IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 005285

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:	Helena Zoe Broadbent
Date of birth:	10 April 1987
Date of death:	28 September 2019
Cause of death:	1(a) Head injuries in a motor vehicle incident
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052
Keywords:	Family violence; dangerous driving causing death; separation; pregnancy.

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there may be words and descriptions that may be culturally distressing.

INTRODUCTION

1. On 28 September 2019, Helena Zoe Broadbent was 32 years old when she passed away at the Royal Melbourne Hospital from injuries sustained in a motor vehicle incident.

2. Helena was a proud Aboriginal woman whose grandmother was part of the stolen generation. Helena lived with her former partner, William Wilson, and their two young daughters at Keilor Downs, Victoria. Helena was 26-27 weeks pregnant with their third daughter when she passed away.

3. At the time of Helena's passing, an active family violence intervention order (**FVIO**) was in place that prevented Mr Wilson from perpetrating family violence against her and their two children and damaging or threatening to damage their property. The FVIO did not prevent Mr Wilson from being at the family home in Keilor Downs.

THE CORONIAL INVESTIGATION

4. Helena's passing 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.

5. 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.

6. 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.

7. Victoria Police assigned Detective Sergeant Daryll Out to be the Coroner's Investigator for the investigation of Helena's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, eyewitnesses and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the passing of Helena Zoe Broadbent 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.[1]

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

Identity of the deceased

9. On 3 October 2019, Helena Zoe Broadbent, born 10 April 1987, was visually identified by her father, Jeffrey Loone.

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

Medical cause of death

11. Forensic Pathologist Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 28 September 2019 and provided a written report of his findings dated 13 February 2020.

12. The post-mortem examination revealed extensive skull fractures involving the occipital, left frontal, temporal, and parietal bones, and base of skull. Associated scalp bruising was also seen, and there was a left periorbital haematoma ("black eye"). Inside the head, there was a laceration of the dura (involving the superior sagittal sinus), extradural, subdural and subarachnoid haemorrhage. In the brain, there was a laceration of the left superior frontal gyrus and superior parietal lobule, cerebral cortical and cerebellar contusions, some white matter haemorrhages, and intraventricular haemorrhage with laceration to the left fornix. Sequelae of the head injuries included Duret haemorrhages and early hypoxic ischaemic encephalopathy.

13. The pattern of injuries was consistent with impact to the occiput at the back of the head ('coup' injury), with probable transmitted force to the left side and base of the skull. Opposite ('contre-coup') injuries to the frontal and temporal lobes of the brain were seen. The left-sided skull fracture was also associated with injury to the underlying dura and brain parenchyma.

[1] 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.

14. The mechanism of injury leading to the occipital skull fracture ('coup' injury) is consistent with that which may be sustained from a fall onto a hard surface, with impact to the back of the head. Given the reported circumstances, this could have occurred from the deceased alighting from the vehicle, falling backwards, and hitting her head on the ground.

15. In the context of the observed injuries, there were no obvious injuries to the head that were unequivocally attributable to a hammer.

16. Fractures to the sternum and left second to fourth ribs would be consistent with anterior compressive force, such as that seen from chest compressions in cardiopulmonary resuscitation. These fractures did not cause or contribute to death.

17. Toxicological analysis of ante-mortem samples, collected at 2.27pm on 28 September 2019 from the Royal Melbourne Hospital showed no ethanol, common drugs or poisons.

18. Post-mortem blood collected at the time of autopsy showed the presence of morphine, midazolam and ketamine (administered in hospital). Ethanol was not detected.

19. The autopsy also confirmed hysterotomy of a gravid uterus. There was no post-mortem evidence of any significant natural disease which may have caused or contributed to death.

20. Dr Young provided an opinion that the medical cause of death was *head injuries in a motor vehicle incident.*

21. I accept Dr Young's opinion as to the medical cause of death.

Circumstances in which the death occurred

22. On the morning of 28 September 2019, Helena and Mr Wilson had a verbal argument. Helena called 000 at 9.05am and advised the call-taker that she and Mr Wilson were arguing over Mr Wilson not changing a dirty nappy, and that he was using cannabis instead. There were no police units available, so Helena's call was referred to a police officer at Keilor Downs Police Station.

