Court Reference: **COR 2020 000670**

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

**Amended pursuant to section 76 of the Coroner Act 2008 (Vic) on 15 November 2024 by order of the State Coroner Judge John Cain*

INQUEST INTO THE DEATH OF NOELINE DALZELL

Findings of:	Judge John Cain, State Coroner
Delivered on:	13 November 2024
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Inquest Hearing Dates:	15 to 18 April 2024
Counsel Assisting:	Ms Carly Marcs of Counsel instructed by Ms Katrina Sonneveld, Coroner's Solicitor

** Amendment on page 2 to correct legal representations*

REPRESENTATION

Department of Families Fairness and Housing	Ms Rachael Ellyard with Ms G Rhodes, instructed by HWL Ebsworth
Mrs Jennifer and Mr Malcolm Dalzell	Ms S Gold with Mr L Cameron, instructed by Robinson Gill Solicitors
Victoria Police	Ms R Kaye KC with Ms M Isobel instructed by the Victorian Government Solicitor's Office
Department of Justice and Community Safety	Mr Liam Brown KC with Ms J Still, instructed by MinterEllison

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ACKNOWLEDGEMENT & CULTURAL WARNING

Aboriginal and Torres Strait Islander readers are advised that this Finding contains the name of a deceased Aboriginal person.

Readers are warned that there may be words and descriptions that may be culturally distressing.

I acknowledge the Traditional Owners of the land where the Coroners Court of Victoria sat in this matter, the Wurundjeri and Dja Dja Wurrung peoples of the Kulin nations. I acknowledge their longstanding connection to Country, and I pay my respects to their Elders past and present.

Much of what this inquest has revealed is confronting and traumatic. I would like to acknowledge all the First Nations people who gave their time, evidence, and insights to my investigation. This process has benefited profoundly from their participation, and I acknowledge the emotional toll of their engagement in the coronial process.

INTRODUCTION

1. Noeline Dalzell was an Aboriginal woman born on 19 January 1971 in Swan Hill, Victoria. She spent the first year of her life in foster care before being adopted by the Dalzell family, who are non-Aboriginal. At the time of her passing, Noeline was 49 years old and resided in Seaford with her three children, Paige, Zachary and Olivia, who were 16, 15 and 13 at the time of her passing.

2. Noeline's family described her as a very beloved mother, daughter, sister and sister-in-law, who had a cheeky grin, loved the ocean, dolphins and the Essendon Bombers, and never missed an episode of Home and Away.[1]

3. In 2002, Noeline commenced a relationship with Mr James Fairhall, later the father of her three children. Their relationship was marred by multiple incidents of reported and unreported family violence perpetrated by Mr Fairhall against Noeline. Noeline was subjected to family violence that was physical, verbal and emotional. The frequency and severity of incidents often heightened in connection with Mr Fairhall's alcohol use. There was a history of threats to kill and between 2016 and 2019, Mr Fairhall demonstrated a propensity to arm himself with knives during family violence incidents.[2]

4. During their 17-year on-and-off relationship, Noeline and Mr Fairhall had contact with Victoria Police, Department of Families, Fairness and Housing (Child Protection and Housing), the Department of Justice and Community Safety, specialist family violence services including The Orange Door, alcohol and other drug services, and housing services.

5. Noeline resisted Mr Fairhall's violence over many years and worked hard to keep herself and her children safe by calling authorities, engaging with various services, relocating, applying for family violence intervention orders, and frequently removing herself and her children from Mr Fairhall's presence and violence.

[1] Dalzell Family Statement dated 15 April 2024, 7.
[2] Inquest Brief, *Victoria Police Family Violence Death Service Delivery Review, formerly, Victoria Police Family Violence-Related Death Assessment (**VP SDR**)*, 4328.

6. Following their mother's passing, the children disclosed further incidents of Mr Fairhall's threatening behaviour and family violence. Family and friends recalled that Mr Fairhall often appeared intoxicated and frequently verbally abused Noeline, including in the presence of their children. In his statement to police, Malcolm Dalzell recalled his sister disclosing that Mr Fairhall physically assaulted her on multiple occasions and on one occasion, had thrown their daughter into a wall.[3]

7. At approximately 3:30 pm on 4 February 2020, Mr Fairhall stabbed Noeline in the neck following an argument. Efforts were made by those at the scene to resuscitate Noeline, however they were unsuccessful. Sadly, Noeline passed away at the scene.

8. In December 2021, Mr Fairhall was convicted of Noeline's murder. On 5 August 2022, he was sentenced to 25 years imprisonment with a non-parole period of 18 years and six months.[4]

THE PURPOSE OF A CORONIAL INVESTIGATON

9. Noeline's passing constitutes a 'reportable death' under the *Coroners Act 2008* (Vic) (**the Act**) as the death occurred in Victoria and the death appears to have been unnatural and unexpected.

10. The jurisdiction of the Coroners Court of Victoria is inquisitorial. The role of the coroner is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased, the cause of death and the circumstances in which the death occurred.

11. It is not the role of the coroner to lay or apportion blame, but to establish the facts. It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

12. The expression 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

[3] Inquest Brief 305, 314–15, 320.
[4] Inquest Brief 38.

13. For coronial purposes, the phrase 'circumstances in which the death occurred' refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating the death, it is confined to those circumstances which are sufficiently proximate and casually relevant to the death.

14. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's 'prevention' role.

15. Coroners are also empowered to:

    a) report to the Attorney-General on a death;

    b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    c) make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.

16. These powers are the vehicle by which the prevention role may be advanced.

17. All coronial findings must be based on proof or relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[5] 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 that they caused or contributed to the death.

18. The proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a

[5] (1938) 60 CLR 336.

weight of evidence commensurate with the gravity of the facts sought to be proved.[6] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[7]

19. The Victoria Police assigned Detective Senior Constable (**DSC**) Rebecca Maydom to be the Coroner's Investigator for the investigation into Noeline's death. DSC Maydom conducted inquiries on my behalf and submitted a coronial brief of evidence.

20. This finding draws on the totality of the material obtained in the coronial investigation of Noeline's passing, that is, the material on the Court file, the coronial brief, further material including expert reports obtained by the Court, together with the transcript of the evidence adduced at inquest and the submissions of Counsel Assisting and the interested parties.

21. In writing this finding, I do not purport to summarise all of the material evidence but refer to it only in such detail as appears warranted by forensic significance and narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

22. With an investigation of this magnitude, it is appropriate that I acknowledge the significant work of all who were involved in assisting me.

23. I thank DSC Maydom, the Coroner's Investigator in this investigation who compiled a comprehensive coronial brief that was of great assistance.

24. I thank Counsel Assisting, Ms Carly Marcs and the counsel and solicitors who represented the interested parties for their work and comprehensive submissions.

25. I also acknowledge and thank Mr Nick Ngai, Senior Solicitor at the Coroners Court of Victoria, who worked on the investigation in the period prior to the inquest and Ms Katrina Sonneveld, Solicitor at the Coroners Court of Victoria, who assisted Mr Ngai

[6] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[7] *Briginshaw v Briginshaw* (1938) 60 CLR 336, 362–3 (Dixon J).

and has worked diligently and provided me with invaluable assistance through the inquest. I have also been greatly assisted by the staff of the Systemic Review of Family Violence at the Court and thank them for their input and assistance.

INQUEST

26. I convened the Coroners Court of Victoria for the inquest on 15 April to 18 April 2024.

SCOPE OF INQUEST

27. The Scope of Inquest was finalised on 26 March 2024 pursuant to section 64(b) of the Act, as follows:

    1. *The assessment, understanding and management of the family violence risk Mr Fairhall posed to Noeline and her children following his release from custody on 6 November 2019. This topic will include:*

        a) *Victoria Police's response to Mr Fairhall's release, reports of his re-offending and the warrant issued for his arrest.*

        b) *Monitoring, management and engagement of Mr Fairhall by Corrections Victoria and Justice Services.*

        c) *Adequacy of family violence services and supports made available to Noeline and her children on behalf of the Orange Door following Mr Fairhall's breach of the Family Violence Intervention Order on 19 November 2019.*

    2. *The adequacy of information sharing coordinated risk assessment and management between all agencies involved with Mr Fairhall and/or Noeline and her children in the 12 months prior to the murder insofar as this informed agency decision-making and action after 6 November 2019. This topic will include information sharing between DFFH - Child Protection, VACCA, DJCS - Corrections Victoria and Justice Services, Victoria Police, DFFH - Homes Victoria, and other key services that had proximate contact with Noeline, her children and Mr Fairhall.*

3. *The progress of implementation of recommendations already made by agencies in internal reviews conducted following Noeline's passing.*

INTERESTED PARTIES

28. Four interested parties were granted leave to appear at the inquest. They were:

- Noeline's Family.
- Department of Families Fairness and Housing (**DFFH**).
- Victoria Police.
- Department of Justice and Community Safety (**DJCS**).

The Victorian Aboriginal Child Care Agency (**VACCA**) were considered an interested party at the inquest and was provided with an opportunity to respond to submissions made by Counsel Assisting and other interested parties. However, VACCA did not have counsel attend the inquest on their behalf.

EVIDENCE

29. A coronial brief was prepared by the Coroner's Investigator containing witness statements, exhibits including material from the forensic pathologists, and also internal review reports that had been conducted by various government agencies which have informed the Court's examination of all the relevant circumstances. The completed reviews include:

- DFFH and DJCS multi-agency system-focused review;
- DFFH Child Protection file review;
- DFFH Child Protection risk assessment project evaluation report;
- Victoria Police Family Violence Related Death Assessment (**FDA**);
- Community Corrections Services (**CCS**) Manager's review; and
- Family Safety Victoria review.

30. With the benefit of these various reports together with other materials in the coronial brief and to avoid unnecessary duplication, a statement of facts and circumstances was agreed among the interested parties and forms the basis for the factual findings in the inquest. These agreed facts and circumstances are set out in full in the finding. I am grateful to all parties for their work in reaching agreement as it has saved significant court time in the running of the inquest and narrowed the scope of the inquest. The agreed facts and circumstances told me what happened, and the focus was then able to shift on why.

31. At inquest, viva voce evidence was heard from five witnesses:

- Assistant Commissioner (**AC**) Lauren Callaway, Victoria Police
- Ms Jenny Roberts, Executive Director Community Operations and Parole, DJCS
- Ms Tanya Gounas, Executive Director Bayside Peninsula Area, South Division, DFFH Child Protection
- Ms Jane Sweeney, Executive Director Family Services, Evidence, Redress and Lived Experience Branch, DFFH Child Protection
- Ms Fran O'Toole, Executive Director Operations, Family Safety Victoria.

32. Witnesses gave evidence concurrently across two separate panels. AC Callaway and Ms Roberts made up one panel (**panel one**) and AC Callaway, Ms Roberts, Ms Gounas, Ms Sweeney and Ms O'Toole made up the second panel (**panel two**).

33. Ten key events were identified relevant to the scope of the inquest and these topics were divided between the two panels.

34. Panel one's evidence addressed the following events:

- Mr Fairhall's release from custody on 6 November 2019;
- Mr Fairhall's Priority Target Management Interface (**PTMI**) was not updated following his release from custody on 6 November 2019, nor following his further breach of the Family Violence Intervention Order (**FVIO**) on 19 November 2019;

- Mr Fairhall's further FVIO breach on 19 November 2019;
- The warrant issued for Mr Fairhall's arrest on 21 November 2019;
- The Orange Door advised Victoria Police on 9 December 2019 that the L17 referral for Noeline was closed as she had accepted a referral to VACCA; and
- Noeline's murder by Mr Fairhall on 4 February 2020.

35. Panel two's evidence addressed the balance of events set out below:

- A Risk Assessment and Management Panel (**RAMP**) referral was requested on 6 November 2019 but denied;
- Mr Fairhall's 'open case' with Somerville Family Violence Investigation Unit (**FVIU**) and advice to CCS and Child Protection on 8 November 2019;
- The safety plan conducted by The Orange Door on 19 November 2019; and
- The Orange Door advised Victoria Police on 9 December 2019 that the L17 referral for Noeline was closed as she had accepted a referral to VACCA.

36. Following the inquest, Counsel Assisting and Counsel for all interested parties provided written submissions. In writing this finding, I have considered all of the evidence and the submissions of the interested parties.

37. I also received a coronial impact statement from Noeline's sister-in-law, Jennifer Dalzell, which she read in open court. I am very grateful to Mrs Dalzell for providing me with the coronial impact statement which enabled me to better understand more about Noeline, her children and family and the great loss and pain they have all felt since Noeline's passing.

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

38. On 6 February 2020, Ms Noeline Michelle Dalzell was visually identified by her sister-in-law, Jennifer Dalzell.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

Autopsy

40. On 5 February 2020, Dr Sarah Parsons, Specialist Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an autopsy and provided a written report of her findings dated 6 May 2020.

41. The autopsy revealed:

- Stab wound to the left neck extending inferomedial under the first rib with transection of the subclavian artery and vein;
- 100 ml left haemothorax;
- Left tension pneumothorax on CT scan;
- Coronary artery atherosclerosis; and
- Chronic inflammation and fibrosis of the lungs.

42. Toxicological analysis of blood detected cannabis metabolites. Cannabis, methylamphetamine and codeine were detected in the hair.

43. Dr Parsons formulated the cause of death as:

(1)(a) Stab wound to the neck.

44. I accept the opinion of Dr Parsons as to the cause of death.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

Summary of circumstances immediately prior to Noeline's passing

45. At approximately 3:30 pm on 4 February 2020, Noeline's children arrived home and found their parents arguing. The available evidence suggests that Noeline tried to move away from Mr Fairhall, but he continued to follow her around the house.

46. At some stage, Mr Fairhall armed himself with a knife and approached Noeline in the loungeroom, holding it against her throat and threatening her. Their children tried to intervene, but he persisted, following Noeline as she moved away into one of the children's bedrooms. Mr Fairhall continued his advances towards Noeline, and the children bravely continued to intervene and come between them. At some point, Mr Fairhall reached over the children and stabbed Noeline once to the neck.

47. Zachary tackled Mr Fairhall to the ground, and he dropped the knife. Noeline fled the room and ran out of the house towards a neighbour's home across the road. Mr Fairhall obtained a second knife and pursued her further.

48. Mr Fairhall then threatened neighbours who were attempting to resuscitate Noeline. Eventually, he dropped the second knife. Police and paramedics arrived at the scene and took over resuscitation. Noeline tragically passed away at the scene and Mr Fairhall was arrested by attending police members.

49. In December 2021, Mr Fairhall was convicted of Noeline's murder. On 5 August 2022, he was sentenced to 25 years imprisonment with a non-parole period of 18 years and six months.[8]

Summary of service engagement

50. The first recorded family violence incident between Noeline and Mr Fairhall occurred on 9 February 2003, wherein police attended at Noeline's request to respond to Mr Fairhall's

[8] Inquest Brief 38.

yelling. Between 2003 and 2019, Victoria Police responded to a total of 27 incidents of family violence by Mr Fairhall against Noeline.[9]

51. Mr Fairhall had been the subject of a total of 21 warrants, predominantly relating to family violence offending and/or civil orders. Between 21 November 2018 and 4 February 2020, there were five L17 reports issued by Victoria Police, prior to the L17 report relating to Noeline's passing. Mr Fairhall was also the respondent, and Noeline the affected family member (**AFM**), on five police-initiated FVIOs between 2004 and 2020 ranging in length from one to four years.[10] At the time of Noeline's passing, there was an active FVIO which recorded Noeline and her children as protected persons, and which prohibited Mr Fairhall's contact with them and his attendance at their Seaford address.[11]

DFFH – Child Protection

52. Child Protection first became involved with Noeline and her children in 2004. Between 2004 and 2019, a total of 23 notifications were received by Child Protection, nine of which progressed to Investigation and Assessment or Protective Intervention. The majority of the notifications related to the children being exposed to family violence perpetrated by Mr Fairhall. The children were subject to protective orders in 2007 and 2008.

