IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 000175

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	TCW
Date of birth:	[redacted]
Date of death:	11 January 2018
Cause of death:	1(a) Neck Compression
Place of death:	[redacted]
Keywords:	Adolescent family violence; family violence; homicide; manslaughter; sexual abuse

INTRODUCTION

1. On 11 January 2018, TCW was 43 years old when she was found deceased at her home in [redacted], Victoria. At the time of her death, TCW lived with her (then) 17- and 19-year-old sons, OMP and EDL. OMP and EDL identify as Aboriginal on their father's side; their father resides in Queensland. TCW is survived by her parents, her sons and her two younger sisters.

2. TCW was described as an artistic and creative person, became a legal street artist in her late-adolescence, later attending the Brougham Art School in Geelong and the Victorian College of the Arts, graduating with a degree in Fine Art in 2014. She was unable to work as an artist in the two years prior to her death, due to her carer responsibilities and stopped working altogether in late-2017 to care for OMP full-time. TCW received a carer's pension and assistance from her parents in relation to OMP's disabilities.[1]

3. On 18 January 2021, His Honour Justice Coghlan found OMP guilty of the manslaughter of TCW and he was placed on a custodial supervision order with a nominal term of 20 years due to his mental health conditions. He is currently housed in a Long-Term Residential Program (**LTRP**).

BACKGROUND

4. OMP was born in Geelong and lived most of his life in Victoria.[2] From an early age, OMP's family observed that he was "*a little bit different*"[3] but they did not want him labelled and loved him unconditionally. When he was in kindergarten, he was diagnosed with an intellectual disability and was found to have an IQ of 59.[4]

5. OMP attended primary school in Aireys Inlet, followed by Brunswick Primary School. When he completed primary school, he was initially enrolled at Brunswick High School, however due to his vulnerabilities, he was moved to Croxton School, a specialist school in Northcote which caters to children with an intellectual disability.[5]

6. By the age of five, OMP began to demonstrate sexually inappropriate behaviours for his age. He reached puberty at the age of nine and developed strong sexual urges from that time, asking inappropriate questions about other people's relationships and looking down teachers' blouses

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1 Coronial Brief (**CB**), Statement of EBI dated 11 January 2018, 283.
2 Forensicare Psychiatric Court Report, Dr Rajan Darjee dated 25 February 2019, 4.
3 CB, Statement of EDL dated 22 January 2018, 264.
4 CB, Statement of EBI dated 11 January 2018, 284.
5 Ibid.

or up their skirts. In about 2014, OMP was referred to the Croxton School's Social Worker, Robyn Booth, after allegedly stalking female students from Brunswick Secondary College.[6]

7. Whilst at the Croxton School, OMP met fellow classmate, RSS, and commenced a relationship with her. OMP reportedly became "*obsessed*" with RSS very early on in the relationship, which later extended to RSS' mother, TKM.[7]

8. On 2 May 2016, OMP sexually assaulted a female peer. A meeting was held including TCW, EDL, maternal grandfather TNC, Ms Booth, OMP's teacher and a psychologist from the Department of Education. Concerns were expressed regarding OMP's lack of empathy regarding this alleged assault.[8] Ms Booth referred OMP to the Children's Protection Society (**CPS**), where he engaged with a social worker/therapeutic practitioner, Thomas Gould.[9] Mr Gould worked with OMP on topics including sexual consent, appropriate behaviour, and how to engage in healthy and respectful relationships.[10]

9. About one month later, TCW called Mr Gould and reported that OMP was involved in another incident where OMP was touching female students on the bottom whilst on the school bus. TCW was understandably concerned about OMP's behaviour towards girls and his lack of insight. Mr Gould commenced weekly counselling sessions with OMP and observed that he had a significant lack of insight regarding his behaviour and its impact on other people.[11]

10. In August 2016, OMP brought a knife to school and stated that he wanted to kill the students that were annoying RSS.[12] He was assessed by the Orygen Youth Health (**OYH**) Youth Access Team (**YAT**), where he reported he was heart-broken, he lay in bed thinking about killing people and thought he might have demon inside him. OMP did not meet the criteria for treatment with OYH and did not have an acute mental illness. He was assessed as being at risk of acting impulsively and would benefit from ongoing psychological support.[13] Due to his intellectual disability, police did not charge OMP in relation to this incident.[14]

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6 CB, Appendix AA – Croxton School Documents.
7 CB, Appendix II – Children's Protection Society (**CPS**) Documents.
8 CB, Statement of Robyn Booth dated 19 February 2018, 303.
9 CB, Statement of Thomas Gould dated 2 March 2018, 315.
10 Ibid.
11 Ibid, 317.
12 CB, Appendix AA – Croxton School Documents.
13 CB, Orygen Youth Health Records, 1145.
14 CB, Police Summary, 8.

11. In November 2016, TCW informed Mr Gould that she was struggling to manage OMP and that his behaviour was becoming verbally abusive and intimidating.[15] Mr Gould referred OMP and TCW to Child FIRST, who could provide referrals and support to TCW.

12. In a December 2016 session with OMP and Mr Gould, OMP was able to recall the topics they previously discussed. He had progressed well and there were no new reports of sexually inappropriate behaviour.[16]

13. In April 2017, Ms Booth raised concerns with TCW regarding OMP's relationship with TKM, RSS' mother. OMP reportedly met with TKM for lunch in secret and spoke to her several times per week on the phone.[17] OMP denied ever having a sexual and/or physical relationship with TKM.

14. From June to August 2017, Ms Booth received several reports from staff at the Croxton School, regarding OMP stealing school-issued iPads to watch pornography. His behaviour towards female peers had further escalated and he was reportedly placing his hands on seats so that girls would sit on his hands.[18] He also reportedly sent an explicit message to a teacher and did not appear to express any remorse or insight into the message, which was reported to the Epping Sexual Offences and Child Abuse Investigation Unit (**SOCIT**).[19]

15. In mid-August 2017, TCW spoke with Ms Booth and advised she might send OMP to Queensland for a few weeks where his cousin resided, as this cousin previously had a positive impact on OMP. OMP went to Queensland shortly thereafter for about three weeks, whilst TCW researched more intensive professional programs to assist OMP.[20]

16. On 15 August 2017, OMP posted a sexually explicit comment on a photo TKM posted to Facebook in 2012. TKM did not initially notice the comment, however when she discovered it a few days later, she contacted OMP and asked him to remove it immediately.[21] He initially denied making the post, however expressed remorse when RSS spoke to him about it. This incident appeared to be the catalyst for the end of OMP's relationship with RSS.[22]

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[15] CB, Appendix AA – CPS Documents.
[16] Ibid.
[17] CB, Appendix AA – CPS Documents, 1028.
[18] CB, Statement of Mr Gould dated 2 March 2018, 322.
[19] CB, Statement of Ms Booth dated 19 February 2018, 309-310.
[20] Ibid, 311.
[21] CB, Statement of TKM dated 18 March 2018, 426-427.
[22] Ibid.

