plan was made to review EDH again after Christmas.

35. An ACIS clinician reviewed EDH again on 29 December 2020. EDH was at work at the time and reported benefits from increasing her medication, despite occasionally feeling sedated. She reported that she was generally feeling well, and she was discharged back into the care of her GP.

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

Circumstances in which the death occurred

36. In the first week of January 2021, EDH was staying with her sister VYM. On 5 January 2021, EDH had an appointment with LJD and disclosed that she had recently seen URE, as she was under the impression that her FVIO had already expired. She explained that she had argued with URE and subsequently blocked his number. She noted that her mood had been fluctuating and that she had been waking with anxiety. EDH told LJD that URE got "*a kick out of messing with people*".

37. On 8 January 2021, EDH worked a shift at the Latrobe Veterinary Hospital. At 10.30am, a veterinarian took a bottle of pentobarbitone (Lethabarb) out of a locked safe in the pharmaceuticals room. Lethabarb is a therapeutic drug used to humanely euthanise animals. The bottle was not placed back into the locked safe and was instead left on a bench in the pharmaceuticals room at 12.35pm.

38. At 5.15pm, EDH observed the bottle of Lethabarb on the bench, moved the bottle slightly, then left the pharmaceuticals room. She returned about one minute later, picked up the bottle and walked out of the room again, towards the toilet. EDH returned from the toilet and collected a blanket from the work area. At 5.19pm, EDH returned to the pharmaceuticals room, took the Lethabarb bottle out from under the blanket and placed it back on the bench. EDH completed her shift at about 7.10pm that evening without further incident.

39. The next day, 9 January 2021, EDH had a day out at the Cowwarr Weir with VYM, KQT and some family friends. Those who attended the Weir that day observed that EDH enjoyed the day, however started struggling with anxiety and became withdrawn on the way home. When she arrived home, EDH had dinner and watched a movie with VYM, before retiring to bed.

40. On 10 January 2021, VYM and KQT asked EDH if she wanted to go to the beach with them, however EDH declined. VYM and KQT left the house at about 10.30am, which was the last time that they saw EDH alive.

41. VYM and KQT returned home at about 5.00pm and located EDH unresponsive, lying on her bed with an intravenous butterfly cannula in her left hand, connected by a tube to a large syringe containing about 50mL of green liquid, believed to be Lethabarb. KQT and VYM immediately called 000 and commenced cardiopulmonary resuscitation. Paramedics arrived

on scene quickly, however they were unable to revive EDH, and she was declared deceased at the scene.

42. Police also attended VYM's home following EDH's passing and investigated the circumstances of her death. Police observed EDH's 'lock screen' photo on her phone was a photo of herself with the words "*I'm sorry. I love you*". In the Notes application, police identified a note saved at 11.01am that day in which EDH evinced her intention to end her life. Police also located a "*Will and Testament*" note in EDH's room, which was dated 15 December 2020.

43. Upon a review of EDH's phone, police observed several photos of injuries that they suspected to be the result of unreported family violence perpetrated by URE. Police also found numerous emails from URE, and he was subsequently charged by police for persistently breaching the FVIO in protection of EDH. He was convicted and fined for this offence in March 2022.

Identity of the deceased

44. On 10 January 2021, EDH, born 1988, was visually identified by her sister, VYM.

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

Medical cause of death

46. Forensic Pathologist Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 12 January 2021 and provided a written report of her findings dated 12 February 2021.

47. The post-mortem examination revealed findings in keeping with the clinical history. Examination of the post-mortem CT scan showed cerebral oedema.

48. Toxicological analysis of post-mortem samples identified the presence of pentobarbitone, diazepam and its metabolite nordiazepam, lamotrigine, venlafaxine and its metabolite desmethylvenlafaxine, metoclopramide, and propranolol.

49. Dr Baber provided an opinion that the medical cause of death was *mixed drug toxicity including phenobarbitone.*

50. I accept Dr Baber's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

51. Given the significant mental health treatment and family violence history, I referred this matter to the Coroner's Prevention Unit (**CPU**)[4] for an independent review of the mental health treatment and family violence service contact prior to the fatal incident.