23. Helena spoke to a member at the Keilor Downs Police Station and explained that she was looking for alternative accommodation and wanted Mr Wilson to leave the property. The member asked Helena if she felt as though she needed to move out immediately and Helena declined but requested assistance to get new accommodation. The member explained the

referral system and advised Helena that she would receive a call on Monday (as it was a weekend, and the service did not work on weekends).

24. The member also checked LEAP and determined that there was an active FVIO in place against Mr Wilson, however it did not appear that he had breached the order and there was no condition on the order preventing him from being at that address.

25. Whilst on the phone with Helena, the member observed that Helena sounded "*a little breathless and distracted*". The member queried if Helena was ok, and she explained that she was gathering her children to attend the Royal Melbourne Show. She otherwise sounded calm and did not appear to be distressed.

26. The member explained that police would not attend, and Helena appeared to be in agreement with that outcome. The member explained that she should call 000 if she felt she was in danger. The member noted that it sounded as though Helena was placing her children into the car at the end of the call.

27. The events from the end of the first 000 call until the time of the second 000 call at 12.54pm, are not known.

28. At 12.54pm, Helena called 000 and reported that Mr Wilson had threatened to kill her and that he was carrying a hammer. She told the call-taker that Mr Wilson repeated the threat again while she was on the phone and asked for police to attend to remove him from the home.

29. Helena told the call-taker that Mr Wilson was about to leave in his car, which had the children's car seats inside. She explained that if he left with her children's car seats, she would not be able to leave. She confirmed that Mr Wilson was drug-affected but was unsure if he was also alcohol-affected.

30. Whilst on the phone with the 000 call-taker, Helena followed Mr Wilson outside and opened the rear left door of Mr Wilson's vehicle, a silver Mitsubishi Triton dual-cab utility (**'the vehicle'**). She started trying to remove one of the children's car seats when Mr Wilson drove off in the vehicle, with Helena still in the back seat and the rear left door still open. Helena could be heard screaming "*he's going to drive off with me and I'm on the car. You fucking idiot*" on the 000 call.

31. Mr Wilson drove the vehicle along Kiwi Retreat, Keilor Downs, to the T-intersection with Saratoga Avenue. At the intersection, Mr Wilson turned right onto Saratoga Avenue. The

momentum of the vehicle as it turned was such that the left rear passenger door opened, and Helena was flung out onto the road. Mr Wilson drove for a short distance along Saratoga Avenue, then stopped briefly to put the car seat back on the rear seat of the vehicle and shut the open car door. Mr Wilson drove off without returning to check on Helena or calling for assistance.

32. Neighbour, Ivan Sucic, heard a "*loud pitch female scream*" emitted by Helena, so he looked outside and saw something on the road. Another neighbour, Brian Hall, witnessed Mr Wilson driving past his home, observed what appeared to be a jumper lying on the road and walked outside to find out what had occurred. He observed Helena lying on the road whilst Mr Sucic was on the phone to 000, so he ran inside and collected a blanket to place over Helena. Helena was unconscious, her breathing was laboured and there was blood on her face and pooling on the ground around her.

33. The first ambulance arrived at about 1.05pm, shortly followed by a mobile intensive care unit (**MICA**) unit. Paramedics immediately commenced aggressive resuscitative measures, and loaded Helena into a road ambulance, for transport to a nearby park, where an Ambulance Victoria helicopter airlifted her to the Royal Melbourne Hospital (**RMH**).

34. At the RMH, clinicians performed an emergency hysterotomy to deliver Helena's unborn child, who was subsequently transferred alive to the Royal Women's Hospital, for further treatment.

35. Helena underwent imaging, which demonstrated significant head injuries and a brain injury, which were deemed non-survivable. Given these injuries, clinicians decided to palliate Helena, and she passed away 6.46pm.

36. After leaving the scene, Mr Wilson drove to the Mount Macedon area, which he later told police was a "*hiding place*". Police intercepted Mr Wilson at about 7.30pm that evening in Mount Macedon, arrested him and provided his caution and rights. He informed police that he had recently purchased cannabis which was inside his car. Inside the car, police located a bag containing cannabis and a large knife.

37. Police interviewed Mr Wilson, and he was charged with dangerous driving causing death, possession of cannabis and the summary offence of failing to stop. Mr Wilson later pleaded guilty to these charges and was sentenced to a total sentence of three years and six months' imprisonment, with a non-parole period of two years and two months.