17. In late-August 2017, a meeting was convened between TCW, her parents, the principal and two teachers from the Croxton School, Ms Booth, and Mr Gould. The purpose of the meeting was to formulate a plan to assist OMP, including commencing OMP on medication to reduce his libido.[23] Ms Booth referred OMP to the Victorian Dual Disabilities Service (**VDDS**) at St Vincent's Hospital and provided a list of concerns in relation to his behaviour.

18. In mid-September 2017, TCW took OMP to the local police station to discourage him from stealing school iPads to access pornography. Whilst at the police station, OMP was recognised as a person of interest in relation to the alleged sexual assault of a minor on public transport. He was arrested, interviewed, and charged with eight counts of sexual assault, and was bailed to appear at Melbourne Children's Court at a later date, on the condition that he not board public transport.[24]

19. OMP was referred by his general practitioner (**GP**) to a psychiatrist, Dr Simon Gillian, and first consulted with him on 27 September 2017. TCW initially wanted OMP to see a forensic child and adolescent psychiatrist, however, was unable to obtain one and Dr Gillian agreed to see OMP. Dr Gillian noted that OMP's sexual behaviour appeared to escalate following the end of his relationship with RSS. Dr Gillian did not observe any history or symptoms suggestive of depression, a major mood disorder, psychosis, or mania/hypomania.[25]

20. Dr Gillian observed that OMP was a difficult historian, often embellished stories and was eager to impress others. He noted that OMP had a poor understanding of time, had little capacity for empathy, and was unable to understand how he may have scared the young girls that he allegedly assaulted. TCW noted that OMP was masturbating frequently at home and in the presence of others in an unrestrained and inappropriate manner. Dr Gillian commenced him on fluoxetine, which has a common side effect of loss of libido.[26]

21. TCW commenced psychological counselling for herself in late-September 2017, in relation to her problematic alcohol use and in relation to the criminal charges that OMP was facing. She first met with psychologist, Zoe Krupka, on 29 September 2017 and reported her concerns about finding support and treatment for OMP. Ms Krupka assisted TCW with sourcing respite, referrals, and other support services, although noted she was encountering difficulties with

[23] CB, Statement of Ms Booth dated 19 February 2018, 311.
[24] CB, Statement of Detective Senior Constable (**DSC**) Daniel Wheelahan, dated 18 April 2018, 465.2.
[25] CB, Statement of Dr Simon Gillian dated 20 March 2018, 334.
[26] Ibid, 339-340.

obtaining an available treatment option. This appeared to be because OMP had not yet had an assessment and did not have any diagnosed mental illness(es).[27]

22. On 2 October 2017, TCW consulted with Dr Gillian alone, where she provided him with relevant background information about OMP. Dr Gillian discussed some of the reasons why OMP was displaying inappropriate sexualised behaviour. TCW was distressed by this conversation and reported to Ms Krupka that she was concerned that Dr Gillian was focusing on the wrong issues. Ms Krupka offered to speak to Dr Gillian, and reassured TCW that sexualised behaviour was not an uncommon issue in young people with an intellectual disability.[28]

23. Dr Gillian reviewed OMP again on 12 October 2017, where he documented a reduction in sexualised activity. Dr Gillian was unclear whether this was an attempt by OMP to gain Dr Gillian's approval or if it was a genuine reduction as a result of the fluoxetine. However, he noted that OMP was regularly trying to access electronic devices at home and school (i.e., stealing) to watch pornography.[29]

24. A paediatrician from Victorian Aboriginal Health Service (**VAHS**), Dr Hsu En Chung, reviewed OMP on 13 November 2017, following a referral from his GP in relation to some behaviours of concern. OMP reported being sexually active since the age of 14, and reported ending his relationship a few months earlier, which is when his sexualised behaviours escalated. TCW noted that OMP's libido had reduced somewhat since commencing fluoxetine and his behaviours of concern were less problematic when he was distracted. She also explained that she had commenced the intake process for the National Disability Insurance Scheme (**NDIS**), which was not going to be available until March 2018 in her area. Dr Chung's impression was of "*significant sexualised behaviours and behavioural misconduct in the setting of intellectual disability, for ongoing assessment and management*".[30] Her plan was to provide respite information to TCW, and to organise ongoing follow-up with Dr Gillian and Mr Gould.[31]

25. OMP and TCW returned to Dr Gillian on 15 November 2017. TCW noted that little had changed for her son, although reported that he was masturbating less. Dr Gillian spoke with

[27] CB, Statement of Zoe Krupka dated 15 February 2018, 360.
[28] CB, Statement of Ms Krupka dated 15 February 2018, 362.
[29] CB, Statement of Dr Gillian dated 20 March 2018, 337-338.
[30] CB, Victorian Aboriginal Health Service (**VAHS**) medical records, 888.
[31] Ibid.

Mr Gould after the session, and expressed concerns about TCW's tendency to walk around the house naked and the impact this may have had on OMP's behaviour.[32]

26. On 22 November 2017, TCW called Mr Gould prior to OMP's session that day. She noted that OMP stole $800 from the gym he attended for boxing classes and expressed her concern that Dr Gillian was judgemental towards her.[33] OMP then attended for his counselling session, and the pair discussed the places OMP liked to masturbate. Mr Gould noted that OMP "*appeared only fixated on his own needs and satisfying his sexual impulse. He struggle[d] to acknowledge how his behaviours affect[ed] others*".[34]

27. In November or December 2017, EDL located OMP in their mother's room, masturbating on her bed with her clothes and jewellery. EDL threatened to tell their mother about what he observed, so OMP walked away.[35] It does not appear that EDL told TCW about this incident, and he noted that he usually did not say anything to her about OMP's behaviour as he did not want to "*put any more stress on [her]*".[36]

28. Around the same time, TCW organised mentoring via a social worker, Daniel Cocker, at the Chin-Up Project, and was referred by VAHS to a foster carer, KHJ, who had experience with fostering many young people. KHJ was unable to provide respite care to OMP as she already had a child in her care, however, was able to provide guidance and support over the phone.[37] TCW disclosed that OMP's behaviour had escalated to the point that she was fearful of OMP and was afraid for her safety and EDL's safety. She also disclosed that OMP's behaviour was also becoming more sexualised towards her, such as appearing without warning whilst she was using the bathroom.[38]

29. KHJ educated TCW about how to teach OMP about appropriate relationships, consent, and sexual education. She noted TCW appeared to be embarrassed about this issue, possibly because she had never received any guidance about 'normal' sexual behaviour in children with intellectual disabilities.[39]

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[32] CB, Statement of Thomas Gould dated 2 March 2018, 324.
[33] Ibid.
[34] Ibid.
[35] CB, Statement of EDL dated 22 January 2018, 277.
[36] Ibid.
[37] CB, Statement of KHJ dated 18 January 2018, 366.
[38] CB, Statement of KHJ dated 18 January 2018, 368-370.
[39] CB, Statement of KHJ dated 18 January 2018, 368.