53. In 2015, four notifications were made to Child Protection expressing concerns regarding Noeline's alleged erratic behaviour, suspected substance use, and mental health. Child Protection, in consultation with VACCA, considered these reports potentially malicious and the concerns unsubstantiated.[12]

54. The concerns raised with Child Protection primarily related to parent-child conflicts, parental substance abuse, family violence by Mr Fairhall towards Noeline, maternal mental health issues, environmental neglect, and threats from Mr Fairhall. During a home

[9] Inquest Brief, *VP SDR,* 4328.
[10] Inquest Brief, *VP SDR - Appendix D Timeline*, 4777.
[11] Ibid.
[12] Inquest Brief, *DFFH Child Protection, File Review in respect of Paige Fairhall, Zachary Fairhall, Olivia Fairhall*, 4220–1.

visit in January 2020, Noeline made several references to financial hardship, citing issues with her Centrelink Jobseeker payment,[13] and applying for the Disability Support Pension due to her declining health.[14]

Department of Justice and Community Safety (DJCS)

55. Mr Fairhall's criminal history dates back to 1993 and comprises primarily violent offences. He also had a history of significant substance abuse, namely alcohol and amphetamines. Between 2014 and 2017, Mr Fairhall engaged with multiple services for treatment and support regarding his alcohol and drug use.

56. Between 2007 and 2019, Mr Fairhall's behaviour resulted in over 18 charges including unlawful assault, intervention order (**IVO**) breaches, threats to kill, and possession of illicit substances. Prior to being charged with Noeline's murder, Mr Fairhall had been charged with a total of 43 offences, the bulk of which related to offending against Noeline. He received varying sentences ranging from Community Corrections Orders (**CCOs**) to short prison sentences, and was incarcerated for the following periods between 2007 and the fatal incident on 4 February 2020:

- 26 February 2007 – 26 August 2007
- 10 September 2016 – 10 March 2017
- 12 December 2018 – 13 May 2019
- 25 June 2019 – 30 August 2019
- 13 September 2019 – 6 November 2019.

57. While Mr Fairhall's DJCS records do not record any contact between him and Noeline during his periods of incarceration, she was listed as his Next of Kin throughout many of his sentences, despite documented FVIOs with full conditions naming her as an AFM.[15]

[13] Inquest Brief, *DFFH Child Protection records,* 2729.
[14] Ibid.
[15] Inquest Brief, *DJCS Community Corrections records for James Fairhall*, 577, 685, 714.

58. Mr Fairhall was subject to five CCOs, and one period of parole. The last CCO commenced on 4 September 2019 and was active at the time of the fatal incident:

- Community Based Order (**CBO**) 1993 (preceded CCO).[16]
- Parole 26 August 2007 – 25 May 2008.
- CCO 15 September 2014 – 14 September 2015.[17]
- CCO 10 March 2017 – 9 March 2018.[18]
- CCO 2019 (15-month CCO commencing 13 May 2019) sentenced in the Magistrates' Court for making threat to kill, unlawful assault, threatening to damage property and contravening an FVIO and a conduct condition of bail.[19]
- CCO 2019 (15-month CCO commencing 4 September 2019) sentenced in the County Court for contravening a conduct condition of bail and an FVIO, making threat to kill, threatening to damage property and unlawful assault.[20]

Department of Families, Fairness & Housing (DFFH) – Homes Victoria

59. In August 2007, Noeline moved to the Seaford address with her three children. The tenancy was facilitated by DFFH on the basis of Noeline's experience of family violence.

60. Between 2009 and 2011, DFFH received complaints from neighbouring properties reporting concerns about the children's exposure to violence, alleged drug use, and police attendance.[21] Noeline received a breach notice during this period in connection with these complaints.[22] Throughout this period, Noeline received several home visits from DFFH, at which time she denied that Mr Fairhall resided at the property permanently but instead

[16] Ibid 2663.
[17] Ibid.
[18] Ibid 1963.
[19] Ibid 1838.
[20] Ibid 2347.
[21] Inquest Brief, *DFFH Housing Victoria records for Noeline Dalzell*, 3988–9, 3997, 3967–4000.
[22] Ibid 3993–6.

visited the children on weekends. In 2019, Noeline faced rental arrears, and received notices to vacate in August and September 2019.[23]

61. In November 2016, Mr Fairhall was approved as a priority housing applicant on the Victorian Housing Register due to his homelessness. Due to his failure to respond to correspondence seeking updated confirmation of his eligibility, Mr Fairhall was removed from the Victorian Housing Register waiting list as a priority applicant in November 2018.[24]

62. Upon his release from incarceration, Mr Fairhall was offered (by the Salvation Army) referrals for temporary accommodation, including rooming houses and caravan parks, however Mr Fairhall declined the referrals as he was concerned that they were not conducive to maintaining his sobriety.[25]

The Orange Door Bayside Peninsula

63. Between November 2018 and February 2020, The Orange Door Bayside Peninsula received six referrals for Noeline as the AFM, and Mr Fairhall as the respondent.[26] Among these, the L17 portal records indicate referrals received for Mr Fairhall were closed due to unsuccessful contact.[27]

64. A referral made in December 2018 for Mr Fairhall remained unassigned until June 2019 and was subsequently closed. A men's practitioner from The Orange Door attempted to contact Mr Fairhall but they did not receive any response from him and therefore closed all case files with no contact.[28]

[23] Ibid 4011–4012.
[24] Ibid 4010.
[25] Inquest Brief, *Salvation Army records for James Fairhall*, 4140–1.
[26] Inquest Brief, *The Orange Door records for Noeline Dalzell*, 3657, 3661, 3665, 3685, 3688, 3695.
[27] Inquest Brief, *DFFH L17 portal records for Noeline Dalzell and James Fairhall*, 3538, 3551, 3554, 3557, 3563, 3571.
[28] Inquest Brief*, FSV, Chronology for the client death review-Noeline Dalzell, 21 November 2018 – 4 February 2020*, 4818.

Mirrool Counselling Centre

65. Between January 2013 and June 2019, Mr Fairhall attended 32 counselling sessions on referral by his treating general practitioner for 'stress management' with psychologist Michael Warner at Mirrool Counselling Centre.[29]

66. On 18 December 2017, Mr Fairhall's Community Corrections officer requested that Mr Warner incorporate anger management into his sessions to fulfil the requirements of Mr Fairhall's CCO, in place of the offence-specific family violence program.[30] Mr Warner agreed and Mr Fairhall attended three further appointments between 9 January and 6 March 2018,[31] one of which referred to an anger management strategy '*Using I statements [and] Walking away*'.[32] On 13 March 2018, Mr Warner provided a letter summarising his appointments with Mr Fairhall at the request of his Community Corrections Officer, for the purpose of discharging Mr Fairhall's CCO.[33] In his letter, Mr Warner advised that Mr Fairhall regularly attended the centre for counselling which focused on '*anger management, assertiveness and conflict resolution as well as his [Mr Fairhall's] issues with alcoholism*'.[34]

CHRONOLOGY OF INCIDENTS AND PROXIMATE SERVICE ENGAGEMENT

67. On 21 November 2018, Noeline and the children returned home to find Mr Fairhall intoxicated and verbally abusive.[35] Mr Fairhall initially asked where Noeline had been, and he made threats to kill her. Mr Fairhall continued to drink alcohol and Noeline left with the children. When they returned, they overheard Mr Fairhall arguing with and threatening neighbours. Noeline took the children out of the home again and upon their return, Mr Fairhall was again verbally abusive and threatening. Noeline then contacted

[29] Inquest Brief, *Mirrool Counselling records for James Fairhall*, 4108, 4115, 4137.
[30] Inquest Brief, *DJCS Community Corrections records for James Fairhall*, 1990.
[31] Inquest Brief, *Mirrool Counselling records for James Fairhall,* 4033–45.
[32] Ibid 4033.
[33] Ibid 4097.
[34] Ibid.
[35] Inquest Brief, *Magistrates Court Victoria records*, 159.

police and advised them that she believed she heard a knife drop and reported that Mr Fairhall often carried a knife with him.[36]

68. Police attended and recorded that Noeline and Mr Fairhall were separated but he had been residing at the Seaford address 'on and off' for approximately six months, in breach of an FVIO in place until 2020.[37] Police issued a Family Violence Safety Notice (**FVSN**), removed Mr Fairhall from the property and made formal referrals.[38]

69. Child Protection later confirmed that The Orange Door had an open referral. Child Protection contacted VACCA with a recommendation of case closure on the basis that enough safety had been identified, which VACCA endorsed. A practitioner from The Orange Door subsequently attempted three phone calls and sent one text message to Noeline, however she did not respond.[39]

70. On 27 November 2018, Child Protection received a report alleging '*physical, emotional, and psychological harm*' inflicted on the children while in their parents' care, specifically Mr Fairhall who was intoxicated and perpetrating family violence. Child Protection noted the family's history of 21 previous reports, with eight having progressed to investigation or protective intervention. Child Protection followed up with Victoria Police and were informed that an FVIO was issued on 21 November 2018 with full conditions, and Mr Fairhall had been charged.[40] Child Protection also contacted The Orange Door, who advised that they were unsuccessful in contacting Noeline but invited Child Protection to consult with a senior practitioner if required.

71. On 8 December 2018, Noeline's neighbours contacted emergency services to report arguing heard from the Seaford address. Police attended and Noeline advised that the children were arguing over whose turn it was to play the PlayStation. Victoria Police recorded that all persons agreed to keep their voices down and there were no concerns identified by Victoria Police. Police recorded the incident as '*No Offence Detected*' and

[36] Ibid.
[37] Ibid.
[38] Inquest Brief, *DFFH Child Protection records*, 3296–8.
[39] Inquest Brief, *FSV, Client death Review: Ms Noeline Dalzell Progress Update, February 2022*, 4785–90.
[40] Inquest Brief, *DFFH Child Protection records*, 3196.

did not submit an L17, nor was the incident recorded on the Law Enforcement Assistance Program (**LEAP**).[41]

72. That same day, Child Protection contacted VACCA to discuss case closure and a collaborative decision was made to close the case on 10 December 2018 as sufficient safety had been identified.[42]

73. On 12 December 2018, Noeline and her children returned to the Seaford address and found Mr Fairhall there in breach of the FVIO. He was also intoxicated.[43] Noeline left with the children and contacted police, who attended and observed Mr Fairhall to be heavily intoxicated. Police arrested Mr Fairhall and transported him to Frankston Police Station. Noeline subsequently advised police that she was unable to attend the station to provide a statement.[44]

74. On 24 January 2019, Mr Warner provided a report to forensic psychologist David Ball to inform a clinical psychological assessment requested by Mr Fairhall's lawyer.[45] The assessment noted that Mr Fairhall was '*functionally illiterate and innumerate*' and had an IQ of 69.[46] Notably, an IQ of 70 or below would have made Mr Fairhall eligible for the Disability Support Pension and support through the National Disability Insurance Scheme.[47]

75. On 8 March 2019, Mr Fairhall appeared at the Frankston Magistrates' Court where he was convicted of family violence offending committed in November and December 2018, including unlawful assault and making threats to kill and damage property. He was sentenced to an aggregate term of five months' imprisonment in combination with a CCO for 18 months. The CCO included a requirement that he undergo medical and mental health assessment and treatment as required and to undertake a men's behaviour change

[41] Inquest Brief, *VP SDR*, 4364–5.
[42] Inquest Brief, *DFFH Child Protection records,* 3276.
[43] *Victoria Police NPR and Leap records,* 90–1; Inquest Brief, *Victoria Police NPR and LEAP records*, 3416–7.
[44] Ibid.
[45] Inquest Brief, *Mirrool Counselling records for James Fairhall*, 4101.
[46] Inquest Brief, *DJCS Community Corrections records for James Fairhall*, 2263.
[47] Australian Government Social Security Guide, V1.311, 3.6.2.50 Assessment of people with intellectual impairments for DSP https://guides.dss.gov.au/social-security-guide/3/6/2/50.

program. He had already served 86 days by way of pre-sentence detention which was declared.[48]

76. Between May to September 2019, Mr Fairhall engaged with The Bridge Centre for post-release support.

77. On 10 May 2019, Mr Fairhall attended an initial assessment and planning appointment with Salvation Army's SalvoCare housing service prior to his release from prison. Consistent with Mr Fairhall's previous disclosures to DJCS staff in 2019, Mr Fairhall reported to SalvoCare that '*housing is his main concern and believes that if he resorts to homelessness that this will affect his mental health significantly and be at breach of his CCO*'.[49]

78. Mr Fairhall was released into the community on 13 May 2019.[50] Initially, he attended weekly supervision appointments at Frankston Community Corrections and registered two unexplained absences. Case notes from a visit to the SalvoCare Eastern office on 23 May 2019 recorded that he was again offered referrals to caravan parks or rooming houses. Mr Fairhall inquired about assistance with funds for a motel room but was informed that SalvoCare could not provide such funds without an established '*exit plan*'.[51] On 21 June 2019, Mr Fairhall attended his last appointment with Mr Warner. Records for this appointment include references to him being on another CCO with requirements for men's behaviour change and alcohol and other drug programs.[52] There were no references to discussions regarding his housing arrangements or Mr Fairhall's status with an FVIO.

79. Mr Fairhall was allocated for offending behaviour programs by Frankston Community Corrections however, screening did not take place as he was subsequently remanded in custody on 25 June 2019.[53]

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[48] Inquest Brief, *Frankston Magistrates Court, Certified extract of orders*, 61–75.
[49] Inquest Brief, *Salvation Army records for James Fairhall*, 4152.
[50] Inquest Brief, *DJCS Community Corrections Services (**CCS**) Manager's Review for James Fairhall*, 483.
[51] Inquest Brief, *Salvation Army records for James Fairhall*, 4149.
[52] Inquest Brief, *Mirrool Counselling records for James Fairhall*, 4030–1.
[53] Inquest Brief, *Victoria Police NPR and LEAP records*, 3409–10.

80. On 24 June 2019, Noeline contacted emergency services and police were requested to attend after Mr Fairhall attended the Seaford address in breach of the FVIO and refused to leave. Noeline subsequently left the home with her children. When police arrived, Mr Fairhall answered the door but upon realising it was police, slammed the door and barricaded himself inside. Following approximately an hour of police attempting negotiation, they forced entry. Police observed that Mr Fairhall was armed with a bloodied knife and had self-inflicted injuries to his neck. He was apprehended by police and taken to Frankston Hospital for treatment before being remanded into custody on 24 June 2019.[54] Police notified Child Protection of the incident.