FURTHER INVESTIGATIONS AND CPU REVIEW

38. As Helena passed away following an incident of family violence with her partner, this case was included in the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[2] I also referred this case to the Coroners Prevention Unit (**CPU**)[3] Family Violence Team, for a review of the family violence service contact with Helena prior to her passing.

39. There was a history of reported family violence perpetrated by Mr Wilson towards Helena, and the pair separated in June 2018, but continued to reside together. There was an active FVIO in place and Helena was in the process of applying to the Victorian Civil and Administrative Tribunal (**VCAT**) to have the lease for the family home transferred from Mr Wilson's mother's name, into her name. She then intended to apply for a full exclusionary FVIO when this process was complete to exclude Mr Wilson from her home.

40. The CPU noted that upon review of the available evidence, the multi-agency risk assessment and management (**MARAM**) framework risk factors in this case included control, stalking, drug and alcohol use, threats to kill (including on the day of the fatal incident), physical violence, mental health issues, pregnancy, threats of suicide, isolation, obsessive and jealous behaviour, recent separation and financial issues.

Review of Victoria Police responses to Helena

Family Violence Related Service Delivery Review

41. Following Helena's passing, Victoria Police completed a Family Violence Related Death Service Delivery Review (**FV-SDR**), which identified several instances of member non-compliance with the Victoria Police Code of Practice for the Investigation of Family Violence (**CoP**) and made findings and recommendations. I have not duplicated the entirety of the FV-SDR here, however I have summarised some of the key events below.

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[2] 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

[3] 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.

42. At the time of Helena's passing, Victoria Police had a record of Mr Wilson's pattern of violence towards Helena:

a) Verbal abuse, physical abuse, false imprisonment and threats to kill by Mr Wilson in September 2016

b) Verbal abuse whilst pregnant which resulted in a full FVIO with exclusion conditions being issued in May 2017. This order expired in May 2018.

c) Verbal abuse and Helena's concerns that Mr Wilson's violence was escalating whilst she was pregnant in August 2018. A family violence safety notice (**FVSN**) was issued; however, Helena was reportedly unsupportive of an FVIO and wanted the FVSN withdrawn.

d) Incident of verbal and physical abuse on 10 May 2019. Helena did not want to pursue criminal charges however wanted an FVIO to protect her. No FVIO was pursued on this occasion.

e) Incident of verbal and physical abuse on 20 May 2019 which was triaged as high risk. Helena was again unsupportive of criminal charges but was supportive of an FVIO. A limited FVIO was issued in June 2019 for two years, expiring in June 2021.

f) On 19 September 2019, Helena called 000 to report potential verbal abuse and that Mr Wilson was allegedly "*doing drugs*" in front of their children. No L17s were submitted and there was no investigation for a potential FVIO breach.

43. With respect to the 19 September 2019 incident, the FV-SDR appropriately identified that no L17s were submitted, and no referrals were made to Child Protection (**CP**) regarding Mr Wilson's alleged drug use. Best practice would have involved submitting L17s and a possible CP notification as well as investigating a possible breach of the limited FVIO due to alleged verbal abuse. CP were actively involved with the family at the time of the fatal incident, and therefore it is possible that a new CP notification in relation to the 19 September 2019 incident may have triggered further action by CP. I now cannot determine that a notification on 19 September 2019 would have prevented Helena's passing, however I am of the view that it was a missed opportunity for police and CP to engage with her and her family, shortly before her passing.

44. As indicated above, Victoria Police made findings and recommendations from the FV-SDR, and I commend Victoria Police for proactively addressing the identified deficiencies and referral to the Professional Standards Command.

Professional Standards Command investigation

45. The Professional Standards Command (**PSC**) investigated seven members, who were identified via the FV-SDR as being potentially in breach of the Victoria Police Manual (**VPM**). All seven allegations were substantiated; four members received workplace guidance, whilst no action was taken against the remaining three members. The final PSC report was dated 15 November 2023, more than four years after the fatal incident. One of the seven members investigated has since moved to a Family Violence Investigation Unit (**FVIU**).