Treatment by LRH

52. The CPU noted that EDH's discharge from LRH on 16 December 2020 and the discharge plan appeared reasonable. She reported that the overdose was an impulsive decision, and she no longer had intent to act on her suicidal ideation. She had long-standing suicidal ideation for many years, and this was unlikely to change during an ED or mental health admission. She was agreeable for community follow-up by the ACIS clinician.

53. The CPU opined that the ACIS clinician's treatment also appeared appropriate. EDH denied any acute risks during her review with the clinician and was engaged and well supported by her private psychologist. She also noted benefits from increasing her medication dose and that she was otherwise feeling well.

54. I accept the CPU's opinion.

Treatment by LJD

55. The CPU noted that LJD engaged EDH well with CBT, which is an evidence-based treatment for depression, anxiety, PTSD and various other mental health conditions. At their final appointment on 5 January 2021, EDH appeared to have improved since the previous session and appeared less confused and more decisive about her relationship with URE, noting that she had recently blocked his number. She also appeared to be more positive and hopeful about her treatment and was making goals for the future. The CPU opined that her presentation at this appointment did not demonstrate an acute risk of suicide. I accept their opinion.

[4] 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.

Access to pentobarbitone

56. The CPU noted that in 2020 the Therapeutic Goods Administration (**TGA**) considered a proposal to change pentobarbitone (the active ingredient in Lethabarb) from a Schedule 4 drug to a Schedule 8 drug, following a South Australian inquest into two suicides associated with pentobarbitone. A decision was made to retain the Schedule 4 classification; however, a new regulation was implemented to require injectable pentobarbitone to be stored in a locked container to prevent unauthorised access. These regulations took effect on 1 October 2020.

57. The owner of Latrobe Veterinary Group, which includes the Latrobe Veterinary Hospital, Katharine Haines, noted that pentobarbitone is kept in a locked safe in the pharmaceutical room, and only veterinarians can access the safe via a combination lock. Drugs of addiction are also kept in that safe, along with keys to open the prescription drugs cupboard.

58. The CPU noted there is little guidance about what constitutes a reasonable timeframe for pentobarbitone to remain out of a locked container when in use. However, it opined that in this case, it did not appear that Latrobe Veterinary Hospital were fully compliant with these regulations. The pentobarbitone was removed from the safe by a veterinarian at 10.30am and after use, it was placed in the pharmaceuticals room at about 12.35pm. It then remained accessible for a period nearly five hours before EDH accessed it at 5.15pm. The person who later discovered the pentobarbitone on the bench does not appear to have escalated this breach to a manager. If the person who discovered the unsecured pentobarbitone escalated this issue to a manager, there may have been an opportunity for management to review the CCTV footage and determine what occurred. It is therefore possible that EDH's access to the pentobarbitone may have been known before the fatal incident.

59. Ms Haines stated that she did not investigate which veterinarian left the pentobarbitone on the bench in the pharmaceuticals room as she was concerned for the welfare of her staff and did not want anyone to feel as though they were responsible for EDH's death. She noted that she has since implemented procedures to record pentobarbitone dosages along with Schedule 8 drugs, purchased more user-friendly safes and updated locks were ordered.

60. The CPU opined that these measures appeared to be reasonable, however noted that it was not clear whether Latrobe Veterinary Group has communicated its expectations to all veterinarians when non-compliance is identified (i.e., the procedure to follow when non-compliance is identified). This communication can be prevention and safety focused, rather than focused on blaming individuals or identifying fault.