30. On 4 December 2017, Dr Chung reviewed OMP again and noted that his stealing had escalated, however his libido remained lowered on the fluoxetine. Dr Chung's plan was for ongoing physical health monitoring at VAHS, and continued engagement with Dr Gillian and Mr Gould. Dr Chung spoke with Mr Gould who noted that OMP's behaviour had deteriorated, and this appeared to have coincided with the breakdown of his relationship with RSS.[40]

31. The next day, TCW attended a meeting at the Croxton School with Mr Gould, Ms Booth, and other staff members. TCW explained that OMP attended court the week before for his pending sexual assault charges and the matter was adjourned to March 2018.[41] TCW noted that OMP's lawyer was seeking a neuropsychological assessment to assist with his criminal proceedings. The group also spoke about obtaining additional staff at school to help OMP get through Year 12 in 2018.[42]

32. Ms Booth observed that TCW "*seemed to be depressed and appeared despondent*".[43] TCW was concerned and stated, "*sometimes I feel like it is going to be just me and OMP stuck in the house so that people can be safe*".[44] Ms Booth was concerned, given the summer school holidays were approaching and asked TCW if she felt safe, to which TCW became emotional and replied "*no*".[45] Ms Booth asked what she and the school could do to assist, and TCW replied that she would call 000 in the event of an emergency.

33. OMP had his final session with Mr Gould prior to TCW's passing on 11 December 2017. The pair discussed OMP's breakup with RSS and OMP stated that it was the most significant event in his life. He stated that he wished he did things differently with her, for example, not begging her to engage in sexual activity.[46]

THE CORONIAL INVESTIGATION

34. TCW'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.

[40] CB, VAHS medical records, 894.
[41] CB, Statement of Ms Booth dated 19 February 2018, 312.
[42] Ibid.
[43] Ibid.
[44] Ibid.
[45] Ibid.
[46] CB, Appendix AA – CPS Documents, 972.

35. 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.

36. 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.

37. Victoria Police assigned Detective Sergeant Glen Scharper to be the Coroner's Investigator for the investigation of TCW's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

38. This finding draws on the totality of the coronial investigation into the death of TCW 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.[47]

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

Identity of the deceased

39. On 15 January 2018, TCW, born [redacted] was visually identified by her father, TNC.

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

Medical cause of death

41. On 11 January 2018, Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy and provided a written report of his findings dated 6 April 2018.

[47] 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.

42. The post-mortem examination revealed several subtle blunt force injuries which were of concern. The most significant finding was a fracture of the superior horn of the thyroid cartilage which was accompanied with adjacent haemorrhage as well as some haemorrhage to the strap muscles of the anterior neck. Dr Bouwer opined that this would indicate the application of blunt force to the neck, which is highly suggestive of compression of the neck.[48]

43. Dr Bouwer also noted bruising to the upper eyelids, petechial haemorrhages and bruises on the left lower eyelid, scleral haemorrhage in the left eye, bruises and abrasions around the nose, mouth, left cheek and chin, indicating blunt forces applied to those regions. There were also multiple subcutaneous bruises around the wrists, back of the hands, forearms, inside the upper arms and in the armpits and a large subcutaneous bruise was present in the lower mid back. Several subcutaneous bruises were also noted on the legs and feet. The bruises on the limbs, especially around the wrists, hands, and forearms, were highly suggestive of a combination of defence type injuries and "*heavy*" handling.[49]

44. The presence of abrasions and bruises on the face, deep soft tissue bruises in the anterior neck structures and the fractured superior horn of the thyroid cartilage were highly suggestive of neck compression, and in Dr Bouwer's opinion, were the most likely cause of death.

45. Dr Bouwer noted that the deceased was allegedly found unconscious in the bath, raising the possibility of drowning. Specific signs of drowning per se do not exist, and it is a diagnosis of exclusion based on the consideration of the circumstances surrounding the death and the autopsy findings. Positive signs of drowning (although not absolutely specific) include froth in the air passages (so-called froth plume) and heavy, wet, overinflated lungs. These features were not present in this case.[50]

46. There was also a focal laceration of the liver around the falciform ligament associated with 50mL of blood in the peritoneal cavity. This injury can occur in the setting of incorrectly performed chest compressions during attempted resuscitation by applying the pressure to low on the chest wall or directly on the upper abdomen. It can also be due to inflicted blunt forces to the abdominal region. In this respect, the large bruise on the mid-back of the deceased may be relevant.[51]

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[48] Medical Examiner's Report (**MER**) dated 6 April 2018, 4.
[49] Ibid.
[50] MER dated 6 April 2018, 4-5.
[51] MER dated 6 April 2018, 5.

47. Dr Bouwer opined that it was highly unlikely for this constellation of these injuries to have been sustained during the process of removing the deceased from the bath, as reported by her son.[52]

48. Toxicological analysis of post-mortem samples detected elevated levels of ethanol (alcohol) in the blood and vitreous humour at 0.18% and 0.24%, respectively. Levels above 0.15% can cause significant central nervous system depression in a non-habitual drinker. In a person who drinks alcohol on a regular basis, such as in chronic alcoholics, interpretation of blood and vitreous alcohol concentrations is problematic as tolerance to the effects of alcohol can develop with regular use. The levels detected in this instance should therefore be interpreted with caution.[53]

49. Toxicological analysis of exhibits submitted by Victoria Police of vomit samples obtained at the scene did not detect common drugs or poisons. The specimens were unsuitable for ethanol analysis.[54]

50. There was no significant natural disease detected that may have caused or contributed to the death.[55]

51. Dr Bouwer provided a Supplementary Report dated 26 October 2020, at the request of the Office of Public Prosecutions (**OPP**), in which he responded to the OPP's queries. The OPP asked the following questions, assuming that the cause of death was compression of the neck:

    a) The amount or degree of force that would be required to cause the death.

    b) How long such force needed to be applied in order for strangulation to cause death.

    c) Whether the injuries sustained were consistent with the version provided by the accused; that is that he "*grabbed her by the neck and placed a pillow over her head to keep her quiet and went too far*"?