46. I also note the delay to investigate the members involved, which significantly impacts the meaningfulness and relevance of the changes that are implemented. This is true of any internal/external investigation or review, not just PSC investigations. The sooner the review can be completed, the more meaningful the recommendations and changes can be and the greater their impact. It is therefore unfortunate that the PSC investigation was completed more than four years after the death occurred. I accept, however, that competing priorities and resourcing pressures mean that these reviews often take several months or years to complete.

47. The Commonwealth Government's recent report into the Rapid Review of Prevention Approaches to domestic, family and sexual violence (**DFSV**), *Unlocking the Prevention Potential*, identified several 'themes' in which DFSV can be prevented. Recommendation 13 states *inter alia*:

> *The Commonwealth and state and territory governments to work together to strengthen multi-agency approaches and better manage risk, with a lens on harm and safety, for victim-survivors of DFSV, including risk of homicide and suicide. This should include:*
>
> *…*
>
> > *e. all jurisdictions establishing mechanisms that are DFSV-informed for independent oversight and accountability of police response and management of DFSV (including members investigated for DFSV). These mechanisms should sit outside of police forces and be civilian-led (states and territories).*

48. I support and endorse this recommendation and encourage the Victorian Government to establish a mechanism or entity for independent oversight and accountability of police response and management to family violence, ensuring they are resourced to undertake prompt and thorough reviews as necessary. I note that the Court also independently investigates police interactions with a deceased person proximate to their death, however I am of the view that this recommendation is broader than the Court's mandate as it would also review police responses to family violence where the affected person is alive.

49. I also note the over-representation of First Nations women who experience family violence and therefore I will recommend that such a mechanism should be developed in consultation with Aboriginal organisations such as the Victorian Aboriginal Legal Service (**VALS**) and other peak bodies.

Inquest into the passing of Noeline Dalzell

50. One of the consistent themes throughout the PSC investigation in Helena's case was communication and access to information, which resulted in members and supervisors making decisions without an accurate understanding of risk. I also note in the recent finding into the passing of Noeline Dalzell, Victoria Police Assistant Commissioner (**AC**) Lauren Callaway explained that FVIUs have improved since 2019, and she explained some of the changes that have since been implemented.

51. In that finding, I noted:

> *Whilst I accept AC Callaway's evidence as to the feedback she has received and the training that is in place now, I have not identified other supporting evidence before the Court to establish that the performance of the FVIUs has markedly improved since Noeline's murder*.

52. My recommendation in the matter of Dalzell was to conduct an independent evaluation of the effectiveness and skillset of the FVIUs. I will not repeat that recommendation here, however I do note what appears to be similarities between these cases and the similar themes that may be explored in such a review.

53. Noeline and Helena were both Aboriginal women who lived in different regions of Victoria, and both experienced a poor police response on several occasions. In both cases, police relied on their level of fear, without offering their professional assessment of the risk involved. Police also made decisions without all of the relevant information available. I am hopeful that

the recommendations made in the finding into Noeline Dalzell's passing will also address the deficiencies identified in this matter.

Child Protection involvement with Helena's children

54. Helena had two periods of engagement with CP: one in August 2018 and one in May 2019. The report made in August 2018 progressed to the investigation stage, however, was closed in September 2018. The second report was made after three L17s were lodged by Victoria Police on 10, 20, and 21 May 2019. This report progressed to the protective intervention stage and remained ongoing at the time of Helena's passing.

55. I note the following in the documented CP interactions with Helena and her family:

    a) Helena does not appear to have been asked about her cultural background until July 2019, after which she was offered and engaged with culturally specific referrals, including consultations with the Victorian Aboriginal Child Care Agency (**VACCA**) and a referral to Elizabeth Morgan House (**EMH**).

    b) Discussions with Helena during an unannounced home visit in May 2019 indicated that Helena believed that she needed to make a police report in order to initiate an FVIO. It does not appear that this misunderstanding was corrected, and Helena was not provided with assistance to apply for an FVIO.

    c) The case plan in June 2019 suggested that Helena was responsible for managing Mr Wilson's violence.

    d) In July 2019, the documented discussion of alternative housing options was limited to offering Helena with refuge in order to 'fast track housing', which Helena declined. Helena also expressed concerns about overcrowding at her mother's house and inability to obtain a rental property, resulting in her returning to live with Mr Wilson. It did not appear that CP provided support to address these concerns.

    e) Helena clearly articulated to CP that she was struggling financially, had accessed her superannuation to purchase a vehicle which subsequently stopped working and required costly repairs. This impacted her independence, isolated her from her family and limited her safety planning options. She also noted that Mr Wilson was reportedly happy that Helena's car was not working because he did not want her to leave him.

f) Inconsistencies and gaps in CP practitioners' assessment of family violence risk to Helena at various points in time.