61. The Court contacted Latrobe Veterinary Group in late-2024 to seek an update on its storage of pentobarbitone and whether any changes had occurred to their practice in the years since EDH's passing. Latrobe Veterinary Group noted that they have introduced the following additional measures:

    a) A daily safe count is performed on all Schedule 8 drugs and pentobarbitone, and any discrepancies are initially followed-up by the veterinarian performing the count and escalated to the clinical manager if the discrepancy cannot be resolved.

    b) A CCTV camera has been installed overlooking the safe where pentobarbitone is stored.

    c) Consideration is being given to the implementation of appropriate Cubex systems[5] to increase the security and tracking of Schedule 8 drugs and pentobarbitone, and to reduce time spent by veterinarians counting stock.

    d) An additional lock-up area has been installed in the main drug dispensary to house drugs which are not Schedule 8 drugs (i.e., pentobarbitone) but might be subject to abuse. This area is locked with a code and is only accessible to veterinarians.

    e) The practice has improved its communication with staff members and encourages staff to bring areas of non-compliance to the attention of the individual involved. If that does not resolve the issue, or the non-compliance issue is serious, staff are required to escalate the matter to a manager at the earliest opportunity. These requirements are communicated to new staff during induction and to ongoing staff through ongoing training.

62. I am satisfied that Latrobe Veterinary Group has significantly improved its practice and culture to ensure that breaches or areas of non-compliance are promptly identified and addressed. I am therefore satisfied that no further actions or recommendations are required.

Victoria Police response to attempted reporting of FVIO breaches – July 2020

63. I note the incident in July 2020 when URE contacted EDH, allegedly in breach of the FVIO, following which EDH attempted to report the issue to police. Victoria Police had no record of EDH making contact during this period, so I am unable to determine precisely what occurred. Based on the statement by EDH's friend, EDH felt the police officer "*talked down*" to her,

[5] Inventory management for veterinary practices.

which may have impacted her willingness or confidence to report future breaches. However, in circumstances where there are no records regarding EDH's contact with police, I am unable to comment further on this matter and make no criticism.

Victoria Police FVIO against EDH – November 2019

64. 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-defense 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, 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.*[6]

65. The Victoria Police *Code of Practice for the Investigation of Family Violence* in place when URE reported EDH to police in November 2019 provided guidance on identifying the predominant aggressor, listing 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.[7]

66. The *Code of Practice* directed that when police members are unsure about who the predominant aggressor is, the AFM should be nominated "*on the basis of which party appears to be most fearful and in most need of protection*".[8]

67. It appears that Victoria Police members did not follow the guidance provided in the *Code of Practice* with respect to the incident reported by URE in November 2019, and misidentified

[6] Family Safety Victoria, MARAM Practice Guides: Foundation Knowledge Guides (February 2021), 124.
[7] Victoria Police, *Code of Practice for the Investigation of Family Violence* (2019) 3nd Edition V4, 23.
[8] Ibid.

EDH as the predominant aggressor. The members would have had evidence of URE's significant history and prior perpetration of family violence against EDH via their case management and data storage database, LEAP, which would have indicated that URE had a greater likelihood and capacity to perpetrate violence against EDH, and that he was perpetrating a pattern of coercion and violence. EDH was reportedly fearful of URE, whilst URE did not report being in fear of EDH.[9]

68. I note that a Sergeant reviewed the criminal brief of evidence against EDH and used their discretion not to charge her. However, in this review, the Sergeant did not explicitly note that EDH may have been misidentified as the predominant aggressor, but rather noted that she "*acted out of character*". This review was also not finalised until March 2020, and police did not take any action to withdraw the FVIO that they applied for against EDH. There is no evidence that police updated their records to reflect the fact that EDH may have been misidentified. As outlined above, EDH's mother noted that the way this incident was handled by police had a significant impact on her "*well-being, mental health and sense of self*".

69. I cannot determine that a different identification of EDH and URE on this occasion would have made a difference to final outcome, however it appears to be a missed opportunity to hold URE to account for his actions and to build trust with EDH. This may have influenced her willingness to engage with police after future breaches of the FVIO.

70. The Court provided Victoria Police with an opportunity to respond to the concerns that EDH may have been misidentified as the predominant aggressor in November 2019. Victoria Police responded by acknowledging that EDH may have been misidentified on this occasion.