52. Dr Bouwer explained that during strangulation, the pressure applied to the neck impedes oxygen supply to the brain by preventing blood flow to and from the brain. The trachea can

[52] Ibid.
[53] Ibid.
[54] Ibid.
[55] Ibid.

also be restricted, making breathing difficult or even impossible. This combination can quickly cause asphyxia, causing unconsciousness or death. [56]

53. He noted that it is always difficult to estimate force in these circumstances, but forces applied to the neck during manual strangulation do not need to be excessive to cause airway obstruction and/or impede blood flow to the brain, as even relatively mild pressure on the neck can have this effect. For example, force applied to the neck for many seconds or minutes may rapidly lead to unconsciousness and ultimately death. That, in combination with airway obstruction by suffocation (such as a pillow blocking the nose and mouth) may further impede breathing and hence rapidly lead to unconsciousness. In this case, the right superior horn of the thyroid cartilage was fractured which may suggest at least a moderate degree of force was applied to have caused this fracture.[57]

54. Dr Bouwer concluded that the injuries and other findings observed at autopsy were consistent with being sustained in this manner or another similar manner (i.e., manual strangulation and/or without external airway obstruction by an object such as a pillow). Dr Bouwer did not change his opinion as to the original cause of death.[58]+

55. Dr Bouwer provided an opinion that the medical cause of death was *unascertained*.[59]

56. At OMP's Special Hearing, before Justice Coghlan, Dr Bouwer gave evidence regarding the cause of death. Dr Bouwer explained that despite providing the initial cause of death as *unascertained*, he noted the presence of injuries including the deep soft tissue bruises in the anterior neck structures, the fractured superior horn of the thyroid cartilage and the abrasions and bruises around the face were "*highly suggestive of neck compression, and, in [Dr Bouwer's] opinion, the most likely cause of death*".[60]

57. I accept Dr Bouwer's opinion as to the cause of death.

Circumstances in which the death occurred

58. On the evening of 5 January 2018, OMP was home alone. His brother was away on holiday with a friend, who left his vehicle parked behind the family home in [redacted] OMP dressed himself in a suit, placed a ring on his left ring finger, and took EDL's friend's car keys. He

[56] Supplementary Report dated 26 October 2020, 2.
[57] Ibid.
[58] Supplementary Report dated 26 October 2020, 3.
[59] MER dated 6 April 2018, 4.
[60] *The Queen v RT* Transcript 282: 24-26.

drove for about one kilometre before he collided with a parked car. He reversed, hit another car, and then drove off. OMP continued driving down the same street before colliding with a telephone pole shortly thereafter. After the collision with the telephone pole, OMP was apprehended by an owner of one of the vehicles he collided with and was held at the scene until police could arrive.[61]

59. Constable Chris Potter spoke with OMP, who provided his name and an incorrect date of birth. Constable Potter observed that OMP was "*very vacant and distant…taking a long time to respond to simple questions*".[62] Constable Potter was concerned about OMP's responses and completed a name check on OMP via the police radio, who confirmed a match with OMP's name and different date of birth. Constable Potter was also advised that OMP was subject to bail conditions in relation to alleged sexual offending.[63]

60. Constable Potter asked OMP about what occurred, and he explained that he "*saw an orange cat run in front of [his] car, and [he] panicked and crashed into the pole*". His reason for driving was that he was on the way to his sister's funeral in Geelong as she had recently died from cancer. Constable Potter was concerned about the answers that OMP provided and was unsure if the photo on file accurately matched him, so OMP was placed under arrest and conveyed to the Brunswick Police Station.[64]

61. At Brunswick Police Station, OMP conceded that he lied to police, provided his correct details, and provided TCW's details. Police called TCW and she explained OMP's intellectual disability. The next day, TCW confided in a friend, that she was "*at her wits end*".[65] She was furious that police did not remand OMP, as he was on bail at the time and could have seriously injured or killed himself or someone else.[66] TCW also disclosed to KHJ that after returning from the police station that OMP allegedly "*belted her across the face and said to her that he was going to kill her if she told his brother*".[67]

62. Following the car accident, TCW appeared to reach a 'breaking point' and acknowledged to herself and others that she was no longer able to control OMP's behaviour and needed to relinquish her parental rights. On 8 January 2018, TCW emailed the Victorian Aboriginal Child Care Agency (**VACCA**) and stated that she wanted to relinquish her parental rights. She

[61] CB, Statement of Constable Chris Potter 5 July 2018, 466.1
[62] Ibid.
[63] Ibid.
[64] Ibid, 466.2.
[65] CB, Statement of [redacted] dated 18 January 2018, 413.
[66] Ibid.
[67] CB, Statement of KHJ dated 18 January 2018, 369.

explained that her "*desperate concern is that he is becoming increasingly violent towards [her]self and his brother and [she was] worried about [their] safety. He has impulse control issues and sexually inappropriate behaviours and these are escalating daily*".[68]

63. The next day, TCW contacted Child FIRST and spoke with intake worker, Nicola Anderson. TCW explained that her son had an intellectual disability and that she wanted to relinquish care as she felt unsafe in his presence. Ms Anderson suggested that TCW should call police in the event that she felt unsafe, which TCW acknowledged, however noted that police usually released OMP every time he was arrested or apprehended. She also stated that "*she felt like she was calling a lot of places to get help including DHHS, VACCA…and other places to relinquish care but she was not getting anywhere*".[69] Ms Anderson explained that Child FIRST was unable to take on parental responsibility for a child, however, was able to provide referrals and other support to TCW.[70]

64. Later that day, TCW emailed OMP's lawyer and asked him to have OMP's next court date moved forward and enquired whether it was possible to have a court-ordered intake into the VACCA Therapeutic Housing due to OMP's escalating behaviour.[71]

65. TCW also received a call that day from Child FIRST Aboriginal Liaison worker, Demi Rutledge, in response to her call to Ms Anderson earlier that day. Ms Rutledge offered a home visit on 16 January 2018 to conduct a risk assessment with OMP. TCW was pleased that she had finally received a call back from a service, as she had made numerous calls to many organisations without receiving a response.[72]