56. In response to the above concerns, CP provided submissions. These are explained in further detail below.

Helena's Aboriginality

57. During CP's first contact with Helena in August 2018, the CP recorded "*No*" as the answer to the question "*is anyone in the family Aboriginal or Torres Strait Islander?*". Similarly, when these questions were asked in May 2019, the answer was "*Neither*". CP noted that when it met with Helena on 30 July 2019, she said that her grandmother was part of the stolen generation and Helena "*never went down the Aboriginal avenue as [it] was too much trouble*". CP submitted that as soon as it was aware of Helena's cultural background, it immediately referred her to VACCA.

58. Upon a review of the L17s (submitted by police), it does not appear that police asked Helena about her cultural heritage either. Various service records over time indicate differing indications of whether Helena was asked at all about her Aboriginal status, with some left empty, some indicating no, and some indicating yes. The reasons why Aboriginal women do not always disclose their First Nations heritage to statutory authorities is well known and documented, however in the lead up to her passing, Helena was engaged with EMH and therefore I will make no further comment about this.

Application for an FVIO

59. CP submitted that it did not consider the words "*Mother is willing to obtain an IVO against father and stated she just needs to make a report to police station*" to indicate that Helena misunderstood the process of initiating an FVIO, but rather that she had made reports to police and was intending to follow up with police. CP further submitted that as police eventually applied for an FVIO, it cannot be said that this was a missed opportunity.

60. The submission from CP was essentially that because Helena reported the incident to police in May 2019, CP's assistance to follow-up or apply for the FVIO was not necessary. It is not clear from the CP records whether the CP workers were aware of the application and warrant. However, if they were, this should have been discussed with Helena to prevent her having to follow up with police, given everything else going on in her life at the time. For victim-survivors who are engaged with many different agencies, service integration, information

sharing and collaboration is key to ensuring the victim-survivor gets the help they need and is not overwhelmed by needing to speak to many different services.

61. As I noted in my Finding into the passing of Noeline Dalzell, *"the current system appears to run the risk of making family violence both everyone's responsibility and no-one's responsibility*".[4] Although there may not have been a positive obligation on CP workers to assist Helena with her FVIO application, I am of the view that it would have been beneficial to assist her with navigating this process.

<u>*Responsibility for safety in the case plan*</u>

62. CP initially submitted that it was unclear how the June 2019 case plan suggested that Helena would be responsible for managing Mr Wilson's violence and was therefore unable to respond to this comment.

63. My concern with the CP response, and upon reviewing the CP records, is that most of the tasks, actions and goals involved Helena. The June 2019 Actions Table listed the following activities/goals under Crisis Management:

    a) *The mother will link with a women's family violence service, a psychologist or other service that will support her in gaining further insight into the gendered nature of family violence, the impact of family violence on the development, safety and wellbeing of the children, cycles of violence, types of violence, triggers that impact her and the children's safety and well-being, safety planning and developing skills into effective non-confrontational conflict resolution. Child protection will provide contact details for a women's family violence service.*

    b) *In the event that the father approaches the mother and disagreements begin to escalate to verbal and/or physical abuse the mother will follow a safety plan initially developed with Child Protection and further developed with the women's family violence service.*

    c) *Given the history of family violence and the recent escalation of family violence the mother is encouraged to obtain a full Intervention Violence Order inclusive of her herself, [and her daughters] as protected people against the father.*

[4] Finding following inquest into the passing of Noeline Dalzell (COR 2020 0670), 62.

d) *Child protection will attempt to interview the father to obtain a better understanding of his family violence and threatening behaviour. Options may be:*

   i. *For the father to be linked to Men's Behaviour Change or psychologist or other service that will support him in gaining further insight into the gendered nature of family violence, the impact of family violence on the development, safety and wellbeing of children, his role and behaviour within the cycles of violence and developing skills into effective non-confrontational conflict resolution.*

   ii. *For the father to be linked to an Anger Management Program to better manage and control impulsive behaviour such as the Tame Your Dragon program. It would be expected that the father would also gain further insight into the above factors regarding family violence.*

   iii. *For the father to be linked to a single or dual diagnosis service inclusive of Mental Health and/or Alcohol and Other Drugs service to address his drug use and violent behaviour. It would be expected that the father would also gain further insight into the above (1.) factors regarding family violence.*