Police misidentification of the predominant aggressor

71. The CPU explained that police misidentification of women as the predominant aggressor is an ongoing issue in Victoria and other Australian jurisdictions and has serious repercussions for victims.[10] Research indicates that when women use violence in heterosexual relationships,

[9] Victoria Police, Criminal brief for November 2019 incident, 5.

[10] Women's Legal Service Victoria, 'Snapshot of Police Family Violence Intervention Order Applications' https://www.womenslegal.org.au/%7Ewomensle/wp-content/uploads/2021/04/Snapshot-of-Police-Family-Violence-Intervention-Order-applications.pdf (2018), 1; Women's Legal Service Victoria, https://womenslegal.org.au/files/file/WLSV%20Policy%20Brief%201%20MisID%20July%202018.pdf (Policy Paper One, July 2018), 1; No To Violence, Predominant Aggressor Identification and Victim Misidentification (Discussion Paper, November 2019), 6; FVRIM, https://content.vic.gov.au/sites/default/files/2022-08/FVRIM%20Primary%20Prevention%20System%20Architecture%20Report.pdf (Report, 2022) 10-1; Parliament of Victoria Legislative Council, Legal and Social Issues Committee Inquiry into Victoria's Criminal Justice System Volume 1 (March 2022), 243

the violence tends to be a consequence of their own victimisation and as a violent resistance to a pattern of controlling, coercive and violent behaviour used against them.[11] It is therefore important that the predominant aggressor is selected by police on the basis of a pattern of coercive and controlling behaviour, rather than using an incident-based approach to investigation which does not take patterns of coercion and control into account.

72. The CPU further explained that misidentification of women as predominant aggressors is often driven by racialized, classed and gendered stereotypes of ideal victims, and women in general, as being submissive to authority, downtrodden, passive, and dependent.[12] Women who engage in violent resistance, as EDH did on 16 November 2019, may not fit these stereotypes, and this in turn may influence police decision-making in favour of the perpetrator.[13]

73. Since EDH's death, Victoria Police have undertaken work to address the issue of police misidentification of the predominant aggressor. Victoria Police have updated and improved guidance on identifying the predominant aggressor in line with Victoria's family violence multi-agency risk assessment and management framework (**MARAM**).

74. Victoria Police also carried out the Predominant Aggressor Identification Trial (**'the Trial'**) in one division between October and December 2022. 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. Following the Trial, Victoria Police have continued their work on addressing misidentification of the predominant aggressor through the Predominant Aggressor Program of Work, which started in December 2022. The findings from the Trial identified ongoing problems with police misidentification of the predominant aggressor, for example:

https://www.parliament.vic.gov.au/49c519/contentassets/6961bccea1ac41dd812811ab0312170d/lclsic-59-10-vic-criminal-justice-system.pdf.

[11] Women's Legal Service Victoria, https://womenslegal.org.au/files/file/WLSV%20Policy%20Brief%201%20MisID%20July%202018.pdf (Policy Paper One, July 2018), 2-3; 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) 112.

[12] Heather Nancarrow et al, 'Accurately Identifying the "Person Most in Need of Protection" in Domestic and Family Violence Law' (Research Report Issue 23, ANROWS, November 2020), 3; Heather Nancarrow et al (n 246) 26; No To Violence, 'Predominant Aggressor Identification and Victim Misidentification' (Discussion Paper, November 2019)12.

[13] Heather Nancarrow et al, 'Accurately Identifying the "Person Most in Need of Protection" in Domestic and Family Violence Law' (Research Report Issue 23, ANROWS, November 2020) 96.

a) Supervisory support prior to submission of the VP Form L17 was uncommon, possibly due to resourcing issues,[14] 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 VP Form 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.[15]

c) There were no documented instances of information sharing with relevant agencies to improve accurate identification of the predominant aggressor.[16] Even uncertainty about the predominant aggressor did not prompt information sharing by police, and the Trial concluded that "*information sharing continues to be under-utilised at the frontline and across the broader systems into Victoria Police*".[17]

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.[18]

e) The Trial found that police continue to take an incident-based approach to assessing predominant aggressors, and 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.[19]