66. Chin-Up Youth Worker, Mr Cocker, visited OMP and TCW at about 11.30am on 10 January 2018. His immediate impression was that both OMP and TCW were in a low mood. TCW "*appeared drained and fed up*".[73] OMP admitted that the reason he stole EDL's friend's car a few nights earlier was due to his desire to see RSS, despite not having seen her for many months. Mr Cocker and OMP worked on strategies to improve his impulse control, and Mr Cocker suggested that OMP might benefit from attending a camp where he could connect with his Aboriginal culture and heritage. OMP and TCW were both in favour of this idea. After his

[68] CB, Appendix V, Email from TCW to VACC dated 8 January 2018, 637.
[69] CB, Statement of Nicola Anderson dated 14 March 2018, 372.
[70] Ibid.
[71] CB, Appendix W – Email from TCW to Michael Milardovic dated 9 January 2018, 642.
[72] CB, Statement of Demi Rutledge dated 8 March 2018, 375-376.
[73] CB, Statement of Daniel Cocker dated 23 January 2018, 353.

session with OMP, Mr Cocker made some enquiries and identified a contact who might be able to organise a camp for OMP.[74]

67. That afternoon, at about 3.30pm, TCW spoke with her mother and explained that she was planning to attend the Fawkner Police Station to obtain more information about OMP's charges from the car accident a few days' earlier. Throughout the day, she spoke with her friend who observed she sounded "*very flat and sad and was crying*".[75] TCW explained that OMP's behaviour was becoming increasingly difficult to control and was desperate for help. Her friend suggested some organisations that TCW could call for assistance.[76]

68. At about 7.00pm that evening, TCW ordered an Uber to collect OMP, so that he could join her at her partner's house. TCW, her partner MCE, and OMP shared dinner together, and MCE did not observe anything out of the ordinary. MCE recalled that OMP had a shower at his house between 8.30pm and 9.00pm, whilst he and TCW went to bed. MCE noted that OMP was "*being his normal boisterous loud self*" that evening and said that he would sleep on the couch downstairs.[77]

69. At about 9.30pm, TCW ordered another Uber for herself and OMP, and returned to their [redacted] home at about 9.38pm. TCW called a friend shortly after arriving home and explained that she had been with MCE earlier and they had argued about her not feeling supported by MCE. She confided in her friend that she felt MCE was pulling away and that she feared being single and alone with OMP.[78] This phone call ended at about 11.07pm, and throughout the entire call, TCW appeared to be consuming alcohol.

70. At about 11.22pm, TCW sent a text message to the partner of her best friend. They continued a conversation via text message for about 12 minutes. TCW called her best friend at about 11.45pm, and a few minutes later, replied to advise that it was a "*pocket dial*".[79]

71. In the early hours of 11 January 2018, TCW's neighbour was awake in her bedroom with the window open. Her bedroom was directly adjacent to TCW's house. Between 2.37am and 3.15am, she heard a loud voice say "*What do you need? Fucking shit*".[80] She was unable to

[74] Ibid, 354.
[75] CB, Statement of [redacted] dated 18 January 2018, 396.
[76] Ibid.
[77] CB, Statement of MCE dated 11 January 2018, 196.
[78] CB, Second Statement of [redacted] dated 15 January 2018, 238-239.
[79] CB, Statement of [redacted] dated 14 March 2018, 244.
[80] CB, Statement of [redacted] dated 11 January 2018, 255.

determine if it was a female or a male voice, but thought it likely originated from TCW's house.[81]

72. At 6.36am, OMP used a payphone located at [redacted], and called 000, requesting an ambulance. He told the 000 call-taker that "*My Mum died in the bath*".[82] OMP initially told the call-taker that he was in front of her, however when asked if he was calling from a payphone, he conceded that he was indeed calling from a payphone and did so because he was scared.[83]

73. OMP made a further seven calls from the same payphone. He first called RSS, who was angry that he had woken her up. He disclosed to RSS that his mother was deceased in the bathtub, and he appeared to be 'fake crying'.[84] RSS did not believe OMP and thought he was lying, so she hung up on OMP and told her mother what had occurred. OMP tried calling RSS a further four times, however she did not answer.[85]

74. Metropolitan Fire Brigade (**MFB**) firefighters arrived on scene first at 6.42am. TCW's front door was unlocked and slightly ajar, so they entered the home and located TCW in the bathroom, lying supine next to the bath, with a towel underneath her and a towel covering her body from the neck down. She was cold to touch and did not have a pulse.[86]

75. Ambulance Victoria arrived on scene shortly thereafter and asked firefighters to move TCW out of the bathroom to allow more room for them to work on her. Paramedics confirmed TCW was in asystole and declared her deceased at the scene.

76. OMP returned to his home from the payphone and spoke with paramedics and firefighters. He explained that he last saw his mother at about 9.00pm the night before, when she went to have a bath.[87] One of the firefighters placed his hand in the bath water and observed that it felt warm. He also checked the faucet and noted it was room temperature and cooler than the bath water.[88] The firefighter used a thermal imaging camera to measure the water temperature, which revealed a temperature between 34 and 35°C.[89]

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[81] Ibid.
[82] CB, Appendix K – 000 Call and Transcript.
[83] Ibid.
[84] CB, Statement of TKM dated 18 March 2018, 430.
[85] Ibid.
[86] CB, Statement of Senior Station Officer (**SSO**) Brendan Veal dated 11 January 2018, 169.
[87] CB, Statement of Paramedic Evan Reed dated 28 February 2018, 191.
[88] CB, Statement of Firefighter Jess Rush dated 5 April 2018, 173.
[89] CB, Statement of SSO Veal dated 11 January 2018, 170.

77. Police arrived on scene shortly thereafter and spoke to OMP, who explained that he placed TCW in the bath at 12.01am, in an attempt to wake her up as she was intoxicated. He ran her a warm bath and then went to bed as he was tired. He explained that when he awoke the next morning, he realised she was still in the bathtub. OMP was arrested, cautioned, and informed of his rights, and was then conveyed to the Melbourne West Police Station where he was interviewed by Homicide Squad investigators.

78. Police investigated the family home and within OMP's room, located four condom wrappers, one condom in the rubbish bin, and one condom on the desk. Within TCW's bedroom, police found an iPhone on the floor, a small bloodstain on a pillowcase which was on the floor, small bloodstains on the fitted bed sheet (still on the bed), one condom on the bed, two condom wrappers on the floor, a condom inside a pair of pink pants which were located on the floor, a pair of black men's underwear on the floor, and a three-quarters full bottle of Peroni.

79. In the lounge room, police located a pile of vomitus at the western end of the couch, with some of the vomitus continuing over the front edge of the seat cushion. TCW's body was located in the kitchen, where firefighters and paramedics moved it, and she was naked underneath a bath towel. Forensic pathologist, Dr Bouwer, attended the scene to examine the body. He assisted to collect what appeared to be animal hairs from TCW's face, as well as swabs from her body.