64. Under the section Physical Injury, the plan stated:

a) *The mother and the father will ensure that [the children] are not exposed to any situation of disagreement. They will ensure that the children are removed from any situation escalating verbally or physically. Children of [their] age are particularly vulnerable to being unintentionally caught in the cross fire of parental conflict and physically harmed.*

65. While Mr Wilson was referenced in the case plan, CP stated that they would attempt to interview him and refer him to other services. There was no expectation that Mr Wilson would complete an anger management or behavioural change course, only that they would refer him to same. There was no specific goal that stated Mr Wilson was not to use violence against Helena or the children or expose them to same.

66. In response, CP submitted that while the Actions Table did not specifically state "*the father must not use violence*", the substance of such a quote is included in the actions table. CP noted "*Child protection* ***will attempt to make contact with the father to discuss the reported child protection concerns and the plans moving forward***" [emphasis added].

67. CP also noted that at the time that this case plan was developed, CP had not spoken to Mr Wilson, Helena had moved away from Mr Wilson, Helena was the only parent in contact with the children and an FVIO was being sought against Mr Wilson.

68. CP attempted to contact Mr Wilson via phone and text message on 9 August 2019. In late-August or early September 2019, Helena reportedly informed CP that she did not want them to engage with Mr Wilson as she was working with Homes Victoria to have the public housing property, she was living in transferred into her name.

69. I note that on 18 September 2019, Helena advised CP that the house transfer was going through and the case note from CP states:

> *Writer to action:*
>
> *Check-in with Childcare*
>
> *Father informed of DHHS involvement*

70. In light of these submissions, CP stated that my preliminary concerns were not open on the evidence available to the Court.

71. I have considered CP's submissions; however, I am not persuaded by them. Although I accept the *substance* of the case plan was to reduce Mr Wilson's offending, there is nothing in the Actions Table that *actually* holds him to account for his behaviour. While CP stated they would attempt to interview him, there was no expectation in the Actions Table that he must complete a behaviour change or anger management program; these were merely listed as suggested options.

72. Although Helena later told CP that she did not want them to contact Mr Wilson, it is unclear what occurred from 4 June 2019 until late-August or early-September 2019, other than the attempted contact on 9 August 2019.

73. Prior to Helena instructing CP not to contact Mr Wilson, I am not persuaded that CP were taking proactive steps to hold Mr Wilson to account for his behaviour, nor reduce the likelihood of reoffending. I cannot determine that these actions would have prevented the fatal outcome, however I remain concerned that CP does not appear to appreciate that there were any deficiencies in their service interaction with Mr Wilson.

Alternative housing options

74. CP submitted that its role is primarily in relation to the wellbeing of children, and not in relation to housing. Despite this, CP noted that it did provide support to Helena with her housing needs by providing a letter of support to Helena for the housing name transfer.

75. I note that Helena clearly articulated to CP that her lack of housing resulted in her returning to a violent partner. I accept that CP's role is not primarily about housing, however, in circumstances where Helena specifically advised that she was returning to live with her violent partner due to her lack of housing, this poses a clear risk to Helena's children. CP further submitted that it *did* assist Helena, however the ultimate outcome was that Helena returned to live in a house with Mr Wilson due to a lack of other options. I note CP's submissions and am unable to take this issue any further.

Helena's challenging financial situation

76. CP noted there was no criticism made against it in relation to this issue and therefore made no submission in response.

Inconsistencies with CP's practitioners' assessments of family violence

77. CP conceded that prior to the systemic changes in respect of family violence in 2019, CP risk assessments, the tools used, and the documentation of these risk assessments were deficient. CP submitted that these issues have been thoroughly ventilated and radically reformed, largely as a result of the Royal Commission into Family Violence in Victoria. I accept that this is an aspect of CP practice that has been well-litigated elsewhere and that significant changes have been made, and therefore further comment is not required.

78. Many of these above issues were highlighted in the recent CP cluster inquest in held into the deaths of four children known to CP. I will not repeat those issues here, other than to acknowledge that they have been discussed in detail in another forum.