[14] Victoria Police, Statement to CCoV dated 15 March 2024 - Annexure A – Predominant Aggressor Identification Trial Report, 14.
[15] Victoria Police, Statement to CCoV dated 15 March 2024, 10, Victoria Police, Statement to CCoV dated 15 March 2024 - Annexure A – Predominant Aggressor Identification Trial Report, 18.
[16] Victoria Police, Statement to CCoV dated 15 March 2024, 10.
[17] Victoria Police, Statement to CCoV dated 15 March 2024 Annexure A – Predominant Aggressor Identification Trial Report, 3
[18] Ibid, 30.
[19] Victoria Police, Statement to CCoV dated 15 March 2024, 8; Annexure A – Predominant Aggressor Identification Trial Report, 4.

f) Which party contacted the police influenced the subsequent direction taken by police[20] - when a male using systems abuse contacted police to make a report about their partner, misidentification was more likely to occur. As occurred in EDH's case, the Trial report noted instances of the female perspective not being appropriately considered or recorded by police in these instances.[21]

75. 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.[22] These included cases which had previously been reviewed by a supervisor at a police station.[23] The Trial report 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*".[24]

76. When the Court wrote to Victoria Police to summarise the above findings from the Trial, Victoria Police acknowledged that there are ongoing concerns with misidentification of the predominant aggressor, including in relation to information sharing. It also noted that addressing issues of misidentification remains a priority for the organisation and is part of an ongoing and comprehensive program of work within Victoria Police. It also noted that the Trial was just one part of a broader program of work aimed at enhancing the correct identification of the predominant aggressor and the timely detection and rectification of misidentification.

77. Victoria Police further noted that it is undertaking significant work to improve internal processes and opined that sector-wide engagement for any system modifications and improvements could not be understated. Victoria Police submitted that inter-agency collaboration and information sharing is a sector-wide challenge and as such, suggests that addressing this issue cannot rest solely with Victoria Police. It submitted that any consultation

[20] Victoria Police, Statement to CCoV dated 15 March 2024 Annexure A – Predominant Aggressor Identification Trial Report, 13.
[21] Ibid, 20.
[22] Victoria Police, Statement to CCoV dated 15 March 2024, 10; Annexure A – Predominant Aggressor Identification Trial Report, 27.
[23] Victoria Police, Statement to CCoV dated 15 March 2024 Annexure A – Predominant Aggressor Identification Trial Report, 27.
[24] Ibid, 26.

and reform should be led by the government and should include Victoria Police as well as many other stakeholders within the sector.

78. I note that whilst the changes outlined above by Victoria Police are positive, there are additional strategies or measures that may be able to reduce police misidentification of the predominant aggressor, and generally improve police responses to family violence. Two such strategies include an expansion of Victoria's co-responder program, and specialist family violence sector reviews of Victoria Police family violence reports. These are discussed further below.

Co-responder programs

79. A co-responder program involves the presence of a family violence specialist worker during police attendance at family violence incidents to provide a collaborative response. Research has identified key benefits from co-responder programs, including higher satisfaction of victims with police, increased willingness of victims to contact police in the future, more information sharing and coordination of services for victims, a greater understanding of family violence by police, and a perceived increase in the accountability taken by police in responding to family violence.[25] It is also a popular option to reduce the rates of misidentification of the predominant aggressor amongst researches, police, and people with lived experience of family violence.[26]

80. The CPU noted the success of the Alexis Family Violence Response Model, which is a co-responder model that operates across the Prahran, Bayside and Somerville Family Violence Investigation Units (**FVIUs**). Evaluations of the program have found many positive effects, including a reduction in family violence recidivism by 85%,[27] increased reporting,[28] and transfer of skills and knowledge between police and specialist family violence workers.