81. On 25 June 2019, Child Protection consulted VACCA, who in turn provided cultural information and advice.[55]

82. On 25 June 2019, The Orange Door received an L17 referral to contact Noeline, prompted by police attendance at the Seaford address; however, the referral did not contain Noeline's contact number and so The Orange Door submitted an information request to the police that same day.[56] Efforts were made in the interim to contact Noeline through alternative contact numbers found in previous L17 referrals.[57]

83. On 5 July 2019, a text message was sent to Noeline and she responded that Mr Fairhall was incarcerated for '*at least two years*'.[58] To verify this information and enable risk assessment, The Orange Door practitioner requested confirmation from the Frankston Magistrates Court, which revealed that Mr Fairhall had two further court hearings listed for 15 and 17 July. Despite making three attempts to contact Noeline between 8 and 19 July 2019, the practitioner did not receive a further response.[59]

[54] Inquest Brief, *VP SDR*, 4357–8; Inquest Brief, *Victoria Police NPR and LEAP Records, 83.*
[55] Inquest Brief, *DFFH Child Protection records*, 3249.
[56] Inquest Brief, *The Orange Door records for Noeline Dalzell*, 3669.
[57] Inquest Brief, *DFFH Child Protection records*, 3248.
[58] Inquest Brief, *The Orange Door records for Noeline Dalzell*, 3676.
[59] Ibid 3670–3.

84. On 10 July 2019, Child Protection received a report expressing concerns regarding Noeline's parenting capacity.[60]

85. On 15 July 2019, Mr Fairhall appeared at the Frankston Magistrates' Court where he was convicted of breaching the CCO imposed on 8 March 2019. The breach of the CCO was constituted by failing to report as directed on 14 June 2019, failing to undergo treatment as required on 31 May 2019 and failing to comply with the alcohol exclusion restrictions between 13 – 14 June 2019.[61] His CCO was cancelled. He was re-sentenced to an aggregate term of six months imprisonment for the November–December 2018 offending and the additional charge of breaching the FVIO by attendance at the Seaford address on 24 June 2019. He had already served 21 days by way of pre-sentence detention (since his arrest and remand on 24 June 2019) which was declared.

86. On 19 July 2019, Child Protection attempted a home visit at the Seaford address but there was no one home.[62]

87. On 19 July 2019, The Orange Door was informed via a Central Information Point (**CIP**) report that Mr Fairhall was incarcerated at Ravenhall with an earliest expected release date of 14 January 2020.[63]

88. On 23 July 2019, Mr Fairhall filed an appeal in the County Court against his sentence imposed at Frankston Magistrates' Court on 15 July 2019.[64]

89. On 26 July 2019, Child Protection emailed The Orange Door to advise of the open case and included details for the Child Protection case manager.[65]

90. On 27 July 2019, The Orange Door emailed Child Protection to advise that they would be closing Noeline's case as they had been unable to contact her beyond some initial text messages and because Mr Fairhall was in custody.[66]

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[60] Inquest Brief, *DFFH Child Protection records*, 3215.
[61] Inquest Brief, *Frankston Magistrates Court, Certified extract of orders*, 97–104.
[62] Inquest Brief, *DFFH Child Protection records*, 3213.
[63] Inquest Brief, *The Orange Door records for Noeline Dalzell*, 3677.
[64] Inquest Brief, *DJCS Community Corrections records for James Fairhall*, 2503.
[65] Inquest Brief, *The Orange Door records for Noeline Dalzell*, 3681.
[66] Ibid 3682.

91. On 31 July 2019, after notifying and inviting VACCA, Child Protection attempted a second home visit and met Noeline at home with Paige and Olivia. Noeline advised that she suspected the report of 10 July 2019 related to an argument between her and Paige in the context of returning from school holidays and difficulty getting back into their routine.[67] They discussed the recent incident with Mr Fairhall, and Child Protection recorded that Noeline had not had contact from him since the incident. Child Protection determined to close the case file as they considered the full exclusion FVIO in place until 21 November 2020 provided sufficient safety together with their understanding that Mr Fairhall's earliest release date was 14 January 2020.[68] Child Protection advised VACCA of the closure rationale.

92. On 1 August 2019, Community Corrections were advised that Mr Fairhall was no longer eligible for offender management programs due to a change in eligibility criteria, namely a CCO of 18 months or longer.[69]

93. On 5 August 2019, Noeline contacted Child Protection with a friend to enquire when Mr Fairhall was expected to be released. The Child Protection practitioner advised that Mr Fairhall would be released in early 2020 and confirmed that Noeline had not yet spoken to The Orange Door, but that Noeline would call them that day.[70]

94. On 2 August 2019, VACCA emailed Child Protection to enquire as to whether a home visit had been conducted and if protective concerns were substantiated. VACCA suggested that in the event the Child Protection home visit had not yet been conducted, that a joint visit be conducted with VACCA.

95. On 6 August 2019, Child Protection confirmed by reply email that the home visit had occurred, and the case was likely to be closed; however, they were unable to meet with Zachary as he was not home at that time.[71] The Child Protection report was subsequently closed on 16 August 2019 with the protective concerns not substantiated.

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[67] Inquest Brief, *DFFH Child Protection records*, 3186.
[68] Ibid 4233–5.
[69] Inquest Brief, *DJCS CCS Manager's Review for James Fairhall*, 487.
[70] Inquest Brief, *DFFH Child Protection records*, 3189.
[71] Ibid 3191–2.

96. Mr Fairhall's appeal in relation to the two sentences imposed upon him at Frankston Magistrates' Court on 15 July 2019 was finalised in the County Court of Victoria on 29 August 2019. The orders of Frankston Magistrates' Court were set aside, and Mr Fairhall was re-sentenced in the County Court for breaching a CCO, family violence offending in November–December 2018 and breaching an FVIO on 24 June 2019. He was sentenced to a combined sentence of imprisonment and a new varied CCO for 15 months which commenced upon his release from custody on 4 September 2019. Conditions of his CCO included: judicial monitoring (first appearance required on 28 October 2019); supervision; alcohol exclusion; treatment for drugs, alcohol, mental health; and programs to reduce re-offending including a men's behaviour change program.[72]

97. On 29 August 2019, Mr Fairhall's referral for an external men's behaviour change program provider was processed, and he was placed in a queue for his regional provider.[73]

98. On 5 September 2019, Mr Fairhall attended an induction appointment at Frankston Community Corrections Office.[74] However, due to the short period between his release and subsequent reoffending, Mr Fairhall was unable to commence offence-specific behaviour programs or make progress towards the conditions of his CCO.[75] On 12 September 2019, Mr Fairhall attended the Seaford address in breach of the FVIO and was reportedly alcohol affected. Noeline would not let Mr Fairhall into the property at which point Mr Fairhall became angry and reportedly stated words to the effect of '*I'll kill you*' to Noeline. Zachary was present at the time and overheard the threat to kill his mother. Police attended and later apprehended Mr Fairhall at a different location. He was subsequently charged and remanded.[76]

99. Following this incident, The Orange Door tried unsuccessfully to speak with Noeline by phone call and text message.

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[72] Inquest Brief, *DJCS Community Corrections records for James Fairhall*, 2408.
[73] Inquest Brief, *DJCS CCS Manager's Review for James Fairhall*, 487.
[74] Inquest Brief, *DJCS Community Corrections records for James Fairhall*, 2449.
[75] Ibid 2354.
[76] Inquest Brief, *Victoria Police NPR and LEAP records*, 3405.

100. On 14 September 2019, a PTMI was generated by Victoria Police in connection with the family violence incident on 12 September 2019. The PTMI was closed, then reactivated and remained active until the fatal incident.[77]

101. On 24 September 2019, The Orange Door emailed Victoria Police to advise that Noeline's referral would be closed due to multiple unsuccessful attempts to contact her.

102. Mr Fairhall's DJCS records between June to November 2019 contain several notes from Corrections Victoria prison staff regarding his homelessness, including references to Mr Fairhall having attributed his return to Noeline's home to his homelessness.[78]

103. A case note completed on 5 November 2019 in Mr Fairhall's DJCS records indicates that Mr Fairhall's case manager would '*fill in housing referral once sentenced*' as Mr Fairhall was expected in court the following day for sentencing.[79]

104. On 6 November 2019, Mr Fairhall appeared at the Frankston Magistrates' Court where the charge of threating to kill Noeline on 12 September 2019 was withdrawn. Mr Fairhall entered a plea of guilty to possession of cannabis and breach of FVIO on 12 September 2019. He was sentenced to 55 days imprisonment reckoned as time served.[80] He was released that day with no housing referral and minimal transitional case planning. He was offered a rooming house, which he declined, and received a housing exit pack and a crisis payment of $500 from Centrelink.

105. Prior to Mr Fairhall's release on 6 November 2019, a discharge checklist was completed which noted that he had accommodation arranged, however his forwarding address was listed as '*no fixed address*'.[81] The checklist also contained a field corresponding to a CCO and was marked '*NA*'.[82] Mr Fairhall's DJCS file contained a copy of Victoria Police

[77] Inquest Brief, *VP SDR*, 4359.
[78] Inquest Brief, *DJCS Community Corrections records for James Fairhall*, 856.
[79] Ibid 741.
[80] Inquest Brief, *DJCS CCS Manager's Review for James Fairhall,* 485; Inquest Brief, *Frankston Magistrates Court, Certified extract of orders*, 126–8.
[81] Inquest Brief, *DJCS Community Corrections records for James Fairhall*, 581.
[82] Ibid.

LEAP person warnings which noted that Mr Fairhall was a person of interest and at the time, subject to case management by the Somerville FVIU.[83]

106. Also on 6 November 2019, a Corrections Advanced Case Manager (**ACM**) emailed a RAMP representative of Community Correctional Services Bayside Peninsula with an outline of actions taken in relation to mitigating Mr Fairhall's risks. The ACM queried whether a RAMP referral was applicable for Mr Fairhall, however the RAMP representative advised that without any active or historical closed cases on the RAMP database for Mr Fairhall or Noeline, the eligibility criteria were not met. Subsequent discussions between the ACM and RAMP representative did not support a report of high and imminent risk of serious injury or death from family violence. A decision was made to liaise further with the Victoria Police Somerville FVIU.[84]

107. Upon Mr Fairhall's release from prison on 6 November 2019, a note regarding his release was added to the PTMI, however a new Management of Risk Template (**MRT**) was not completed to reflect his increased risk.[85]

108. From 6 November 2019, Mr Fairhall's whereabouts were unknown by his Community Correctional Services Case Manager, and he could not be contacted. Corrections Victoria notified Child Protection of Mr Fairhall's release into the community after he failed to present for his CCO supervision appointment.[86]

109. On 7 November 2019, Mr Fairhall's Community Corrections officer contacted Somerville FVIU, who advised that there was an '*active case*' for Mr Fairhall.[87]

110. On 8 November 2019, Community Corrections notified Community Based Child Protection that a full FVIO remained in place and that following Mr Fairhall's release on 6 November 2019, Community Corrections had been unable to contact him.[88] They

[83] Ibid 597.
[84] Inquest Brief, *DJCS CCS Manager's Review for James Fairhall*, 485–6.
[85] Inquest Brief, *VP SDR*, 4372.
[86] Inquest Brief, *DJCS Community Corrections records for James Fairhall*, 2428.
[87] Inquest Brief, *DJCS CCS Manager's Review for James Fairhall*, 485.
[88] Ibid.

further advised Child Protection that Somerville FVIU had an open case for Mr Fairhall but were also unaware of his whereabouts.[89]

111. Child Protection determined to register a wellbeing report, to consult VACCA, and to follow up with the Somerville FVIU to ascertain information regarding their open case with Mr Fairhall.[90]

112. On 11 November 2019, Corrections Victoria advised Somerville FVIU that they intended to proceed with contravention proceedings and obtain a warrant for Mr Fairhall's arrest as they remained unable to contact or locate him.[91]

113. On 13 November 2019, Corrections advised Child Protection that they were still unaware of Mr Fairhall's whereabouts and that his mother's address was the only address on file. That same day, Child Protection were advised by Somerville FVIU that a uniform member of Frankston Police Station was responsible for notifying Noeline of Mr Fairhall's release from prison, however they were unable to confirm if this had in fact occurred.[92] Child Protection later confirmed with The Orange Door that their last attempt to contact Noeline was in September 2019 and noted that during a previous contact with The Orange Door, Noeline had indicated that she did not wish to engage. The Orange Door closed its referral on 13 September 2019 after confirming Child Protection's involvement with the family.

114. Due to Mr Fairhall's continued non-contact with Corrections Victoria, contravention proceedings were initiated on 14 November 2019. On 19 November 2019, Mr Fairhall's lawyer contacted Corrections Victoria and advised that Mr Fairhall would present at Frankston Community Corrections for an appointment. Mr Fairhall failed to attend and on 21 November 2019, a warrant was issued for his arrest. This warrant remained unexecuted by Victoria Police at the time of Noeline's murder.[93]

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[89] Inquest Brief, *DFFH Child Protection records*, 3151.
[90] Inquest Brief, *DFFH Child Protection records*, 3152.
[91] Inquest Brief, *DJCS CCS Manager's Review for James Fairhall*, 486.
[92] Inquest Brief, *DFFH Child Protection records*, 3121–2.
[93] Inquest Brief, *DJCS CCS Manager's Review for James Fairhall*, 486.

115. On 19 November 2019, Mr Fairhall attended the Seaford address in breach of the FVIO, intoxicated and verbally abusive. Noeline did not permit him to enter, and she contacted police. Mr Fairhall left the premises on foot and police arrived shortly thereafter. Noeline indicated to police that she did not wish to answer any questions or make a statement and did not provide any further information regarding the incident or their relationship.[94] Police reported that Noeline was not fearful of Mr Fairhall and that she knew he would leave as soon as she mentioned that she would call the police.[95] Police did not hold any concerns that Mr Fairhall would attend the Seaford address again that evening but advised Noeline that they intended to obtain a statement from her regarding the charge of breaching the FVIO.[96]

116. A practitioner from The Orange Door contacted Noeline that same day following an L17 report by police. The practitioner conducted a brief safety plan with Noeline, who confirmed that the children had their own mobile phones, that she felt safe at home and Mr Fairhall did not have a key to the property.[97]

117. On 20 November 2019, a warrant was issued for Mr Fairhall's arrest due to contravention of his court orders, his CCS case manager's inability to contact him, and given the risks associated with his offending.[98]

118. On 21 November 2019, a final FVIO was made protecting Noeline and their children from Mr Fairhall and prohibiting his contact with them. The order was current at the time of the fatal incident.[99]

119. Child Protection conducted a home visit that day and spoke with Noeline, Paige and Olivia, who advised they had not had contact with Mr Fairhall since 19 November 2019. Child Protection determined to close the case file and advised VACCA of the rationale for closure, namely that '*no new concerns of significance had been received and given*

[94] Inquest Brief, *Victoria Police NPR and LEAP records*, 3397.
[95] Ibid.
[96] Ibid 3396–7.
[97] Inquest Brief, *The Orange Door records for Noeline Dalzell*, 3738.
[98] Inquest Brief, *DJCS CCS Manager's Review for James Fairhall*, 485–6.
[99] Inquest Brief, *VP SDR - Appendix D Timeline*, 4777.

time elapsed; intervention is assessed as impractical or inappropriate, with other cases of greater potential risk to be prioritised for action'.[100]

120. On 22 November 2019, The Orange Door emailed Child Protection to advise that a safety plan had been formulated. The practitioner expressed concerns to Child Protection in relation to the number of previous referrals for Noeline and Mr Fairhall's history of family violence. The practitioner advised that they had consulted their Aboriginal and Torres Strait Islander practitioner, who suggested that Noeline be referred to VACCA for support and sought the support of Child Protection for the referral.[101]

121. On 24 November 2019, The Orange Door spoke with Noeline on the phone and obtained her verbal consent to a referral being made to VACCA.[102] The Orange Door records included a completed referral form,[103] however the referral was never sent to VACCA due to a process breakdown.[104]

122. On 2 December 2019, The Orange Door emailed Child Protection for a CRIS history check, at which time Child Protection advised they had an open case and provided contact details for the relevant Child Protection caseworker.