79. In submissions made by DFFH in response to the investigation into the passings of four children who were killed whilst CP were involved, DFFH advised that a myriad of changes had since occurred that would address issues relating to risk assessment and staff capability. These include but are not limited to:

a) The introduction of the SAFER risk assessment framework. This framework aims to the improve risk assessment and risk management decisions of CP Practitioners and improve reliance on developed professional judgement.[5]

b) The launch of the CP workforce strategy 2017 – 2020 and the CP workforce strategy 2021 – 2024.[6] These strategies aim to 'support, strengthen and enable the child protection workforce to deliver outcomes for children into the future'[7] and provides a high-level roadmap for recruiting, retaining, supporting and developing the child protection workforce.

c) The proposed review of the CP operating model by DFFH.[8]

80. I note that the CP involvement with Helena and her children did not materially contribute to her passing. I cannot determine that different actions by CP workers would have resulted in a different outcome or would have prevented Helena's passing, however I have referenced them to highlight the changes that have since occurred in CP practice and policy.

Elizabeth Morgan House Aboriginal Women's Service

81. At the time of her passing, Helena was actively engaged with EMH, who were assisting her with transferring the Keilor Drive home into her name and making an application for a Family Violence Flexible Support Package (**FSP**). EMH and Helena noted that the FSP could be used to pay for her car repairs, whitegoods, and other housing-related needs. They agreed to place the application on hold until the housing situation was sorted out, so all her needs could be covered in one FSP application.

82. The FSP was established in response to the Royal Commission into Family Violence (**RCFV**). Whilst the FSP was designed to be flexible in nature, it appears that its delivery is not always as flexible as envisaged, and updates to packages/multiple packages are sometimes discouraged by the various providers. This can result in delays to applications, as seen with Helena, which can impact a victim's safety plan. In Helena's case, Mr Wilson used her lack of a reliable vehicle and child safety seats to control her and limit her independence. Sadly,

[5] Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, page 163-164.
[6] Department of Families, Fairness and Housing, *Child protection workforce strategy 2017-2020*, (2018); Department of Families, Fairness and Housing, *Child protection workforce strategy 2021-2024*, (2021).
[7] Department of Families, Fairness and Housing, *Child protection workforce strategy 2021-2024*, (2021), 8.
[8] Department of Families Fairness and Housing, supplementary material filed 24 November 2023, paragraphs 14 to 21.

her passing occurred in circumstances where Helena was trying to resist his violence and these methods of control.

83. EMH similarly noted deficiencies in the FSP process, namely:

a) The process "*tends to be rather drawn-out*", as FSP providers do not specify timeframes, and the amounts offered by different providers varies significantly.

b) The victim needs to be actively linked with a family violence service provider in order to be eligible for an FSP. EMH noted that when family violence service providers are at capacity, victims may experience additional delays in accessing FSPs.

c) EMH noted it was common for their service to experience a lack of communication from FSP providers, leading to further delays in the process.

d) EMH opined that the FSP process lacks cultural sensitivity and awareness of the specific needs and challenges faced by Aboriginal woman and children experiencing family violence. EMH believe this contributes to support services that are not tailored to the cultural context or fail to adequately address the unique barriers to seeking help.

84. EMH made several suggestions about the FSP process, including:

a) That all FSP providers comply with consistent and comprehensive guidelines, removing situations in which "*some providers appear to be more lenient than others*".

b) Enhancing the FSP online portal to make it more user-friendly and transform it into an end-to-end platform, rather than relying on email correspondence between FSP providers and case managers.

c) Develop culturally tailored FSP services that are specifically designed to meet the needs of diverse communities, such as Aboriginal and Torres Strait Islander peoples.

d) Implement a trauma-informed approach to service delivery within the FSP program to better support people who have experienced family violence.

85. I support these suggestions. Regarding recommendation a), I am of the view that this can be strengthened further, to assist with situations such as those faced by Helena. I intend to make a recommendation to ensure that package updates are not discouraged or disallowed.

86. I note with respect to recommendation c) that VACCA *does* provide FSPs for Aboriginal victim-survivors. I support any other culturally specific FSPs for First Nations people, however in circumstances where they already exist, I do not need to make a recommendation for same.