80. An examination of the bathroom identified small bloodstains on the door and bathroom floor, and a fine silver coloured neck chain. The bath was about half-full of water, and at the bottom of the bathtub were a silver-coloured earring, five small metal squares, a tap nut and a metal soap tray. Within the laundry, police located a large red coloured carpet mat with vomit stains and a pillow on top of the carpet mat. Under the carpet mat was a doona with vomit staining, and under the doona was another pillow with vomit staining.

81. At the Melbourne West Police Station, OMP was examined by Forensic Medical Officer, Dr Ciaran Joyce. Dr Joyce provided advice that OMP was fit to be interviewed, in the presence of an independent third party (**ITP**), and that detectives needed to use simple language and allow time to ensure that OMP understood the questions. OMP was also physically examined, and swabs were taken from under his fingernails and from his genitals.[90] Three parallel abrasions were observed on OMP's neck, which Dr Joyce opined were likely the result of the

[90] CB, Confidential Forensic Medical Reports by Dr Ciaran Joyce dated 15 January 2018, 457-463.

simultaneous applications of blunt force and movement of a sharp-edged object(s) against the skin. Dr Joyce opined that they likely occurred in the preceding few days.

82. OMP was interviewed by police in the presence of an ITP. He explained that his mother became intoxicated and was unconscious, so he ran a bath to help wake her up. He placed her in the bathtub and fell asleep, leaving her in the bath. He said that he did not kill his mother, but that it was an accident as it was his "*fault for leaving her in there [the bathtub] but it was an accident*".[91] He denied being sexually inappropriate with or killing TCW, although conceded that he had hit her in the past. He explained the injury on his neck was the result of his ex-girlfriend scratching him one year earlier.[92] OMP was released into the custody of his grandparents.

CRIMINAL INVESTIGATION AND COURT PROCEEDINGS

83. Police conducted a reenactment at TCW's house on 26 January 2018, when the weather conditions closely mirrored those on 11 January 2018. Police filled TCW's bath with hot water, recorded at 40℃ (hotter than comfortable), and noted that that water temperature dropped from 40 to 35℃ in one hour.

84. A sample taken from TCW's left nipple revealed a DNA profile, which was contributed to by at least three people, and from which two sperm fractions were isolated. Analysis of the sperm fraction excluded MCE's DNA profile and was 58,000 times more likely to have originated from OMP than any other person.

85. Samples from under TCW's fingernails on her right hand and left hand were 100 billion times more likely and 15 billion times more likely, respectively, to be that of OMP's, rather than another person. Vaginal and anal swabs from TCW did not provide any useful information for investigators. A condom located on TCW's bed, and one located on OMP's floor had DNA on the outside which closely matched that of TCW and inside closely matched that of OMP. Bloodstains on the sheets in TCW's bedroom closely matched OMP's profile. The vomit-stained carpet found in the laundry was closely matched to OMP. Genital swabs taken from OMP by Dr Joyce revealed a close match to the DNA profile of TCW.

86. OMP was arrested by police on 30 January 2018, and was conveyed to the Melbourne West Police Station, where he participated in an interview, with an ITP. He denied all questions in

[91] CB, Record of Interview with OMP dated 11 January 2018, 1362.
[92] Ibid.

relation to the alleged sexual assault and murder of TCW, although admitted to vomiting in the lounge room. He explained that his mother was incontinent of urine on the evening of 10 January 2018, and he helped her into the bath to wash herself. OMP was charged with one count of rape that day, followed by one count of murder on 12 February 2018. OMP was remanded at the Melbourne Youth Justice Centre (**MYJC**) in Parkville.

87. In April 2018, whilst on remand at the MYJC, OMP's behaviour deteriorated, as he became increasingly withdrawn, did not attend to his personal hygiene, was talking or mumbling to himself and described hearing voices.[93] Until late-May 2018, there was some doubt from his treating psychiatrists and other mental health clinicians about whether he was mentally unwell. However, by June 2018, he was felt to be psychotic.[94] OMP was transferred to the Orygen intensive psychiatric unit in late-June 2018 where he was commenced on depot paliperidone injections, which appeared to significantly improve his behaviour and presentation.[95]

88. On 23 November 2020, Justice Coghlan found that pursuant to section 94 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (**CMIA**), that OMP was not fit to stand trial and was unlikely to become fit to stand trial within the next 12 months.[96] His Honour ordered a Special Hearing before a judge alone, pursuant to section 101 CMIA.

89. The Special Hearing was held from 25 November to 7 December 2020 before Justice Coghlan. His Honour found OMP not guilty of charges 1 and 2 (rape and murder, respectively) and found him guilty of charge 3 (manslaughter).[97] His Honour determined OMP would be subject to a Custodial Supervision Order, with a nominal period of 20 years. The Department of Families, Fairness and Housing (**DFFH**) advised the Court on 22 February 2022 that OMP could be housed in an LTRP.[98]

CPU REVIEW - ASSESSMENT OF MENTAL HEALTH TREATMENT

90. As part of my investigation, I directed the Coroners Prevention Unit (**CPU**)[99] review the medical and mental health treatment provided to OMP. I specifically requested the CPU

[93] Forensicare Psychiatric Court Report, Dr Darjee dated 25 February 2019, 11.
[94] Ibid.
[95] Ibid.
[96] Order of Justice Coghlan dated 16 March 2022 in the matter of *DPP v OMP*.
[97] Ibid.
[98] Ibid.
[99] 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

consider whether there were any missed opportunities for OMP's treating clinicians to escalate his care or prevent TCW's death.

Dr Simon Gillian

91. Dr Gillian explained he did not observe any anger displayed by OMP towards TCW, nor any explicit sexual conduct towards her. He appeared to have been largely unaware of OMP's behaviour at home until after the fatal incident, when he spoke with OMP's grandparents. Dr Gillian explained that when he last saw TCW, he could not have envisaged her passing, however with the benefit of hindsight, conceded "*there were clear warning signs*".[100]

92. Dr Gillian explained that OMP had poor impulse control in several areas, was unable to control his sexual urges, had started lighting fires, regularly stole money and electronics, and became more aggressive. Dr Gillian noted that OMP's intellectual disability and long history of being unable to learn from past mistakes, OMP found it nearly impossible to change his behaviour.[101]

93. Dr Gillian was asked whether he considered referring OMP to an adult Forensic Psychiatrist or public mental health service. Dr Gillian explained that he did not make this referral, as he believed TCW's six-day delay in responding to a text message in which she declined an appointment offered on 11 December 2017 indicated an absence of any acute risks. He also explained that in his prior public and private practice, he had treated many patients with intellectual disabilities and impulsive behaviours, and therefore believed he was capable of treating a patient such as OMP. Dr Gillian further noted even if such a referral was made, the significant delays faced by patients in seeing Forensic Psychiatrists or Forensicare meant that it cannot be known if OMP would have even had the opportunity to see another clinician prior to TCW's passing. He also noted that OMP did not have a diagnosed mental illness at the time, which may have further prevented his acceptance by these services.[102]

94. Dr Gillian was not aware of the escalation in OMP's theft, aggression, and sexualised behaviour towards TCW in late November 2017 and early December 2017. The CPU explained that a clinician's risk assessment is based upon the information provided to them

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.