123. On 4 December 2019, Child Protection attempted to contact Noeline by phone without success.

124. On 7 December 2019, police attended Noeline's home following a Crime Stoppers report that Mr Fairhall was present at the Seaford address in breach of the FVIO. Notes from this Information Report generated as a result of a call to Crime Stoppers include:

> '*MR FAIRHALL is well known to Victoria police for family violence and was at 8 Whitby Way Seaford at the time of this call. The resident of the property is his partner, Noeline DALZELL who has an IVO against MR FAIRHALL… was recently released from prison and police are looking for him. He is regularly incarcerated*

[100] Inquest Brief, *DFFH Child Protection, File Review in respect of Paige Fairhall, Zachary Fairhall, Olivia Fairhall*, 4235.
[101] Inquest Brief, *The Orange Door records for Noeline Dalzell*, 3739–42.
[102] Ibid 3746.
[103] Ibid 3767–74.
[104] Inquest Brief, *DFFH and DJCS Multi-Agency Review,* 4197–8.

and when he is released he returns to the property [and] breaches the IVO by returning to the property. MR FAIRHALL is not physically violent towards his family and will not be violent towards police. He uses ice but does not have weapons/firearms…. MR FAIRHALL gets verbally abusive towards DALZELL, particularly when he is drinking. MR FAIRHALL is racist towards DALZELL because she is Aboriginal, and yells and screams at her. There are concerns for the children as they are regularly exposed to this behaviour and DALZELL is unable to care for them with MR FAIRHALL around…MR FAIRHALL keeps the blinds closed when he is at the property and takes the chip out of his phone.'[105]

No family violence reports were made by Victoria Police and Mr Fairhall was not located.[106] Police established that Noeline had recent contact with Mr Fairhall and suggested that if she has further contact with him, she should advise him of the warrant for his arrest and instruct him to attend a police station.[107]

125. On 9 December 2019, The Orange Door emailed Victoria Police to advise that the L17 referral for Noeline had been closed as she had accepted a referral to VACCA.[108]

126. On 10 December 2019, Child Protection was unsuccessful in contacting Noeline and subsequently left a message with the children's school. Child Protection later spoke with Victoria Police, who confirmed a warrant had been issued for Mr Fairhall's arrest. Child Protection documented that it was unknown whether police had checked for Mr Fairhall at Noeline's address.[109]

127. On 8 January 2020, Child Protection conducted a home visit with Noeline and the children. They advised they had had no contact with Mr Fairhall since the 19 November 2019 incident. Child Protection closed the file and advised VACCA of its closure

[105] Inquest Brief, *VP SDR, Appendix E*, 4779.
[106] Inquest Brief, *VP SDR*, 4366.
[107] Inquest Brief, *Exhibit 1 – Victoria Police, Body worn camera footage*, 7/12/2019 09:035hrs.
[108] Inquest Brief, *The Orange Door records for Noeline Dalzell*, 3747.
[109] Inquest Brief, *DFFH Child Protection records*, 2731.

rationale, including that there were no new concerns of significance and intervention would be impractical or inappropriate.[110]

128. Between 8 January 2020 and the time of the fatal incident on 4 February 2020, there was no other contact with Noeline or her family by any services or agencies.

FOCUS OF THE INQUEST

Information sharing

129. The Royal Commission into Family Violence (**RCFV**) findings identified the need for transparent information exchange and sharing between police, the courts and other parts of the family violence system. Relevant information sharing mechanisms in place at the time included:

    a) The Family Violence Information Sharing Scheme (**FVISS**). Corrections Victoria (which at that time incorporated CCS) is a prescribed Information Sharing Entity (**ISE**) under this scheme.[111] This meant that CCS staff could request and share information with other ISEs in order to manage the assessed risk of family violence to victims.

    b) The CIP, which allows Corrections Victoria and other relevant government agencies to consolidate critical information about family violence perpetrators into a single report for frontline specialist family violence workers. In Corrections Victoria's case, this information is drawn directly from its IT systems.

    c) RAMP, which is a formal meeting of relevant agencies and organisations to coordinate the response to those perpetrators who present the most serious and imminent risk of family violence.

[110] Inquest Brief, *DFFH Child Protection, File Review in respect of Paige Fairhall, Zachary Fairhall, Olivia Fairhall*, 4235.
[111] At this time, The Orange Door, Victoria Police, Corrections Victoria, Child Protection, and VACCA were all ISEs.

d) Integration of aspects of DJCS' E*Justice and Victoria Police's LEAP systems.[112]

130. Also in place at the time of Noeline's passing was the Multi Agency Risk Assessment and Management framework (**MARAM**) which aims to establish a system-wide shared understanding of family violence, guiding professionals across the continuum of service responses, across the range of presentations and spectrum of risk. It provides information and resources that professionals need to keep victim survivors safe, and to keep perpetrators in view and hold them accountable for their actions, covering all aspects of service delivery from early identification, screening, risk assessment and management, to safety planning, collaborative practice, stabilisation and recovery.[113] The MARAM risk assessment tool is capable of being shared under FVISS or other information sharing schemes, but is not an information portal or mechanism.

131. Whilst information sharing has significantly improved since the Royal Commission,[114] this inquest heard evidence of specific examples where the sources of information and the platforms that store that information[115] (LEAP, Interpose, PTMI, L17, CIP, CRM, TRAM, and The Orange Door via a platform specific to the contracted agency)[116] can create dislocation and fragmentation. The evidence suggests that the transfer of information between any one of these platforms can be discretionary (such as from LEAP to E*Justice), incomplete/restricted (such as from the PTMI to LEAP), and in the case of the L17 portal, largely unidirectional. For example, The Orange Door CRM and L17 portal are described as an 'integrated practice' but it is largely a one-way system.[117] The distinction between the mere integration of information and systems or platforms that

[112] Statement of Jenny Roberts, 12; Inquest Brief, 7055.
[113] https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management-framework/executive-summary.
[114] For example, through the CIP initiative.
[115] Victoria Police use LEAP, Interpose, PTMI, and L17. DFFH use L17. The Orange Door uses the Tools for Risk Assessment and Management (**TRAM**) and the Client Relationship Management (**CRM**) systems. Most FV services use the Specialist Homelessness Information Platform (**SHIP**).
[116] Refer to List of Abbreviations.
[117] T 541 (Gounas and O'Toole).

also enable interface and collaboration is important in the context of information relevant to perpetrator risk of family violence.

132. In the period before Noeline's passing, there were many agencies that had responsibilities to the family that held varied current and historical information relevant to family violence risk. This included (but is not limited to):

- Corrections Victoria while Mr Fairhall was in custody and CCS upon his release;
- The Orange Door upon receipt of L17s from Victoria Police;
- Specialist family violence services with historical risk information;
- Child Protection from notifications and information on CRIS; and
- Victoria Police general duties police respond to incidents and hold information in LEAP, whereas the FVIU separately hold information in the PTMI and have the MRT.

133. The impact of these arrangements is easily seen in Noeline's case. CCS did not have all the relevant information about the FVIU risk rating or the MRT information relevant to Mr Fairhall and the implications for Noeline and her children. When Mr Fairhall was released from custody, sharing this information relied on the ACM calling other agencies to advise them. For other agencies to get relevant information, they needed to proactively identify services that may have records, request information from the specific ISE under the FVISS or request a CIP; however, the CIP information does not have all information held by Victoria Police.

134. In her evidence, Ms Roberts advised that the Bayside region CCS and The Orange Door have developed an arrangement to facilitate information sharing. The arrangements include quarterly meetings between senior staff of The Orange Door and CCS Bayside.[118]

135. I note that DJCS (CCS) has submitted a business case to DFFH to obtain access to the L17 Family Violence Portal, which would allow more timely access to L17 family

[118] Statement of Jenny Roberts, 12 [51]–[54].

violence incidents including the narrative which will support CCS staff to more appropriately assess and manage family violence related risk. This proposal appears to have merit and is worthy of support.

136. DJCS (CCS) have also introduced a new Practice Guideline 10.4.3 Treatment and Rehabilitation Programs, which provides guidance to CCS staff in monitoring an offender's engagement by conducting case conference and/or multi-agency meetings for offenders with complex treatment needs or presentations.[119]

137. Enhancement of E*Justice, the primary IT system used across the corrections system, is under development. New functionality will establish a single point of reference for family violence information (perpetrator, victim survivor information, screening and ancillary risk assessment information), updated in real-time which can be accessed by staff in prisons and CCS.

138. Counsel Assisting submitted that I should consider making recommendations:

    a) That the Victorian Government supplement and enhance the CIP to enable the multi-directional flow of information relevant to perpetrator risk among all relevant Departments and agencies in a way that is timely, proactive, complete and where possible and appropriate to manage risk, automated;

    b) The Victorian Government immediately formalise the sharing of CIP reports by approving Child Protection practitioners as requestors; and

    c) The Victorian Government support the Corrections Victoria business case for access to the L17 portal and consider whether Corrections Victoria would also benefit from access to CIP reports to assist them to manage risk.

139. These proposed recommendations are directed at enhancing the information sharing arrangements. In their submissions to the Court, Victoria Police stated that whilst they are supportive of information sharing within the existing CIP scheme, they oppose any expansion of CIP that would involve sharing LEAP information on the basis that it

[119] Ibid 12 [53].

contains broad law enforcement data with information that may not be relevant to family violence risk assessments. Victoria Police does support Corrections Victoria participating and having access to the CIP reports; however, they do not support Corrections Victoria having access to the L17 Portal.[120]

140. In their submissions, DFFH expressed support for the principle behind the proposed recommendation but did not support the 'mechanism'. DFFH submitted that the proposed recommendation does not take account of the significant information sharing that is possible through the FVISS and the MARAM information sharing arrangements. DFFH further submitted that an expansion of the CIP would not be any more efficient than the FVISS and MARAM arrangements already in place. They also pointed to funding concerns and the need for legislation as other reasons for not supporting the proposal.

141. In relation to the proposal by Counsel Assisting that Child Protection workers should be included as CIP requestors, DFFH did not oppose this, but submitted that it would have resourcing implications, it would impose an additional burden on Child Protection workers, it may not result in a more timely exchange of information and has financial implications which may reduce the responsiveness of the CIP.

142. DFFH do support Corrections Victoria having access to the L17 Portal, although I note that this access is already underway with the support of Victoria Police.

143. In their submissions, DJCS correctly highlighted that any enhancement of the CIP would require wide consultation with a number of agencies that supply information to the CIP. Consultation would consider the feasibility of reforms, cost implications and issues related to technology. DJCS submitted that any recommendation should be framed in terms of investigating, supplementing, and enhancing the CIP. DJCS also confirmed that DFFH have conditionally approved CCS having access to the L17 portal as is envisaged by proposed recommendation 3.

144. Taking into account the submissions of Victoria Police, DFFH, and DJCS, the information sharing arrangements can, in my opinion, be improved to address aspects

[120] CCP submissions [57]–[58].

that remain 'clunky' and do not facilitate easy and seamless information sharing to support fast, high quality risk assessment and management as was intended by the RCFV.

145. There appears to be substantial merit in considering enhancement to CIP so that it is a single information sharing portal, available to all relevant agencies, that holds all information relevant to risk management of a particular perpetrator and AFM. Ideally, such a platform would have different access permissions that would manage an agency's access to specific information. For example, Victoria Police do not want to grant complete LEAP access to Child Protection or The Orange Door; however, with the right permissions, those agencies could glean from the platform that there was information available and could then seek access directly from the relevant agency.[121]

146. An enhanced and expanded CIP could also enable the creation of feedback loops and the automation of information sharing and responsive action for certain categories of information, such as the fact that a warrant has been issued, an offender has been released, or a further L17 report has been received.

147. An example of this is already occurring within CCS. Ms Roberts explained that CCS have access to E*Justice which picks up data from LEAP and then creates notifications within the E*Justice system. In Noeline's case, once the Corrections warrant had been issued for Mr Fairhall, any contact between police and Mr Fairhall that was recorded on LEAP would cause a notification to be sent to the E*Justice platform.[122]

148. I note that in March 2021, the Victorian Government had identified that CIP reports involve manual collection of information, and that there are a number of systems with information needed for CIP reports which cannot work together. An opportunity to automate and improve all systems was identified, and regular changes to improve the CIP were noted, in addition to increasing the number of services that can request CIP

[121] See for example, discussion of the Orange Door being unable to request information of which it is not aware; T 97 (AC Callaway).
[122] T 237 (Roberts).

reports.[123] It is unclear from the evidence reviewed what progress has been made in relation to this.

149. Systems like this which enable real timely information sharing and collaboration relevant to an offender's risk should be expanded. It is not clear why in the particular context of family violence offenders like Mr Fairhall, CCS cannot also have access to the L17 portal. Hopefully, the Corrections Victoria business case for access to the L17 portal will be successful.

150. Having reviewed all the evidence and the submissions for the interested parties, I make the following recommendations:

Recommendation 1:

That the Victorian Government investigate supplementing and enhancing the CIP to enable the multi-directional flow of information relevant to perpetrator risk among all relevant Departments and agencies in a way that is timely, proactive, complete and automated (where possible and appropriate to manage risk).

Recommendation 2:

The Victorian Government immediately formalise the sharing of CIP reports by approving Child Protection practitioners as requestors.

151. I note that work is underway to allow Corrections Victoria access to the L17 portal so the proposed recommendation relevant to that issue from Counsel Assisting is not necessary.

152. At the time of the inquest hearing, ongoing funding of CIP had not been confirmed. Helpfully, the Victorian Government 24/25 Budget has now included '*$24 million to support information sharing between police, courts and other agencies through a key*

[123] https://www.vic.gov.au/central-information-point.

central information point'.[124] This funding may go some way to enabling the enhancements suggested in Recommendations 1 and 2.

Mr Fairhall's release from custody on 6 November 2019

153. On 6 November 2019, Mr Fairhall was released from custody by the Frankston Magistrates' Court after serving 55 days for breaching the IVO on 12 September 2019.[125] Mr Fairhall's prison discharge form records that he has no fixed address. The '*accommodation arranged*' box has been ticked.[126]

154. Mr Fairhall did not expect to be released on 6 November 2019, and he had told his case worker on 30 October that he believed he would be sentenced at his next court appearance.[127] CCS were notified of his release on 6 November 2019 and tried unsuccessfully to call him, but his phone was switched off. CCS proactively followed up with:

- Mr Fairhall's emergency contact (by phone without success);
- Somerville FVIU, who advised that they had an active case open and provided the contact details for the Victoria Police member responsible for the case;
- Child Protection to inform them of Mr Fairhall's release; and
- The CCS RAMP representative about a possible referral to the RAMP Panel.