87. With respect to recommendation d), I note that all FSP providers are specialist family violence services who decide whether or not to approve a given application. It is the case manager working directly with the victim-survivor (in this case, EMH) that should be trauma-informed, to ensure the most appropriate support is offered and provided to victim-survivors. To that end, I therefore intend to make recommendations a), b), and d) to Family Safety Victoria, in further detail.

Housing Victoria

88. At the time of fatal incident, records indicate that CP, EMH and Housing Victoria (**HV**) were coordinating a change to the name on the lease for the family home, from Mr Wilson's mother to Helena. Helena's intention was to apply for a full exclusionary FVIO once this change of name occurred.

89. I am unable to determine, from the records provided, why Helena did not pursue a full FVIO with exclusion conditions prior to this time, although she may have misunderstood this as an option or was attempting to manage her safety with Mr Wilson. Helena's records indicate that she was not always clear on the FVIO process or what orders she had in place, and it appears that the relevant services did not consistently clarify her understanding or knowledge of her options.

90. I note that since Helena's passing, amendments were made to the *Residential Tenancies Act 1997* (Vic) (**RTA**) regarding the intersection of family violence and residential tenancies. Prior to the changes that came into effect in 2021, there were some provisions to assist victims of family violence, however they have since been strengthened and expanded.

91. People experiencing family or personal violence now have greater protections under the RTA, and VCAT is required to hear their applications urgently (within three business days). For example, a renter can challenge a notice to vacate on the grounds of family or personal

violence, and provisions are extended to renters of caravan parks and rooming houses, not just traditional rental properties.

92. If these provisions had been in place at the time of Helena's passing, she may have been able to change the lease from her mother-in-law's name into her own name in a much shorter timeframe, via an expedited process. This may have permitted Helena to apply for a full FVIO sooner, which would have allowed police to breach Mr Wilson for attending the home. However, even if this was the case, I cannot determine now that those changes to the RTA, or indeed the existence of a full FVIO, would have prevented Helena's passing.

FINDINGS AND CONCLUSION

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

e) the identity of the deceased was Helena Zoe Broadbent, born 10 April 1987;

f) the passing occurred on 28 September 2019 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052, from *head injuries in a motor vehicle incident*; and

g) the passing occurred in the circumstances described above.

RECOMMENDATIONS

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

1. I endorse and support Recommendation 13 (e) of the Commonwealth Government's Rapid Review of Prevention Approaches to domestic, family and sexual violence (**DFSV**), *Unlocking the Prevention Potential*. I recommend the **Department of Premier and Cabinet** (or another suitable department) establish a mechanism or entity for independent oversight and accountability of police response and management of family violence, ensuring they are resourced to undertake prompt and thorough reviews as necessary. This should be civilian-led and sit outside Victoria Police.

   Given the over-representation of First Nations women who experience family violence, I therefore recommend that such a mechanism should be developed in consultation with Aboriginal organisations such as the VALS.

2. That **Family Safety Victoria** make the following changes to the Flexible Support Package:

a) Ensuring that all FSP providers comply with consistent and comprehensive guidelines, removing situations in which "*some providers appear to be more lenient than others*", in particular, that updates to packages are not discouraged or disallowed, providing they comply with the guidelines.

b) Exploring enhancements to the FSP online portal to make it more user-friendly and transform it into an end-to-end platform, rather than relying on email correspondence between FSP providers and case managers.

c) Require all case managers who assist victim-survivors to access FSPs to be trained in trauma-informed care and practice, to better support people who have experienced family violence.

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

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

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

Jeffrey & Tracie Loone, Senior Next of Kin (C/- Maurice Blackburn)

Chief Commissioner of Police (C/- VGSO)

Department of Families, Fairness and Housing

Department of Premier and Cabinet

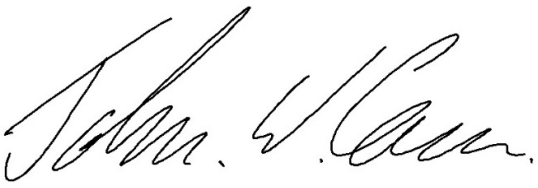
Family Safety Victoria

Royal Melbourne Hospital

Transport Accident Commission

Detective Sergeant Daryll Out, Coroner's Investigator

Signature:



Judge John Cain
State Coroner
Date: 22 July 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.