[100] CB, Statement of Dr Gillian dated 20 March 2018, 346.

[101] Ibid, 340.

[102] Ibid, 347.

by the patient and their carers, families, or others. Dr Gillian was not able to control the information that TCW chose not to disclose to him.

95. Dr Gillian concluded that the most significant barrier he faced in treating OMP was TCW's revelation that she would walk naked around the house, which he believed was a contributing factor to OMP's hypersexualised behaviour. With the benefit of hindsight, Dr Gillian noted that TCW may have been selective about the information she provided to Dr Gillian after he expressed concerns about her nudity.[103] The CPU concluded that based on the information that was available to Dr Gillian, his treatment of OMP was reasonable in the circumstances, and did not identify any prevention opportunities.

Treatment by Mr Gould

96. Mr Gould noted that OMP had impulse control and dishonesty issues, and his inappropriate sexualised behaviours were initially contained within his relationship with RSS. When the relationship ended, he maintained an unhealthy focus on RSS and lacked insight into the impact of his behaviour on others.

97. Like Dr Gillian, Mr Gould was unaware that OMP had been caught masturbating on TCW's pillows. Mr Gould opined that TCW felt shamed by Dr Gillian and therefore may have felt uncomfortable with disclosing everything in the fear that she might be further shamed.[104] Mr Gould did observe OMP being demeaning towards TCW during sessions, however, did not appear to know about the physical or sexual violence he was perpetrating against her in the home.[105] The CPU concluded that based on the information available and known to Mr Gould, his treatment was responsive and appropriate.

Support from the Croxton School and Ms Booth

98. The CPU noted that the Croxton School proactively met with TCW and others to discuss management strategies for OMP. Risk assessments, student support plans and safety plans were implemented to maintain the safety of OMP and his peers. As his behaviour escalated, the Croxton School provided increased supervision and implemented one on one supervision towards the end of 2017.[106] The School appropriately made referrals to CPS, VDDS and

[103] Ibid.
[104] CB, Statement of Mr Gould dated 2 March 2018, 329.
[105] Ibid.
[106] CB, Statement of Robyn Booth dated 19 February 2018, 310.

SOCIT, as required. The CPU did not identify any prevention opportunities in relation to the support provided by the Croxton School or Ms Booth.

Treatment by Ms Krupka

99. TCW's sessions with Ms Krupka focused on the many stressors in her life, in particular, caring for OMP, although she did not disclose that he was perpetrating violence against her. Ms Krupka made a referral to a Forensic Child and Adult Psychiatrist, Dr Adam Deacon, to assist with a new assessment of OMP's intellectual capacity and treatment requirements. Unfortunately, Dr Deacon was unable to review OMP until February 2018.

100. The CPU noted that Ms Krupka's treatment and management of TCW was appropriate and demonstrated a high level of responsiveness to her needs. The CPU did not identify any prevention opportunities with Ms Krupka's treatment.

OMP's mental health diagnoses

101. The CPU noted that after TCW's passing, OMP was diagnosed with a psychotic illness and met the criteria for a diagnosis of schizophrenia.[107] An assessing psychiatrist from Forensicare, Dr Rajan Darjee, opined that overt symptoms of this illness were not apparent until after TCW's passing, and he was not clearly suffering symptoms of psychosis until two to three months after her death. Dr Darjee opined that OMP may have been in the prodromal phase of his psychotic illness at the time of TCW's death, which later manifested.

102. Dr Darjee opined that in addition to his intellectual disability, OMP had an autism spectrum disorder, which accounts for his long-standing isolation, difficulties with communication, emotional detachment and difficulties relating to others.[108] He also noted that OMP met the criteria for hypersexual disorder or compulsive sexual behaviour disorder, given his level of sexual preoccupation and disinhibited sexual behaviour in the community over many years.[109]

Summary of mental health treatment

103. The CPU concluded that the mental health treatment and services provided by Dr Gillian, Mr Gould, Ms Krupka, and the Croxton School were appropriate, responsive, and reasonable in the circumstances. Unbeknownst to many of the clinicians, TCW did not divulge the full

[107] Forensicare Supplementary Psychiatric Court Report, Dr Rajan Darjee dated 17 April 2019, 4.
[108] Ibid.
[109] Ibid.

details of OMP's behaviour at home, which may have affected the clinicians' risk assessments or decision-making.

104. I accept the CPU's opinion with respect to the mental health treatment provided to TCW and OMP.

CPU REVIEW - ASSESSMENT OF FAMILY VIOLENCE SUPPORTS

105. In addition to a review of the mental health treatment provided to OMP and TCW, I directed the CPU Family Violence team review the circumstances of TCW's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[110] I also requested the CPU consider OMP's use of adolescent family violence (**AFV**) towards TCW and EDL, and whether there were any prevention opportunities.

106. The CPU noted that there have been multiple and significant family violence reforms implemented since TCW's passing, however identified some missed opportunities in the responses to OMP's use of Adolescent Family Violence (**AFV**), which may have been addressed by the aforementioned reforms.

Failure to appropriately identify and responds to adolescent family violence (AFV)

107. The CPU noted that disclosures about OMP's use of AFV occurred from about May 2016 until January 2018. The disclosures were primarily made by TCW, however EDL also made disclosures of physical abuse perpetrated by OMP against him. These disclosures increased in the weeks prior to TCW's death.

108. The CPU noted that despite TCW's disclosures, the services involved did not identify that AFV was occurring. The services did not complete any family violence risk assessments, safety planning or offer referrals to specialist family violence services.

109. The CPU also noted that following TCW's death, Victoria's Family Violence Risk Assessment and Management Framework transitioned from the Common Risk Assessment Framework (**CRAF**) to the Multi-Agency Risk Assessment and Management Framework (**MARAM**). Several of the services accessed by TCW and OMP are now prescribed under the MARAM and are now provided with comprehensive guidance to identify, assess and respond

[110] 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.

to family violence. An adolescent-focused MARAM practice guide is currently in development.