155. Prior to Mr Fairhall's court hearing, Victoria Police also did not consult with Noeline before finalising the brief of evidence in relation to Mr Fairhall's offending against her and her son Zachary on 12 September 2019, and did not fully investigate Noeline's complaint in relation to Mr Fairhall's threat to kill her and her son. Statements from Zachary, Olivia or Paige who were all present during the offending were not obtained. Without corroborative evidence in support of the charge, a decision was made to

[124] Victorian Government, Gender Equality Budget Statement: Safety: Prevention and Support, 4 May 2024 at https://www.budget.vic.gov.au/safety.
[125] Inquest Brief 126–8.
[126] Ibid 581.
[127] Statement of Jenny Roberts, 4.

withdraw it. Victoria Police did not consult Noeline before withdrawing the charge against Mr Fairhall for threatening to kill her.[128]

156. Victoria Police did not contact Noeline prior to Mr Fairhall's release from custody on 6 November 2019.

157. The failure to notify Noeline of Mr Fairhall's release from custody on 6 November 2019, and that he was homeless,[129] was a significant matter for Noeline and her family. Mr Fairhall's homelessness was identified (including by Mr Fairhall himself) as the cause for his consistent breaches of the FVIO.[130] He would attend at Noeline's address frequently when he was at liberty and alcohol affected.[131] In order to keep herself and her children safe from Mr Fairhall, Noeline needed to know when he was going to be entering and exiting custody. Noeline's children also wanted access to this information.

158. Together, Noeline's children say that it would have been helpful to know in advance when Mr Fairhall was about to be released from prison because they did not know he was coming, he would simply turn up unannounced. They had no time to prepare themselves. There were times when the door was locked that Mr Fairhall broke a window to let himself in.[132]

159. Communicating Mr Fairhall's release date to Noeline does not appear to be prioritised and consistent with the usual practice, the responsibility was left with the informant. It is unclear if Noeline became aware through the informant or some other way. Communication with other agencies appears to have been a greater priority than informing Noeline.

160. An offender's release should be flagged on the PTMI and the CIP as a prompt for police and other agencies to ensure all associated service providers in the AFM's sphere are

[128] T 78 (AC Callaway); The Coroner can be satisfied, on the balance of probabilities, that Noeline was not consulted because of a combination of the Form completed by police prosecutors at Inquest Brief 4567, the lack of any other documented consultation with Noeline, and AC Callaway's evidence of not being able to establish that the informant did have any discussions with Noeline.
[129] Mr Fairhall's Prisoner Discharge Form records that he had no fixed address; See Inquest Brief, 581.
[130] Inquest Brief 182.
[131] See Inquest Brief, *Transcript of recorded statement of Paige Fairhall, 4 February 2020,* 218.
[132] Coronial Impact Statement of Jennifer Dalzell dated 15 April 2024.

aware of an offender's release, triggering the need for an updated risk assessment, and implementation of an effective and ongoing safety plan.

161. Child Protection and CCS made efforts to find out whether or not Victoria Police had notified Noeline of Mr Fairhall's release. They were told that the informant would have been required to do so but could not confirm whether in fact it had occurred.[133] In addition, Mr Fairhall's PTMI was not updated to reflect his release when it should have been.[134]

162. The evidence at inquest was that responsibility for notifying Noeline of the court outcome (Mr Fairhall's sentence) lay with the informant[135]—a constable from Frankston Uniform. AC Callaway gave evidence as to the problems that arise:

> '*Informants are not routinely present at court unless the matter is contested, they are not present when a matter is finalised by way of plea*[136] *and they are not bound by policy to attend court for family violence proceedings unless required by the court or prosecution.*[137] *There is no direct line of communication between Corrections Victoria (the agency releasing the offender) and the Informant. There is no timeframe associated with the general requirement that informants notify victims of court outcomes, nor any compliance system attached to this general requirement.*'[138]

163. Where the informant did not notify the AFM, the evidence around how this omission would be discovered and remedied was unclear. AC Callaway suggested that the court outcome '*does make it back to the police station… and the informants are notified*'.[139] Whether informants consistently act upon this information remains uncertain and

[133] T 356 (Gounas).
[134] T 185 (AC Callaway).
[135] T 33 (AC Callaway): '*The Informant of the original charges holds the responsibility to tell victims what has happened at Court*'.
[136] T 85–6 (AC Callaway).
[137] Inquest Brief, *Victoria Police Manual – Policy Rules – Family Violence*, 4871.
[138] T 86 (AC Callaway).
[139] T 46 (AC Callaway).

Victoria Police do not have responsibility for notifying other agencies of an offender's release.[140]

164. Responsibility for notifying family violence victims or AFMs in FVIOs of relevant court outcomes should be a priority and be subject to robust monitoring and compliance. These events should in turn trigger a requirement that a new risk assessment be conducted for risk posed to the family. An offender's release should also be flagged on the PTMI (if in existence).

165. In Mr Fairhall's case, a particular CCS ACM took an expansive and proactive approach to their role and took steps to immediately notify the FVIU and Child Protection of Mr Fairhall's release. Whilst their statutory responsibilities lie only with administering the requirements of a CCO, Ms Roberts explained that her staff are trained to also '*have a mind to community safety clearly and so hence why the information sharing with Victoria Police and Child Protection [occurred] upon his [Mr Fairhall's] release from custody*'.[141] This particular mindset and proactive sharing of risk relevant information is prescribed under the MARAM and should be encouraged.

166. There are compelling reasons why Noeline (and other AFMs) should be notified within a very short period, (no more than 48 hours) of, Mr Fairhall's release. The current arrangements for notification are inadequate and result in AFMs in family violence matters being at greater risk and unaware that there may be a need to reassess risk and ensure that risk management arrangements are adequate. This may involve engagement with other services.

167. Counsel Assisting submitted that I should consider making recommendations:

    a) Victoria Police, in consultation with DJCS, develop a policy to ensure that any victim of family violence offending or an AFM in an active FVIO is notified of a court outcome within 48 hours. In cases of high-risk offenders, consideration

[140] T 91 (AC Callaway).
[141] T 322 (Roberts).

be given to placing responsibility for this with an advanced family violence practitioner embedded within the FVIU (see Recommendation 5 below);

b) Corrections Victoria issue and implement its new practice guideline requiring Corrections staff to notify agencies including The Orange Door of the release from custody of a family violence offender;[142]

c) If Counsel Assisting's first recommendation is accepted, CIP be enhanced so that the release of a family violence offender (whether from a prison, a police cell or direct from a court) triggers an automated notification of that information directed to all relevant agencies.

168. Counsel for Noeline's family endorse Counsel Assisting's proposed recommendations but suggest that the notification to the AFM or the victim should occur on the day of the court outcome or as soon as possible thereafter.[143] In their submissions, DFFH supported timely notification but did not support changes to the CIP and suggested that the Victim's Register may be an alternate avenue to consider.

169. In their submissions, Victoria Police opposed the proposed recommendations as in their view it did not consider arbitrary time frames helpful, the Victims Charter already sets a time frame for notifying victims and it is also impractical and unreasonable to set time limits given the scope of the task. In addition, Victoria Police did not consider a new protocol necessary as there is already arrangements in place.

170. Victoria Police does support the concept of automated notification via enhancements to CIP but pointed out that it is not consistent with the comprehensive reports model operating in CIP presently and that change would involve an assessment as to the current system's capacity to undertake this function and may involve additional funding and possible legislative change.

[142] T 96 (Roberts).
[143] Counsel Assisting submissions [15].

171. In their response to the proposed recommendations of Counsel Assisting, DJCS indicated they were prepared to assist Victoria Police to develop a new policy, however, were unclear as to what contribution DJCS could make.

172. In relation to the other proposed recommendation, DJCS referred to changes that have now been made to the Practice Guide 5.7 and 5.8 and that it is clear from these changes that CCS practitioners should request and proactively share '*risk relevant information*' and collaborate with all relevant services to assist with assessing and managing the safety of the victim survivors. It is suggested that Mr Fairhall's release on 6 November was risk relevant information that would have been shared and that CCS staff would work closely with The Orange Door through referrals secondary consultations and by sharing CCS family violence risk assessments and risk management plans.[144]

173. Having carefully considered the response of the interested parties to the suggested recommendation of Counsel Assisting, I have concluded that timely notification (within 48 hours) will provide the best opportunity to protect victims and AFMs and give them the opportunity to work with support agencies to manage their safety and have protection measures in place. The Victim's Register is not an answer as this only applies to sentenced prisoners and requires victims to opt-in. This would have been of no assistance to Noeline. The most effective way to ensure that victims and AFMs are protected is for Victoria Police to have a robust policy and clear requirements that compliance can be measured, monitored and compliance measured.

174. In relation to the proposal that CCS implement new practice guidelines requiring notification to other agencies, I am satisfied that the new Practice Guidelines 5.7 and 5.8 address this issue. Corrections Victoria should, however, continue to monitor and review the operation of the guidelines to ensure that they are working effectively and providing timely notification.

175. I accept that there are some practical issues that will arise from modifications to the CIP and the challenges of making enhancements to the program may be significant.

[144] DJCS submissions [13], [14].

Nevertheless, an automated information transfer system would be a desirable solution to the notification and communication issues among agencies and I do think there is merit in work being done to investigate the viability of this proposal.

176. In conclusion I make the following recommendations:

Recommendation 3:

Victoria Police (in conjunction with DJCS) develop a policy to ensure that any victim of family violence or an AFM in an active FVIO case is notified of a court outcome. It is desirable for Victoria Police to notify all victims and AFMs in an active FVIO, however I consider it essential that in cases where an offender is considered high risk, that this notification occur within 48 hours.

Recommendation 4:

If Recommendation 3 is accepted, the Victorian Government investigate enhancement to the CIP to include a capability that the release of a FV offender (from prison, police cells or directly from a court) triggers an automated notification of that information to all other agencies.

Proactive victim engagement

177. Whilst Mr Fairhall was still in custody, it is possible that Noeline could have benefited from the kind of proactive approach to policing outlined by AC Callaway in her evidence at the inquest:

> '*...this is an example where proactive policing can be really good, the offender goes into gaol not for family violence offending but she is connected to the Orange Door. He's in for a year. The Orange Door reach out to the FVIU, and they say, 'Look, we think now is the time that we can actually engage with her, she might be ready to leave the relationship, put in an intervention order and do - and potentially move out of the area'. So the FVIU worked with the Orange Door and the victim completely*

in a proactive way, there was no family violence incident, he was in gaol for other types of offending and they were able to work with her, build up trust in the relationship and have her move from the area, leave the relationship, get an intervention order in place. So that's an example where the beauty of the FVIU worked really well.'[145]

178. This is not to suggest that Noeline could or should have done anything to facilitate this but is suggesting that as Mr Fairhall was in custody as a sentenced prisoner on several occasions in the years prior to the murder of Noeline, there were missed opportunities to engage with Noeline in a way that might have overcome her reticence to work with police and The Orange Door to improve their ability to hold Mr Fairhall accountable for his violence and keep Noeline safe. A further opportunity may have arisen for Victoria Police if they had created a victim management plan for Noeline in line with the VPM Policy on Tasking and Coordination. This policy requires the officer in charge of the FVIU to assign a case manager to ensure a victim management plan is developed.[146]

179. I note Noeline's ability to engage does not exist in a vacuum. As Associate Professor (**A/Prof**) Kristen Smith advised in her expert report, there is an extensive evidence base that indicates a key barrier to Aboriginal women engaging with family violence support and other related services is directly related to a fear of child removal if support is sought.[147] A/Prof Smith explained that in the context of Noeline's children having been removed from her in the past, directly connected with their exposure to family violence, this experience of removal for the children would also likely negatively impact on their perception of programs and services perceived as proximate to Child Protection.[148]

180. A/Prof Smith further opined that it is very likely that these lifelong experiences with Child Protection, alongside ongoing Child Protection investigations in the months leading to her death, created further barriers for Noeline to access supports and other

[145] T 162 (AC Callaway).
[146] Inquest Brief, *VPM Tasking and Coordination: Part 6 Victims*, 4850.
[147] Amended Expert Report in relation to the Coronial Inquest into the death of Noeline Dalzell, A/Prof Kristen Smith dated 5 April 2024, 21.
[148] Ibid 22.

related services.[149] Other barriers she identified of likely relevance to Noeline and her children include systemic, internalised, lateral and complex racist exclusion that act as further barriers to accessing family violence supports and services for Aboriginal and Torres Strait Islander people.[150]

181. I note that A/Prof Smith referenced research in her expert report that highlights concerns for Aboriginal women who have experienced family violence in Victorian and New South Wales contexts, with police acting inappropriately, or their disengagement, police frequently disbelieving or downplaying the experiences of Aboriginal women, usually subtly, but sometimes overtly, blaming the women for the violence they endured.[151]

182. Unfortunately, a victim management plan was not created by the FVIU. I am not in a position to form a conclusion as to why there was no victim management plan created, it is possible that it was because FVIU was very new or there was a lack of skill and/or training within the Somerville FVIU. What is clear from the evidence of AC Callaway is that proactive victim engagement by police has the best chance of success where there is a close working relationship with The Orange Door or a specialist family violence worker, including from VACCA or another culturally appropriate service.

183. It is possible that proactive victim engagement could be strengthened within Victoria Police if an advanced family violence practitioner worked closely with police within the FVIU, sharing skills and training. Counsel Assisting suggested I should consider recommending that two permanent and full-time family violence practitioners be embedded within each FVIU to improve proactive victim engagement.

184. I acknowledge that Victoria Police are reluctant to have other practitioners embedded in their units. In their written submissions, Victoria Police suggested that this is a complex issue and raises significant strategic and practical issues which have not been canvassed in the inquest and that they suggest are beyond the scope of this inquest. They also suggested there are funding and demand considerations that would need to be considered.

[149] Ibid.
[150] Ibid 23.
[151] Ibid 16.

185. Embedding a family violence practitioner within Victoria Police teams was considered in the RCFV with numerous examples given of how it has occurred in various regions, including the Repeat Police attendance and High Risk Response Program at Eastern Domestic Violence Service, the Whittlesea Family Violence Police Outreach Partnership Response, and Taskforce Alexis in Moorabbin.[152] In recommending establishment of Support and Safety Hubs (now established as The Orange Doors), the RCFV report outlined that police could be involved in a local hub either by embedding a family violence worker in the relevant local police family violence team, or police participating in joint triage of L17s, and the decision of how to approach this could be determined locally.[153]

186. I note that since the RCFV, some of the models of embedding a family violence practitioner within Victoria Police have been independently evaluated (specifically Taskforce Alexis) and learnings documented around implementation and models of governance.

187. Notwithstanding the concerns raised by Victoria Police, I have come to the conclusion that embedding a Family Violence practitioner within the FVIU is worthy of further investigation.

[152] Royal Commission into Family Violence Final Report, Part II, 255.
[153] Royal Commission into Family Violence Final Report, Part II, 275.

Recommendation 5:

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

An independent evaluation of the pilot program should be completed within two years of commencing operation in each of the regions selected.

RAMP referral

188. No RAMP referral was made by any organisation involved with the family in the context of escalating risk in the lead up to the fatal incident.[154]

189. Mr Fairhall's Corrections ACM took immediate steps upon being notified of Mr Fairhall's release, including notifying Child Protection and the Somerville FVIU, and trying to contact Mr Fairhall and his emergency contacts.[155]

190. The ACM also emailed a RAMP representative with an outline of actions taken in relation to mitigating Mr Fairhall's risks and queried whether a RAMP referral was applicable.

191. RAMP is a formally convened meeting of key local agencies and organisations who conduct a multi-agency risk assessment of people who are at risk of serious harm from family violence. The panel focuses on the perpetrator while simultaneously centralising the safety of victim survivors, mostly women and their children. They are engaged when the usual service system has not or cannot mitigate serious risk posed by the perpetrator

[154] DFFH Child Protection Bayside Peninsula file review, 12.
[155] Inquest Brief 2430–2.

due to systemic and structural barriers. RAMP is intended for the most high-risk family violence cases.