81. I note the comments made by State Coroner, Judge Cain, in his finding into the death of Carolyn James on the potential positive impact that a co-responder model may have had in

[25] 6 Nancarrow, H. et al., *Accurately Identifying the "Person Most in Need of Protection" in Domestic and Family Violence Law* (ANROWS Research Report 23, 2020) 21.
[26] Ibid, 96.
[27] Dr Lisa Harris, Dr Anastasia Powell and Dr Gemma Hamilton, Alexis – Family Violence Response Model (Evaluation Report, 2017) 28.
[28] Hamilton, G., Harris, L., & Powell, A., 'Policing Repeat and High-Risk Family Violence: Police and Service Sector Perceptions of a Coordinated Model' (2021) 22(3) *Police Practice and Research*, 145.

that case. I am similarly of the view that this model may be beneficial and support any work towards implementing a co-responder model in Victoria.

Specialist family violence sector reviews of Victoria Police family violence reports

82. The Family Violence Reform Implementation Monitor's (**FVRIM**) recent report *Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor* made recommendations in relation to improving accurate police identification of the predominant aggressor. As noted above, Victoria Police are currently undertaking a program of work designed to address "*the intent of all [FVRIM] recommendations*", however this does not include the implementation FVRIM recommendation five:

> *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.156F*[29]

83. As outlined above, the Trial was designed in consultation with the specialist family violence sector, however, during the Trial reviews of family violence reports were conducted by police without input from specialist family violence practitioners. The results of the Trial indicated that the ability to identify when a person has been misidentified as the primary aggressor is still an issue for Victoria Police. I consider therefore that the Trial does not constitute implementation of FVRIM recommendation five.

84. If recommendation five were implemented in full, wherein police *and* specialist family violence practitioners reviewed family violence reports where a woman has been identified as the respondent, prior to being committed to LEAP, there is potential to significantly reduce the rates of misidentification by:

a) Drawing on the expertise of the family violence sector in assessing predominant aggressors.

b) Facilitating skills and knowledge transfer from the family violence sector to police.

c) Reducing issues related to the focus on criminality in the police station context identified in the Trial, by involving specialist family violence workers outside of the station environment and broader police culture.

[29] FVRIM, Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor (Report, December 2021), 6.

d) Promoting information sharing between Victoria Police and the family violence sector.

e) Ensuring appropriately thorough consideration of the information available to police, including past LEAP records, when determining the predominant aggressor, noting that this was a key issue in the police misidentification of EDH as the predominant aggressor in November 2019.

f) Ensuring all of the above is done before the L17 is committed to LEAP, triggering harmful actions such as applications for FVIOs in protection of family violence perpetrators and family violence referrals which misidentify victims as perpetrators.

85. The CPU suggested that I consider making the following recommendation:

a) That Victoria Police and Safe and Equal collaborate to implement recommendation five of the FVRIM, by trialling a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent before it is committed to Victoria Police's LEAP database

86. In response to correspondence from the Court indicating my intention to make the above recommendation, Victoria Police submitted that it supported this recommendation 5 of the FVRIM in principle, along with the other FVRIM recommendations. It also noted that referral of family violence reports between appropriate agencies in relation to family violence is guided by the *Family Violence Referral Protocol 2018* (**the Protocol**)[30], which supports the partnership between the Department of Families, Fairness and Housing, Family Safety Victoria, the Department of Justice and Community Safety and Victoria Police. Victoria Police submitted that under the Protocol, Safe and Equal may not be the appropriate agency to co-design or test any change in processes.

87. Victoria Police also stressed that any proposed reform must be driven in a whole of government setting to determine the best solutions and avoid unintended consequences. It concluded by submitting that I should not make the above recommendation.

[30] Family violence referral protocol between DHHS, Family Safety Victoria and Department of Justice and Regulation and Victoria Police 2018 (word) - DFFH Service Providers.

88. In the intervening period between the Court's contact with Victoria Police, and their response provided 4 February 2025, the State Coroner Judge Cain made a recommendation in his finding into the death of FCP[31], namely:

> *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.*

89. I support and endorse the State Coroner's recommendation and, in those circumstances, am satisfied that I do not need to make a further recommendation.

Court Applicant Practitioner – Latrobe Valley Magistrates' Court

90. I commend the Applicant Practitioner for correctly identifying URE as the predominant aggressor in his relationship with EDH, despite EDH being listed as the respondent on the police-initiated FVIO application. The Applicant Practitioner completed a safety plan with EDH, made appropriate referrals, and contacted The Orange Door (where EDH had been referred by police as a respondent) and informed them of their concerns.