110. In 2018, the Family Violence Information Sharing Scheme (**FVISS**) was also implemented, which requires organisations such as those interacting with OMP and TCW, to proactively seek and share information to manage family violence risk. The CPU expects that the introduction of MARAM and the FVISS has improved the ability of services to identify AFV, which was not available to TCW at the time of her passing.

Respite referral provided to TCW

111. The CPU noted that the referral for respite support made for TCW was informal in nature. She was provided with the contact details of a foster carer, who she spoke with on several occasions, however the referral was informal in nature and was not to an accredited organisation. When TCW made disclosures of AFV to the worker, the worker did not report them to any other organisation. It is not clear that the support worker was under any obligation to make such a report, and therefore no adverse comment is made against her. However, if the referral for a respite carer was made formally, it is possible that the disclosure of AFV may have resulted in a formal disclosure and escalation process. The CPU recommended that referrals for respite are made to accredited organisations to ensure that foster carers have an escalation point. I accept and adopt this recommendation. Whilst I cannot make an individual recommendation to each organisation that might refer a family to respite care, I will make a broad comment on this issue (see below).

Specialist accommodation services of adolescents who use violence

112. The CPU noted that the recommendations from the Royal Commission into Family Violence (**RCFV**) and from Australia's National Research Organisation for Women's Safety (**ANROWS**) and recommended that the Victorian Government develop additional crisis and longer-term supported accommodation with attached therapeutic support for adolescents who use violence in the home. The Victorian Government has asserted that this recommendation has been implemented following their allocation of significant funding to crisis accommodation for children experiencing family violence.[111] However, this accommodation is not tailored to meet the specific accommodation needs of young people

[111] Ibid; Jo Howard et al, 'The PIPA project: Positive Interventions for Perpetrators of Adolescent violence in the home (AVITH)' (Research Report Issue 4, ANROWS, March 2020), 60 <Campbell_RR_PIPA.pdf (anrowsdev.wpenginepowered.com)> .

using AFV, nor to address the risk they pose to others in crisis accommodation. The CPU suggests therefore that this RCFV recommendation has not been implemented and that there is still a lack of crisis accommodation for young people using AFV.[112]

113. Young people with a disability who use AFV may require even further specialised crisis accommodation, and it appears that such accommodation is not readily available. This is reflected in a recent ANROWS paper, in which mothers of young people with a disability who use AFV detail the significant difficulties they have faced in accessing respite.[113]

114. I agree with the recommendations of the RCFV and ANROWS and note that the Victorian Government should also consider how this accommodation could be made available for young people with a disability.

Family violence training for NDIS service providers who work with adolescents who use violence

115. The CPU noted that the NDIS is particularly ill-equipped to effectively support families where AFV is occurring, and noted there is a lack of clarity regarding the role of the NDIS in managing AFV. In the present case, TCW was waiting to access the NDIS at the time of her passing, however I note that this remains an ongoing difficulty for families accessing the NDIS where AFV is concomitant.[114]

116. The CPU suggested that the Victorian Government explore the inclusion of NDIS providers in the Multi-Agency Risk Assessment and Management Framework (**MARAM**), like other frontline agencies. I accept the suggestion and recommend that the State Government conduct research into the need for MARAM prescribed NDIS providers and support legislative change to include NDIS private providers operating in Victoria in the MARAM.

117. Similarly, the CPU suggested that the Victorian Government support ANROWS' calls for further research regarding people with disability who use family violence in order to build an evidence base for work in this area. I support and adopt this recommendation.[115]

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[112] Jo Howard et al (n 61) 60.
[113] Georgina Sutherland et al, 'A socio-ecological exploration of adolescent violence in the home and young people with disability: The perceptions of mothers and practitioners' (Research Report, Issue 19, ANROWS, October 2022), 25-6 < RP.20.08-Sutherland-RR2-AVITH-Mothers-Practitioners.pdf (anrowsdev.wpenginepowered.com)>.
[114] Ibid.
[115] Georgina Sutherland et al, 'A socio-ecological exploration of adolescent violence in the home and young people with disability: The perceptions of mothers and practitioners' (Research Report, Issue 19, ANROWS, October 2022), 29.

Lack of specialist support for young people who use AFV and have a disability

118. The CPU noted that whilst AFV has received some policy attention, it remains a developing area, and the intersection of AFV and disability requires further consideration. The Victorian Government has provided increased investment into AFV services, and there is now an AFV service available in the area where TCW and OMP lived. However, the CPU noted that Victorian AFV services may still be ill-equipped to support families where the user of AFV also has a disability.

119. The CPU recommended that the Victorian Government review whether current Victorian AFV services, including Addressing Family Violence Programs (**AFVPs**) are equipped to work with young people who have a disability and who are using AFV, and provide resourcing and/or training as necessary, where this is not the case. I accept and adopt this recommendation.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was TCW, born [redacted];

    b) the death occurred on 11 January 2018 at [redacted], from *neck compression*; and

    c) the death occurred in the circumstances described above.

COMMENTS

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

1. To ensure families accessing AFV services receive the most appropriate support and assistance, I emphasise the importance of organisations making referrals to accredited organisations and support workers and encourage all agencies and organisations to ensure that their referrals are made to an accredited organisation or worker.

RECOMMENDATIONS

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

(i) In line with the recommendations of the RCFV and ANROWS, I recommend that the Victorian Government develop additional crisis and longer-term supported accommodation options with attached therapeutic support for adolescents who use family violence in the home. The Victorian Government should also consider how this accommodation would be accessible to young people with a disability.

(ii) That the Victorian Government review whether NDIS service providers in Victorian are equipped to work with young people who have a disability who also use AFV and provide resourcing and/or training to address any deficiencies.

(iii) That the Victorian Government review the current Victorian AFV and AFVP service providers to determine whether they are equipped to work with young people who have a disability who also use AFV and provide resourcing and/or training to address any deficiencies.

(iv) That the Victorian Government support ANROWS' calls for further research regarding people with disability who use family violence in order to build an evidence base for work in this area.

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

Pursuant to section 73(1B) 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:

TNC and EBI, Senior Next of Kin

The Victorian Government

Croxton School

Family Safety Victoria

Victorian Aboriginal Child Care Agency

Victorian Aboriginal Health Service (C/- King & Wood Mallesons)

Detective Sergeant Glen Scharper, Coroner's Investigator

Signature:

Judge John Cain
State Coroner
Date: 23 October 2024

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.