192. The Corrections RAMP representative advised that without any active or historical closed cases on the RAMP database for Mr Fairhall or Noeline, the eligibility criteria were not met. Subsequent discussions between the ACM and Corrections RAMP representative did not support a report of high and imminent risk of serious injury or death from family violence. A decision was made to liaise further with the Victoria Police Somerville FVIU.[156] This assessment was made on the basis of information held or able to be accessed by CCS without any additional inquiries being made with other agencies and without reference to RAMP representatives from other agencies. There was an information sharing arrangement in place between CCS and FVIU that commenced in June 2019 however this case was not included in the information sharing arrangement. CCS were also prescribed under FVISS and could have requested risk information from various services to inform their assessment. Somerville FVIU had an active case and a high-risk rating, and information held by The Orange Door and Child Protection may have also been relevant to the assessment of suitability for referral to RAMP.

193. The evidence does not support a conclusion that had further inquiries been made and additional information provided, that there would have been a referral to RAMP. RAMP at that time was restricted to five new referrals per month and other criteria that needed to be satisfied, nevertheless it would have been appropriate to ensure that all relevant and up to date information was obtained from all agencies to inform the decision. This would have resulted in a complete risk assessment being provided to the joint chairs of the RAMP panel and/or the RAMP coordinator to determine if the referral was accepted or declined.[157] Mr Fairhall was a high-risk offender with a long history of family violence. His release had not been anticipated and the ACM had responded promptly to manage the risk posed by Mr Fairhall. Consideration of a RAMP referral was clearly appropriate, and the ACM acted appropriately in discussing it with the CCS RAMP representative.

[156] Inquest Brief 485–6.
[157] Victorian Risk Assessment and Management Panel Program: Operational Guidelines.

The assessment as to whether Mr Fairhall met the criteria for referral to the RAMP should have been made with all relevant and up to date information available by the RAMP coordinator and co-chairs.

194. Counsel Assisting proposed a recommendation that Family Safety Victoria move to update RAMP guidelines in order to ensure that:

- Applications are assessed by an experienced family violence practitioner or a police member of a FVIU;
- Referrals are assessed against predetermined criteria that are consistent across all agencies;
- 'Internal' RAMP coordinators play a consultative role only;
- Before refusing a RAMP referral, assessors ensure a request is made of the CIP so that they have the benefit of relevant information; and
- Insofar as any cap exists for the number of RAMP referrals, consideration be given to excluding RAMP referrals for high-risk offenders from the cap within any given period, in circumstances where the RAMP does not currently conduct ongoing case management.

195. The RAMP Guidelines were updated in March 2024 and released to RAMP members in May and June 2024. The new guidelines are broadly consistent with the suggestions made by Counsel Assisting. In relation to caps on the number of referrals, although there is still a cap in place, there is some flexibility built into the Guidelines to have cases classified as eligible but not recommended because the cap has been met. These cases may be deferred to the next meeting, or the co-chairs can make an exception and allow the case to be dealt with at the meeting. This discretion is appropriate and allows the co-chairs to deal with an appropriate case, even if it will exceed the cap.

196. I am satisfied that these changes adequately address the issues raised in relation to the operation of RAMP.

Role and purpose of FVIU

197. Mr Fairhall was '*on the books of the FVIU*'[158] on 7 December 2019 and had been since 14 September 2019 when his PTMI was generated.[159] His persistent pattern of offending against Noeline and the steps necessary to keep her safe from him meant that he was classified as a high-risk offender. This information was not completely visible to the uniform members who responded to incidents on 19 November 2019 and 7 December 2019. Whilst uniform members were responsible for responding to these incidents, Mr Fairhall was also being managed by the FVIU. This had the unintended consequence of blurring of the lines of responsibility for an incident as opposed to a person.[160]

198. The incident on 19 November 2019 was classified as high risk (a score of 9) by uniform members.[161] Through their secondary review process, the FVIU determined that the matter was not high risk and should sit with uniform members to follow up and investigate.[162] AC Callaway described this dual responsibility in this way:

> '*So, the way I've described it is Mr Fairhall himself is a high-risk perpetrator, I think that's fairly well established. The incident that is attended where we fill in the family violence report gives a scoring of, it's 9 and 5; 9 to the first part, 5 to the second part. That is high risk. That goes up to the FVIU to have a look at. They then consider all factors and decide to retain the management of him, but the operational incident goes to Uniform…*'[163]

199. AC Callaway's evidence at inquest clarified that under the new risk assessment tool being implemented in FVIUs now, this would no longer occur, and the incident would be retained by the FVIU.[164]

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[158] T 164 (AC Callaway).
[159] Inquest Brief, *Statement of Detective Senior Sergeant Shane Pola*, 4752.
[160] T 74–5 (AC Callaway).
[161] T 223 (AC Callaway).
[162] T 224 (AC Callaway).
[163] T 401 (AC Callaway).
[164] Ibid.

200. When enquiries were made of the FVIU by other agencies, they were told that there was an active case open in relation to Mr Fairhall. What this actually meant in terms of case management was unclear to other agencies. For example, Child Protection were told on 8 November 2019 that the FVIU had an '*active case*' for Mr Fairhall.[165] Based on this communication, Child Protection practitioners understood there was a management plan in place from Victoria Police regarding Mr Fairhall and that it was being managed by the Somerville FVIU: '*So we assumed … that that there was active management oversight from Victoria Police of Mr Fairhall and … that staff thought that that meant that there was active attempts to locate Mr Fairhall*'.[166]

201. The evidence at inquest revealed that this was not the case. The lack of proactive investigation and engagement by the FVIU was not something that was or could have been known by other agencies.

202. The FVIU were only '*passively monitoring*' Mr Fairhall and his PTMI had four identified risk management strategies:

- passive monitoring (a purely reactive strategy);[167]
- remand if the opportunity presented itself;
- spot checks regarding intervention order compliance; and
- frontline monitoring through Noeline herself.

203. AC Callaway explained that item 4 was '*any incident that happened that the police would turn up, take family violence reports, do a new risk assessment*'[168] which amounts to normal police business.[169] Item 3 was never conducted,[170] and item 2 is inconsistent with the PTMI entry on 23 January 2020 where the documented plan was to execute the

[165] T 349 (Gounas).
[166] T 350 (Gounas).
[167] T 181 (AC Callaway).
[168] T 121 (AC Callaway).
[169] T 130 (AC Callaway).
[170] T 122 (AC Callaway).

Corrections warrant and bail Mr Fairhall from the police station.[171] Plainly, a plan to bail Mr Fairhall upon execution of the Corrections warrant was inconsistent with the risk he posed to Noeline at the time.

204. I am concerned that the strategy outlined above places the responsibility for managing the risk of Mr Fairhall's violence on Noeline. In her expert report, A/Prof Smith noted:

> '*The burden of managing family violence risk in Aboriginal and Torres Strait Islander contexts is often inappropriately placed on Aboriginal and Torres Strait Islander women, particularly mothers*.'[172]

205. Finally, item 1 on the PTMI amounts to making a note of how uniform members have responded to further incidents of family violence.[173]

206. Overall, AC Callaway's assessment of Victoria Police's compliance with the PTMI and associated requirements in the VPM relevant to Noeline and Mr Fairhall was that it would not be considered best practice but was '*a fairly decent endeavour to get the model up and running*'.[174] By way of explanation, AC Callaway also stated that Victoria Police were still within the first year of rolling out investigative units within family violence.[175]

207. I disagree with this assessment by AC Callaway. Whilst I acknowledge that the FVIU had only been in place for six months and that the new unit needed time to develop procedures and an operating model, I agree with Counsel Assisting that the response of the FVIU to Mr Fairhall and Noeline from 6 November 2019 until the day of her murder fell far short of best practice. The FVIU added little or no value and represented a significant missed opportunity to actively engage with Noeline and other agencies to assess risk and develop a plan to keep Noeline and her family safe. Noeline may well

[171] Inquest Brief, *PTMI*, 3509.
[172] Amended Expert Report in relation to the Coronial Inquest into the death of Noeline Dalzell, A/Prof Kristen Smith dated 5 April 2024, 10 [8.4].
[173] T 180 (AC Callaway).
[174] T 149–50 (AC Callaway).
[175] T 123–4 (AC Callaway) but see Statement of Detective Senior Sergeant Shane Pola dated 26 May 2020, Inquest Brief, 4751: '*Somerville FVIU transitioned from the Somerville Family Violence Unit (FVIU) into an investigative unit in June 2018 and is staffed by one Detective Senior Sergeant, two Detective Sergeants, twelve Detective Senior Constables, three Family Violence Court Liaison Offices (FVCLO) and two analysts*'.

have declined to engage, but it is reasonable to expect that even a newly created FVIU would have done more than passive monitoring of an identified high risk family violence perpetrator between 6 November 2019 and her death.

208. In addition, I note that the risk assessment MRT completed by the Somerville FVIU in September was not updated to reflect Mr Fairhall's release from custody on 6 November 2019 but was noted in the PTMI narrative.[176] LEAP was updated to reflect that Mr Fairhall was a person of interest (**POI**) and was subject to PTMI case management.[177]

209. AC Callaway in her evidence detailed that '*the minimum level of review is four entries a month, so that would be once a week, a fortnightly review, at Detective Sergeant and Senior Sergeant level of all PTMIs*'.[178] The minimum required by such reviews or entries remain unclear, however it would be reasonable to expect that it would entail active management and monitoring of the case and following up on recent connections on the case, which would then inform the PTMI.

210. It also appears reasonable that if a PTMI has been reviewed that should operate as a further trigger within the proposed multi-agency interface, which also includes the specific criteria against which the PTMI has been reviewed and any new or updated information in the PTMI.

211. The High-Risk Management plan for Noeline, formulated by the FVIU following Mr Fairhall's offending on 12 September 2019, was inadequately completed.[179] It also failed to identify that Noeline was Aboriginal.[180] Despite the creation of the plan in September 2019, the only time that the FVIU actually contacted Noeline was on 23 January 2020.[181] The deficiencies in completing the MRT then flowed into deficiencies in identifying appropriate proactive prevention strategies.[182] AC Callaway's evidence with respect to the incomplete and inadequate MRT was that it was reflective of the fact

[176] Inquest Brief 4372.
[177] Inquest Brief 597.
[178] T 117.
[179] Inquest Brief 3511–21.
[180] Inquest Brief, *High Risk Management Response Template*, 3511. See also T 171 (AC Callaway).
[181] T 169. See also T 183 (AC Callaway).
[182] T 182 (AC Callaway).

that it was completed within the first six months of its existence and the member doing it lacked training and experience.[183] In her evidence, AC Callaway stated that '*I think the - the FVIU units today have a - have a much different approach to the MRT and POI management*'.[184]

212. AC Callaway's evidence was that the FVIU are much improved since 2019, with FVIUs and all sergeants having received mandatory training in family violence, including in the FVISS and the Child Information Sharing Scheme (**CISS**). She noted:

> '*We have a family violence investigation unit specialist operative course. It wasn't in place in 2019, but it's in place now and there are 12 different modules for that… some of the relevant ones to the matters we've discussed today include information sharing under the FVISS and CISS. Family trauma informed practice, victim management support and assessing safety and welfare of children affected by family violence.*'[185]

213. In addition to the training that has been implemented, AC Callaway also referenced her own experience of receiving positive feedback from 'services' in relation to the FVIUs.[186]

214. 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 FVIUs has markedly improved since Noeline's murder.

215. The FVIU program in Victoria Police is the primary family violence strategy for managing high risk offenders. These units have been operating for some five years now and Counsel Assisting submitted that there would be merit in conducting an independent evaluation of the effectiveness and the performance of the FVIUs. Such a review may

[183] T 176 (AC Callaway).
[184] T 176 (AC Callaway).
[185] T 162, 564 (AC Callaway).
[186] T 162 (AC Callaway).

also be able to assess the merit of co-locating advanced family violence practitioners with the FVIU as envisaged by Recommendation 5 above.

216. Such a recommendation is supported by Noeline's family but not by Victoria Police. In their submissions, Victoria Police suggested that this would not be straightforward for an independent evaluator to assess the operation of the model given its uniqueness and that there may not be funding for such a review given the tight fiscal environment. Victoria Police also added that the primary focus is the roll out of version 3 of the Case Prioritisation and Response Model (**CPRM**) to better support FVIU demand and further work to review, assess and analyse workloads of the FVIU. Victoria Police stated '*that this work is necessary to ensure that Victoria Police specialist family violence response are viable into the future, including maintaining the independent discretion of police in responding to all community safety issues*'.[187]

217. In the lead up to the roll out of the CPRM, there would seem to be some merit in a review and an evaluation of the current arrangements and operation of the FVIU to provide a benchmark to measure the success or otherwise of version 3 of the CPRM. I note that review assessment and analysis of workloads is anticipated following version 3 CPRM roll out and it may be appropriate that the review suggested by Counsel Assisting take place before the roll out commences to provide the benchmark for future assessments. In these circumstances the proposed recommendation of Counsel Assisting would appear appropriate.

Recommendation 6:

Victoria Police engage an external independent suitably qualified person to conduct an evaluation of the effectiveness and skillset of the FVIUs. The review ideally should be conducted prior to the rollout of the CPRM to provide valuable benchmarking information to assist in the evaluation of the CPRM program which has been foreshadowed by the Chief Commissioner of Police in his submissions.

[187] CCP submissions [48].

Leadership and oversight in management of FV cases

218. Oversight and leadership in the management of situations like that faced by Noeline and her children was a theme explored by the DFFH and DJCS Multi-Agency System-Focussed Review of The Death of Ms Noeline Dalzell.[188] The Multi-Agency Review identified that although there was some information sharing between Child Protection and The Orange Door following notifications and the L17 report, '*neither service took the lead in supporting Noeline and the children coordinating risk assessment and management, for example, by initiating a case conference*'.[189]

219. The DFFH and DJCS Multi-Agency Review in recommendation 2 proposed that:

- DFFH and DJCS should develop and implement cross-system policies and procedures for multi-disciplinary case conferencing where a coordinated approach is required to address family violence risk. This should be focused on timely perpetrator risk management and support for victim survivors; and
- A key component of the work was identification of a lead agency/practitioner. For family violence cases where there is serious risk, but which at a point in time do not meet RAMP eligibility, a lead agency or practitioner should be identified to coordinate risk management and service provision.

220. This recommendation was put to the panel during the inquest who were collectively asked for their views on who the lead agency/practitioner should be. Ms Sweeney's view was that The Orange Door should have led information sharing and case conferencing with respect to Noeline.[190] However, Ms O'Toole explained that this is not necessarily the case because Noeline did not want longer term referrals (apart from VACCA) and because The Orange Door is a brief, voluntary intervention service that is more akin to a crisis intervention service. Longer term work like case coordination and management is done through a specialist family violence service.[191] Notwithstanding, Ms O'Toole

[188] Inquest Brief 4157–4215.
[189] Inquest Brief 4191; T 332.
[190] T 329 (Sweeney).
[191] T 331 (O'Toole).

conceded that it would have been possible, in Noeline's case, for The Orange Door to have convened a meeting of professionals to talk about her case.[192] Ms Gounas clarified that any of the agencies involved with Noeline and Mr Fairhall could have called a case conference and in her view, with the benefit of hindsight, Child Protection should have.[193] If they had done so, and invited police, the FVIU would have attended because Mr Fairhall was subject to a PTMI.[194]

221. I note that the MARAM framework, specifically MARAM Practice Guide Responsibility 10, requires all prescribed organisations to have established strategies for working collaboratively with key partners within their local area to improve outcomes for victim survivors; established mechanisms that delineate referral processes and pathways; regular meetings to discuss how to best support victim survivors and appropriately share information to enable comprehensive risk assessment and consideration of matters relating to the safety and wellbeing of victim survivors.[195] I also note that each of the organisations is prescribed by MARAM, and were prescribed at the time of their engagement with Noeline and her family.