91. Victoria Police are currently working towards establishing clear contact points for the family violence sector to raise possible misidentification of the predominant aggressor, as well as a clear authorisation pathway and guidance for police withdrawal of FVIO applications at court in these circumstances.

92. As discussed above, I am of the view that correct identification of the predominant aggressor is crucial, and I support any work towards ensuring a clear authorisation pathway and guidance for police withdrawal of FVIO applications at court in those circumstances. Although I cannot determine that withdrawal of the FVIO against EDH would have prevented her death or changed the outcome, the police response she received in relation to this incident was a clear stressor for her.

[31] Finding into death without inquest – FCP (COR 2020 1981).

Quantum Support Service

93. The CPU reviewed the contact between EDH and Quantum Support Services in August and September 2018 and did not identify any concerns relating to the family violence risk assessment and management provided to EDH. However, as outlined above, EDH's mother expressed concerns that the support worker allocated to EDH was a family friend and that this made EDH feel uncomfortable. She also noted that many of the local workers at The Orange Door were known to the family, which may have further contributed to her decision not to engage with the service over a substantial period of time.

94. The CPU explained that conflicts of interest such as the one present in this case are more likely to arise in regional and remote areas and for clients involved in close-knit or smaller communities. Whilst the *Code of Practice: Principles and Standards for Specialist Family Violence Services for Victim-Survivors* prompts services to consider privacy and confidentiality issues specific to these cohorts, it does not explicitly guide services not to allocate clients to workers who are personally known to them. The CPU suggested that I make a recommendation that Safe and Equal update *Code of Practice: Principles and Standards for Specialist Family Violence Services for Victim-Survivors* or a similar practice guiding document to include:

    a) clear instructions not to allocate workers to clients who they know personally, including family friends and acquaintances

    b) clear guidance on what workers should do if they identify that they know a client personally after a referral has been made to them

    c) clear guidance on how services should manage referrals where the client has a personal association with all available workers.

95. I accept and adopt this recommendation. I cannot determine that EDH would have engaged differently if she was not allocated to a case worker who was also a family friend, however it seems prudent that conversations of a deeply personal nature such as family violence are not occurring with someone known to the victim. Therefore, I am of the view that clear guidance about this specific issue should be provided to the sector and will make a recommendation to that effect.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was EDH, born 1988;

    b) the death occurred on 10 January 2021 at Warragul, Victoria, 3820, from *mixed drug toxicity including phenobarbitone;* and

    c) the death occurred in the circumstances described above.

97. Having considered all of the circumstances, I am satisfied that EDH intentionally took her own life.

COMMENTS

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

1. I support Victoria Police's work towards establishing clear contact points for the family violence sector to raise possible misidentification of the predominant aggressor, as well as a clear authorisation pathway and guidance for police withdrawal of FVIO applications at court in these circumstances.

2. I note the comments made by State Coroner, Judge Cain, in his finding into the death of Carolyn James on the potential positive impact that a co-responder model may have had in that case. I echo these comments and support an expansion of these programs in Victoria.

RECOMMENDATIONS

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

(i) That **Safe and Equal** update *Code of Practice: Principles and Standards for Specialist Family Violence Services for Victim-Survivors* or a similar practice guiding document to include:

1. clear instructions not to allocate workers to clients who they know personally, including family friends and acquaintances

2. clear guidance on what workers should do if they identify that they know a client personally after a referral has been made to them

3. clear guidance on how services should manage referrals where the client has a personal association with all available workers.

I convey my sincere condolences to EDH's family and loved ones 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:

KQT, Senior Next of Kin

WIH, Senior Next of Kin

VYM

Chief Commissioner of Police (C/- Victorian Government Solicitor's Office)

Latrobe Regional Health

Latrobe Veterinary Group

Safe and Equal

Detective Senior Constable Jory Coster, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 11 April 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.