222. No member of the panel was able to update the Court as to the progress of implementation of recommendation 2 of the multi-agency review,[196] and the responses provided did not address the key aspect of this recommendation—which is the identification of a lead agency with overall responsibility for risk management and service provision. It would have been of assistance if DJCS and DFFH were able to provide an update on steps taken to implement this key recommendation.

223. Counsel Assisting submitted that I should make a recommendation '*that the Victorian Government adopt a whole of Government approach to identifying a central contact person for responsibility for coordination oversight of family violence perpetrators, affected family members and associated service providers*'.[197] The intention of this

[192] T 332 (O'Toole).
[193] T 333 (Gounas).
[194] T 334 (AC Callaway).
[195] https://content.vic.gov.au/sites/default/files/2020-06/PG%20Responsibility%2010_0_0.pdf at p 388.
[196] See discussion with Ms Sweeney at T 337–9.
[197] Counsel Assisting submissions [52].

submission is supported by DFFH although they do not support the recommendation that there be a central contact person. In their submissions to the Court, DJCS submitted the recommendation is unnecessary as the work is already underway in response to recommendation 2 of the Multi-Agency Review.

224. I accept that work is underway to respond to recommendation 2 but it is nevertheless very concerning that such a significant and important issue has not been resolved and that in their evidence, the key leaders in this area were not able to answer the question as to who was to take the lead role in a case like Noeline's.

225. The situation is further confused when the role and function of the FVIU and the PTMI review that is required by officers managing a case in the FVIU is unclear. The minimum required by the regular reviews remains unclear, however it would be reasonable to expect that it entails active management and monitoring of the case and seeking follow-up on recent connections on a case, which would then inform the PTMI.

226. With respect to the need for a central contact, I note AC Callaway's evidence in response to Counsel Assisting's suggestion that Victoria's system is '*referral-based*':

> '*It is a whole of government system and as Ms O'Toole pointed out, it is the only one of its kind in Australia and all other jurisdictions come to see us to set - to model themselves on the Victorian system. It has lots of components to it from prevention, such as respectful relationships and schools, through to crisis response, through police and Safe Steps, through to case management work and rehabilitation. It is a comprehensive system that's got legislated risk assessment, legislated information sharing schemes and other - and from what I hear cause I often host other policing jurisdictions and agencies that come to Victoria that we are the envy of other States as far as a - a system and it is a system that has been growing each year over the last, since the Royal Commission.*'[198]

227. Assuming this is correct, the current system appears to run the risk of making family violence both everyone's responsibility and no-one's responsibility. In Noeline's case,

[198] T 548.

all stakeholders could have taken a leadership role and case management ownership, and none did. This includes organisations such as Child Protection who were prescribed under the MARAM Framework at the time not only as an ISE, but as a Risk Assessment Entity.

228. In circumstances where there were multiple individual organisations moving within their own sphere of influence, without anyone taking ownership over the perpetrator or assessing and managing risk alongside the AFMs, I am left troubled that there does not appear to be a clear plan or arrangement to identify the key person or organisation that is to assume the leadership/coordination role.

229. I also note that any leadership or coordination needs to be undertaken without disempowering victims of family violence or undermining their expertise in keeping themselves safe.

230. One option is for the FVIU investigator to take on such a role, noting however that the parties may take issue with this suggestion. Nevertheless, the FVIU investigator has access to various information, including information from general duties officers, the issue of warrants, whereabouts required, and access to LEAP.

231. When issues arose in locating Mr Fairhall, according to AC Callaway, police have the most up to date information and can find answers to relevant questions for example '*...do they have a car and a licence? Do they have an address? Do they have a job?*',[199] and the FVIU investigator appears to be the one person able to answer these questions. It is open to the investigator to approach other agencies, such as The Orange Door, Child Protection, and/or schools and highlight the need to develop a plan to address the risk, and to convene a case management meeting for the purpose of information sharing and risk assessment and planning.

232. This highlights the importance of rapport building between the victim and a central contact who is also responsible for ensuring that all relevant protective factors are in place and who has meaningful engagement with the victim in a way that informs them

[199] T 45 (AC Callaway).

of available options (for example, surveillance) and proactively offering support. If a central contact were in attendance with Noeline on 7 December 2019, the added benefit of a central contact could have focused the conversation with Noeline on communicating the risk, how to manage the risk, discussion of CCTV cameras or sensor lighting as an effective deterrent. It is likely the central contact would also have a direct effect on the successful engagement following 'warm' referrals. I note that in Noeline's case, the only organisation she appeared to willingly engage with or accept a referral to was VACCA.

233. Despite the earlier comments about the FVIU with respect to Noeline's case and in the absence of an identified alternative, the evidence at inquest suggests that the FVIU investigator is potentially the most suitable position to perform the role of a central contact person with responsibility for coordinated oversight of family violence perpetrators, AFMs, and associated service providers. This is suggested because of their access to information, such as information from general duties officers, access to LEAP and Interpose.

234. In circumstances where the system is comprised of multiple individual organisations moving within their own sphere of influence, without anyone taking ownership of the perpetrator and advising and supporting AFM(s), it appears, at least on the face of it, that the FVIU could assume the leadership role even if that role was confined to ensuring that a case management meeting was convened in a timely manner to ensure all agencies had relevant information and that risk had been identified, assessed and mitigation plans implemented. In order to avoid the sorts of issues that arose in the Somerville FVIU's handling of Mr Fairhall and Noeline, FVIUs would need to be upskilled and strengthened, particularly in the area of proactive engagement.

235. The possibility of giving this leadership role to the FVIU is likely to be hotly debated and the conclusion may be that the FVIU is not the appropriate body to perform this leadership role, however the space cannot be left empty and if not the FVIU it needs to be filled by another agency. This is not a matter that was resolved through evidence at the inquest and is not something that I can resolve in this finding. There needs to be a whole of government approach to the question including the key roles and responsibilities

of the role. I note that identification of a lead agency or practitioner may be considered incongruent with the MARAM framework and risks other agencies taking a passive approach to the assessment and management of family violence risk.

Recommendation 7:

DJCS and DFFH take immediate steps to complete work on recommendation 2 of the Multi-Agency Review and identify who is to take the leadership role, including identifying and implementing a central contact person or agency with responsibility for coordinated oversight of family violence perpetrators, affected family members, and associated service providers. Given the rate of family violence perpetrated on First Nations women and children, this approach needs to include First Nations community organisations, and incorporate expertise from those with lived experience.

PTMI access

236. The available evidence raises some questions as to the PTMI's effectiveness as a dynamic risk management tool. According to AC Callaway, it was '*reasonable*' for there to have been a delay of three days between the breach offence on 19 November and any update of the PTMI,[200] and a delay of five days between the issuing of the Corrections warrant on 21 November and the update to the PTMI on 26 November.[201] There was also inconsistent ownership of the PTMI; the Information Report from 7 December was '*allocated on 20 December and that is the day that the member who owns the PTMI actually changes work units and then it's reallocated on 8 January*'.[202] What, if anything, happened with Mr Fairhall's PTMI during the month-long period where it does not appear to have been allocated, is not known.

237. Uniform members who routinely respond to family violence incidents like the one on 19 November do not have access to the PTMI, MRT and other relevant risk information

[200] T 138–9 (AC Callaway).
[201] T 142 (AC Callaway).
[202] T 143 (AC Callaway).

stored in those systems. Uniform officers do not have access to Interpose which is where the PTMI is stored.[203] AC Callaway's view was that this is appropriate because uniform officers do have access to LEAP, and LEAP is sufficient because it has prior incidents and warning flags which is '*all the uniform officers need*'.[204] As AC Callaway explained, intelligence sits within Interpose, incidents go into LEAP. Uniform members attending incidents can submit information reports, but they cannot view them because '*they don't need Interpose for their daily access of their duties*'. In response to a question asked by Counsel Assisting, AC Callaway stated, '*I'd put it to you that the… Interpose details around risk management strategies and that is far more detailed isn't really suitable to sit in the operational system because it's too much information*'.[205]

238. Counsel Assisting submitted that I should consider making a recommendation that Victoria Police make PTMIs and MRTs for high-risk family violence offenders accessible to uniform police members who respond to family violence incidents. Victoria Police oppose such a recommendation on the basis that PTMI and MRT are for the use of investigators and contain more information than attending police need to manage the individual incident or event they are attending. Victoria Police submitted that extending access to this system to frontline police is not operationally appropriate.

239. In their submissions, Counsel Assisting suggested that by separating intelligence from incidents in the way outlined by AC Callaway, police leadership are reinforcing the erroneous approach of focussing on responding to <u>incidents</u> instead of identifying and responding to <u>patterns of family violence behaviour</u>. Further, Counsel Assisting suggested that detecting these often-insidious patterns of behaviour is complex and difficult. Making assessments of behaviour, risk and vulnerability to risk, during a family violence call-out, is even harder. If a diligent uniform member on their way to respond to a family violence complaint seeks to familiarise themselves with the history of a family

[203] T 82 (AC Callaway).
[204] T 206–7 (AC Callaway).
[205] T 207 (AC Callaway).

and check to see if there are any outstanding investigative steps that might be recorded on a PTMI, this uniform member should be encouraged to access this information.

240. Having carefully considered the submissions from Counsel Assisting and Victoria Police, I am concerned that uniform police are responding to family violence incidents having reviewed the LEAP information which, in cases of high-risk perpetrators, will only be part of the picture and the PTMI and MRT may contain other highly relevant information. It is desirable that police attending an incident have access to all relevant information to assist their response. I accept that too much information may overwhelm the attending police officers but there needs to be a balance so that front line police have appropriate information to assist them in managing an incident when they attend. Having reviewed the evidence in Noeline's case, I think there is more that can be done to ensure that the best information is available to front line police and that Victoria Police should review current information sharing arrangements between front line police and FVIUs to explore and investigate ways that information sharing can be improved.

Recommendation 8:

Victoria Police make PTMI and MRTs for high-risk family violence offenders accessible to uniform police members who respond to family violence incidents.

Keeping offenders in view

241. In its internal file review, Child Protection noted that throughout Child Protection's involvement with the Dalzell family, there was a consistent overreliance upon Noeline to protect herself and the children from the family violence perpetrated against her by Mr Fairhall.

242. Safety plans relied consistently on Noeline taking action, such as asking Mr Fairhall to leave or calling police, despite these strategies not being successful in the past. Any involvement with the family focused primarily on Noeline's capacity to protect the children and there was no evidence of attempts by Child Protection to engage with Mr

Fairhall or hold him accountable for his behaviours. Although his behaviour necessitated Child Protection involvement with his family, Mr Fairhall was largely invisible throughout the majority of Child Protection involvement.[206]

243. Timely enforcement of criminal sanctions is one of the ways the family violence system can hold perpetrators accountable and keep them in view, particularly where a perpetrator declines to engage with any voluntary services. Mr Fairhall's history demonstrates that he was often successfully prosecuted for his offending against Noeline but that these short periods of imprisonment had no impact upon his recidivism. Counsel Assisting suggested that an alternative means to manage the risk created by recidivism should be explored.

244. Given the nature of Mr Fairhall's persistent and serious violence, I note with interest the recent pilot of a Changing Ways program, as outlined by both Ms Sweeney, and as an action in the multi-agency review, as providing intensive, coordinated responses to high-risk adults using family violence and the victim survivor(s) impacted by their violence.[207]

245. The program documentation speaks to "*better coordinating across the service system so that serious-risk adults using family violence become and remain in view of services, tailoring an intensive response for victim-survivors, tailoring interventions that directly or indirectly engage the adult using family violence who poses a serious risk, and using multiple approaches to support them to take responsibility for stopping their family violence*".[208]

246. Given neither Victoria Police nor Corrections could locate or engage Mr Fairhall, I am interested to see how this pilot program might engage and keep family violence offenders such as Mr Fairhall 'in view'. I note that one of the services in the pilot program is

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206 DFFH Child Protection, *File Review in respect of Paige Fairhall, Zachary Fairhall, Olivia Fairhall* (also referenced by the Court as DFFH Child Protection, *Bayside Peninsula Area Review-undated*, Inquest Brief 4220.

207 Statement of Ms Sweeney, 8.

208 Changing Ways: Intensive interventions for serious-risk adults using family violence (formerly known as the Serious-risk Pilot) Program Requirements, 7.

Aboriginal-led, returning to the fact that Noeline had indicated that she was willing to engage with an Aboriginal-led service (VACCA).

247. Counsel Assisting suggested that I should consider making a recommendation that the *Serious Offenders Act 2018* (Vic) be amended to expand its reach to include a cohort of perpetrators of family violence that are high risk repeat offenders and are not able to be managed through existing arrangements.

248. The *Serious Offenders Act* provides for enhanced protection of the community by requiring offenders who have served custodial sentences for certain serious sexual offences or certain serious violent offences and who present an unacceptable risk of harm to the community to be subject to ongoing detention or supervision.[209] Supervision Orders can include a range of conditions including mandated treatment aimed at rehabilitation of an offender,[210] as well as conditions governing where an offender is to reside, curfew and the circumstances under which an offender may leave the place of residence.[211] The scheme operates only in respect of offences listed in the schedules. Schedule 2 pertains to offences of serious violence, which include many serious offences such murder, manslaughter, causing serious injury, and kidnapping.

249. It was not suggested by Counsel Assisting that any legislative reforms operate as a replacement for existing initiatives that address the drivers of family violence. The criminalising of behaviour in isolation, particularly without increased funding for prevention and early intervention, fails to address the underlying causes of family violence. Further, it risks oversimplifying the issue as an individual at fault, ignoring the broader systemic inequalities that fuel such violence. It is acknowledged, however, that there exists a subset of offenders who are unwilling or unable to realise the benefits of prevention programs and for whom existing interventions and rehabilitation measures remain ineffective.

[209] *Serious Offenders Act 2018* (Vic) s 1.
[210] Ibid s 31.
[211] Ibid s 34.

250. In their submissions, DJCS correctly stated that there is significant consultation and policy work that would be required to consider such a proposal and that this was not canvassed in evidence at the inquest. Furthermore, the impact on the current scheme has not been considered and that this would need to be done and in addition, expert clinical evidence would need to be obtained to ascertain the viability and effectiveness of such a proposal.

251. I accept that Counsel Assisting's proposal is a significant expansion of the Serious Offender scheme and that there will be many who consider this proposal raises complex and significant issues, not least of which is the ability to assess the risk posed by a particular offender. Nevertheless, the management of high-risk recidivist family violence offenders is complex, and the current strategies are not protecting all victims and AFMs. I therefore think there is merit in other options being explored by the Victorian Government and that the Victoria Law Reform Commission (**VLRC**) may be an appropriate body to consider such a proposal.

Recommendation 9:

That the Attorney General consider a reference to the VLRC to consider legislative amendment in order to expand the *Serious Offenders Act 2018* scheme to encompass serious repeat family violence offenders who pose an ongoing and high risk of violence to AFMs.

Review of CCOs

252. The response of CCS staff to Mr Fairhall's release and non-engagement was appropriate and fell well within the existing relevant service delivery outcomes which require CCS to issue a warrant within six weeks of a breaching offence.[212] Whilst six weeks may be appropriate for some types of offending, FVIOs and CCOs only maintain efficacy if they are enforced in a timely manner. Offenders can become emboldened when there are no criminal justice responses to their offending conduct. A number of past inquests have

[212] T 233 (Roberts).

considered the timeline between a breach of a CCO being detected and the offender ultimately being dealt with and urged reform in this area.[213] Mr Fairhall's release on 6 November 2019 brought this issue into stark relief. By virtue of his plea of guilty to the offending on 12 September 2019, he admitted to breaching the condition of the CCO which required him not to commit further offences. The evidence around why this plea did not and could not (in future) trigger immediate breach CCO proceedings is complex and would probably require minor legislative amendment of Part 3C of the *Sentencing Act 1991* (Vic).

253. Ms Roberts explained that because Mr Fairhall's CCO was imposed by the County Court, it needed to go back to County Court for hearing.[214] Whilst returning offenders to face the same judicial officer who imposed the original CCO is preferable, it is not a requirement of the *Sentencing Act 1991* (Vic),[215] and in practice it cannot always be accommodated.[216] Counsel Assisting submitted that consideration be given to balancing the preference for consistency of the Judicial Officer against the need for expediency in cases like Mr Fairhall's. The preference for consistency in the presiding Judicial Officer should not preclude breach proceedings being issued immediately (or as soon as possible) by Corrections Victoria upon a plea or finding of guilt to a breaching offence. A CCO is a term of imprisonment that offenders serve in the community. When offenders breach these orders, the response of the justice system needs to be swift, else it risks becoming meaningless and ineffective.

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[213] See, eg, *Finding Into Death Without Inquest, Danny Lee O'Brien* (Coroners Court of Victoria, State Coroner Judge Cain, 19 January 2023) [88]; *Finding Into Death With Inquest, Kylie Jane Cay* (Coroners Court of Victoria, Deputy State Coroner English 25 May 2021) 48; *Finding Into Death Without Inquest, Simone Quinlan* (Coroners Court of Victoria, State Coroner Judge Cain, 6 July 2021) 19; *Finding Into Death Without Inquest, MJW* (Coroners Court of Victoria, State Coroner Judge Cain, 12 August 2021) 16–17; *Finding Into Death Without Inquest, Joshua Tovey* (Coroners Court of Victoria, State Coroner Judge Cain, 13 September 2023) [39]–[52].

[214] T 38 (Roberts).

[215] Section 83AJ of the *Sentencing Act 1991* (Vic) does require that proceedings for contraventions of CCOs imposed by higher courts be transferred to the original sentencing court (jurisdiction) but not the particular judicial officer.

[216] For example, if a judicial officer has retired. In those circumstances, another judicial officer is provided with relevant background materials and pre-sentence reports and proceeds to deal with the breach.

254. Counsel Assisting submitted that DJCS (Corrections Victoria) should implement a fast-track procedure for processing family violence offenders when they plead guilty to an offence that breaches a CCO imposed for family violence offending. In their submissions, DJCS suggested that any recommendation should be reframed to refer to investigation of such reform rather than implementation so that the complexities that may arise can be investigated and addressed. I accept that Counsel Assisting's proposed recommendation does give rise to some complex implementation issues and that it may be more appropriate to frame the recommendation as an investigation.

Breach proceedings

255. Noeline's case provides a powerful example of the need for a timelier path for dealing with CCO breaches while offenders like Mr Fairhall are still in custody and before they disappear into homelessness. Consideration should also be given to alternative methods of mitigating risk in this particular context, for example through providing point-in-time intensive case management and providing a plan for therapeutic interventions. Alternatively, where an offender is refusing to engage with services, consideration should be given to the imposition of conditions akin to bail that could restrict a family violence offender from the area within which they have repeated their offending, particularly where they have not engaged with the local CCS or established any connections to the local area. While this would not serve to directly address the violence, it would put further barriers in place to perpetration of family violence against an existing victim(s). These matters may be able to be investigated by DJCS as part of the work it does in investigating the fast-track for breach proceedings.

Recommendation 10:

DJCS Corrections Victoria work in partnership with Court Services Victoria to investigate a fast-track procedure for processing family violence offenders when they plead guilty to an offence that breaches a CCO imposed for family violence offending. Consideration be given to:

- **Enabling service of charge-sheet and summons prior to release;**
- **Facilitating an assessment with the offender, where possible, to assess reasons for non-compliance and suggested options for improving compliance (i.e., offender might not have transportation options or housing stability); and**
- **Empowering the judicial officer hearing the plea for the breaching offence to amend the CCO order in any way that the Court considers necessary to mitigate the risk of further offending during the period of delay until the determination of the CCO breach proceeding. Such powers to include for example, geographical exclusion orders.**

Allocation to CCS office could be a risk mitigation strategy

256. When Mr Fairhall was initially assessed for his CCO, it was understood that he was allocated to Frankston CCS automatically given the proximity to his intended residential address, or existing pro-social supports. Given that Mr Fairhall was homeless, there was, arguably, no compelling reason for him to be managed by Frankston CCS, close to where Noeline and the children resided. The evidence as to why an offender like Mr Fairhall could not be referred to another catchment area for the purpose of complying with his CCO was not compelling.[217] In cases like Mr Fairhall's where his engagement with pro-social supports was minimal and he had refused housing referrals, consideration could have been given to establishing pro-social supports for him in a location far removed (geographically) from the AFM and their supports. This consideration has force especially in circumstances where an offender has failed to make meaningful progress within an existing CCS catchment area.

257. I also note that Mr Fairhall's housing was a persistent issue that would need to be addressed even if he was allocated to another CCS catchment area. Mr Fairhall did not comply with the law, and being told to live somewhere else with no access to housing is unlikely to have prevented him from returning to Noeline's home. Opportunities to address Mr Fairhall's housing include his removal from the housing wait list for not responding to a posted letter, RAMP, and DFFH/Corrections housing prioritises sentenced prisoners not those released from remand where it could be expanded to consider patterns of offending.

258. I note there are a small number of residential men's behaviour change programs, including Breathing Space in Western Australia,[218] and Ngarra Jarranounith Place for Aboriginal men in Victoria.[219] While there is no indication Mr Fairhall would have engaged with such a program if there was one he was eligible for in Victoria, a program

[217] See discussion at T 66–9 (Roberts).
[218] https://www.communicare.org.au/get-support/family-domestic-violence/breathing-space/.
[219] https://www.dardimunwurro.com.au/ngarra-jarranounith/.

such as this may have addressed issues around the drivers of his violence, plus the shortfalls in his attending counselling and anger management in place of specific men's behaviour change programs.

Service of warrants

259. The execution of warrants is a responsibility of Victoria Police.[220] There is no formal method of prioritisation.[221] There are three primary avenues of inquiry that police consider when attempting to execute a warrant—driver's licence, address and employment.[222] Mr Fairhall had none of these, which made it difficult for police to execute the Corrections warrant. Whilst a system of '*monthly supervisor checks*'[223] on each unexecuted warrant existed at the relevant time, there is no evidence to suggest Mr Fairhall's warrant was processed pursuant to this system during December 2019 or January 2020. Victoria Police still do not know why Mr Fairhall's warrant was not picked up in the monthly supervisor check or why it was never executed.

260. A further issue with respect to the warrant for Mr Fairhall's arrest was identified by AC Callaway as being the fact that it was a Corrections warrant which AC Callaway described as '*not a family violence warrant*'.[224] Even though he had breached the FVIO on 19 November, Mr Fairhall was not charged in relation to this offence and therefore there was no arrest warrant within the police system for a family violence offence. This is the flow on effect of not actively investigating family violence breaches in a timely manner.

261. Warrants sought by Corrections Victoria (as opposed to bench warrants) are required to be physically sent via mail or DX '*in order for them to go onto the system*'.[225] It is not

[220] T 44 (AC Callaway).
[221] T 45 (AC Callaway).
[222] T 45–6 (AC Callaway).
[223] T 49 (AC Callaway).
[224] T 100 (AC Callaway).
[225] T 195 (AC Callaway).

clear why this antiquated process still operates and only with respect to Corrections warrants. Counsel Assisting submitted that I should recommend that DJCS should implement a non-paper-based system for serving warrants. DJCS accept that in principle this recommendation has merit but raised concerns that its implementation will require identifying appropriate IT solutions and associated systems. I accept the appropriate solution will need to be identified but do not think this task is insurmountable, particularly in circumstances where other organisations send and receive warrants electronically.

262. The evidence is inconclusive as to precisely why Victoria Police failed to execute Mr Fairhall's Corrections warrant. Evidence was provided of demand pressures, the extraordinary volume of unexecuted warrants on the system and the difficulties faced by police when offenders are homeless. Conversely, AC Callaway gave evidence of a particular operation called 'Operation Janus', implemented in 2020–21 where enforceable actions are linked to PTMIs and are prioritised accordingly, with a reported success rate of 96 percent.[226] This extraordinary result suggests that when the execution of family violence warrants is prioritised by Victoria Police, they are capable of good results.

263. Counsel Assisting submitted that I should recommend that Victoria Police make 'Operation Janus' a permanent practice. Victoria Police submitted this is unnecessary as the principles from operation Janus have now been embedded and incorporated in local FVIU practices.

Recommendation 11:

Corrections Victoria implement a digital, non-paper-based system for Corrections warrants that will enable them to be processed without relying on mail or DX.

[226] T 106–9 (AC Callaway).

Children as victims in their own right

264. I note that the invisibility of Noeline's children as victims and their need for support is considered in the Multi-Agency Review:

> '*There is little evidence of community services seeking or acting on the voices of Paige, Zachary and Olivia in relation to the details and severity of violence within their family or in relation to what would support them to feel safe and well. There is also no evidence that culturally appropriate therapeutic supports were offered to Paige, Zachary and Olivia from the time services became aware of the escalating family violence within the family*.'[227]

265. I also note recent studies on and by children of parents who have died from intimate partner homicide,[228] and recent reporting by the Commission for Children and Young People has noted in their most recent Annual Report (22/23) that children in families bereaved by domestic homicide potentially remain invisible and lacking comprehensive support through the service system:

> '*The Commission noted that, unlike some jurisdictions, Victoria has no multi-agency protocol in place when a child is bereaved as a result of domestic violence. As a result, there is no clear understanding about what each agency will do and what they will be responsible for, despite quality service.*'[229]

[227] Inquest Brief, *Multi-agency system-focussed review of the death of Ms Noeline Dalzell*, 4194.
[228] Eva Alisic et al, *Children and Young People Bereaved by Domestic Homicide: A focus on Australia* (Report, 2023).
[229] Commission for Children and Young People, *Annual Report 2022–23* (Report, 23 October 2023) 48.

FINDING AND CONCLUSION

266. Having investigated the death of Noeline Michelle Dalzell and having held an inquest from 15 to 18 April 2024, I make the following findings, pursuant to section 67(1) of the Act:

    a) The identity of the deceased is Noeline Michelle Dalzell born 19 January 1971;

    b) The death occurred on 4 February 2020 at 8 Whitby Way, Seaford, Victoria;

    c) The cause of death was *stab wound to the neck*; and

    d) The death occurred in the circumstances described above.

I am deeply saddened by the persistent and preventable violence that Noeline's children observed and experienced throughout their lives. I commend their resilience, and extraordinary bravery as evidenced throughout this inquest.

I convey my sincerest sympathy to Noeline's family for their loss.

TABLE OF RECOMMENDATIONS

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

Recommendation 1:

That the Victorian Government investigate supplementing and enhancing the CIP to enable the multi-directional flow of information relevant to perpetrator risk among all relevant Departments and agencies in a way that is timely, proactive, complete and automated (where possible and appropriate to manage risk).

Recommendation 2:

The Victorian Government immediately formalise the sharing of CIP reports by approving Child Protection practitioners as requestors.

Recommendation 3:

Victoria Police (in conjunction with DJCS) develop a policy to ensure that any victim of family violence or an AFM in an active FVIO case is notified of a court outcome. It is desirable for Victoria Police to notify all victims and AFMs in an active FVIO, however I consider it essential that in cases where an offender is considered high risk, that this notification occur within 48 hours.

Recommendation 4:

If Recommendation 3 is accepted, the Victorian Government investigate enhancement to the CIP to include a capability that the release of a FV offender (from prison, police cells or directly from a court) triggers an automated notification of that information to all other agencies.

Recommendation 5:

Victoria Police and The Orange Door in two regions as a pilot collaborate to embed advanced family violence practitioners within each FVIU to assess, jointly respond to and manage repeat and/or high-risk family violence matters and improve proactive victim/AFM engagement. I note the complexity of placing a Family Violence

Practitioner within the structure of a statutory organisation such as Victoria Police and acknowledge that this will need to be a senior worker with extensive experience and provided with supervision by a specialist family violence service.

An independent evaluation of the pilot program should be completed within two years of commencing operation in each of the two regions selected.

Recommendation 6:

Victoria Police engage an external independent suitably qualified person to conduct an evaluation of the effectiveness and skillset of the FVIUs. The review ideally should be conducted prior to the rollout of the CPRM to provide valuable benchmarking information to assist in the evaluation of the CPRM program which has been foreshadowed by the Chief Commissioner of Police in his submissions.

Recommendation 7:

DJCS and DFFH take immediate steps to complete work on recommendation 2 of the Multi-Agency Review and identify who is to take the leadership role, including identifying and implementing a central contact person or agency with responsibility for coordinated oversight of family violence perpetrators, affected family members, and associated service providers. Given the rate of family violence perpetrated on First Nations women and children, this approach needs to include First Nations community organisations, and incorporate expertise from those with lived experience.

Recommendation 8:

Victoria Police make PTMI and MRTs for high-risk family violence offenders accessible to uniform police members who respond to family violence incidents.

Recommendation 9:

That the Attorney General consider a reference to the VLRC to consider legislative amendment in order to expand the *Serious Offenders Act 2018* scheme to encompass

serious repeat family violence offenders who pose an ongoing and high risk of violence to AFMs.

<u>Recommendation 10:</u>

DJCS Corrections Victoria work in partnership with Court Services Victoria to investigate a fast-track procedure for processing family violence offenders when they plead guilty to an offence that breaches a CCO imposed for family violence offending. Consideration be given to:

- **Enabling service of charge-sheet and summons prior to release;**
- **Facilitating an assessment with the offender, where possible, to assess reasons for non-compliance and suggested options for improving compliance (i.e., offender might not have transportation options or housing stability); and**
- **Empowering the judicial officer hearing the plea for the breaching offence to amend the CCO order in any way that the Court considers necessary to mitigate the risk of further offending during the period of delay until the determination of the CCO breach proceeding. Such powers to include for example, geographical exclusion orders.**

<u>Recommendation 11:</u>

Corrections Victoria implement a digital, non-paper-based system for Corrections warrants that will enable them to be processed without relying on mail or DX.

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:

Noeline's Family

Attorney General, Jaclyn Symes MP

Secretary, Department of Justice and Community Safety

Secretary, Department of Families, Fairness and Housing

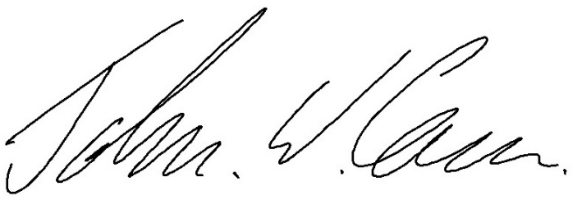
The Chief Commissioner of Police

The Orange Door (Family Safety Victoria)

Victorian Government

Detective Senior Constable Rebecca Maydom, Coroner's Investigator

Signature:



Judge John Cain
State Coroner
Date: 15 November 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 inquest. 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.