IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001981

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	FCP
Date of birth:	[redacted]
Date of death:	11 April 2020
Cause of death:	1(a) Drowning whilst inebriated (ethanol)
Place of death:	[redacted]
Keywords:	Family violence; drowning; mental health; suicide

INTRODUCTION

1. On 11 April 2020, FCP was 45 years old when was found deceased in a dam at the rear of her home in [redacted]. At the time of her death, FCP lived with her partner, LFQ, and his four children.

2. FCP had a complex history of mental illness, substance abuse and family violence. She was in a 17-year relationship which ended in 2016 and culminated in protracted legal proceedings between FCP and her former partner regarding the care of their two children. In late-2016, FCP attempted suicide by taking an overdose of medication and placing a plastic bag over her head. She was transported to a psychiatric ward for inpatient treatment and was diagnosed with an acute episode of psychosis.

3. FCP was diagnosed with anxiety, depression, complex post-traumatic stress disorder (**PTSD**), benzodiazepine and alcohol addiction and paranoid thoughts. It appears her mental health continued to deteriorate following separation from her partner, including during her relationship with LFQ.

4. FCP had intermittent engagement with drug and alcohol counsellors, including Nexus Primary Health in 2018 and a brief stay in a residential withdrawal program in July 2018. FCP also experienced several inpatient psychiatric admissions in August 2018 (at the Northern Hospital) and September 2019 (Werribee Hospital; Wyndham Private Hospital), following suicide attempts.

5. FCP commenced a relationship with LFQ in late-December 2016, following the death of LFQ's wife. They lived together with LFQ's four teenage children from March 2017, and became engaged in 2018. LFQ described his relationship with FCP as very close and supportive and that they had a "*psychic connection*". He explained that he encouraged her to start her own spiritual counselling business and that he advocated for FCP to see her children with her former partner. FCP's friends depicted a different side of this relationship and alleged that FCP was the subject of controlling behaviour as well as physical and financial abuse.

THE CORONIAL INVESTIGATION

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

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned Senior Constable Jodie Fiera to be the Coronial Investigator for the investigation of FCP's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, friends, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of FCP including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

11. On 11 April 2020, FCP, born [redacted], was visually identified by her partner, LFQ.

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

Medical cause of death

13. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 16 April 2020 and provided a written report of her findings dated 29 September 2020.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

14. Dr Baber opined that the circumstances and autopsy findings were entirely consistent with drowning. The autopsy diagnosis of drowning can be difficult to make as there are no specific signs; some signs seen in "classical" drowning include a foam plume around the mouth (which can quickly disappear), heavy and overdistended lungs (emphysema aquosum), bloodstained fluid within the airways, and in some cases pleural effusion may be present. In this case, the lungs were overdistended and met in the midline overlying the mediastinum.

15. There was no significant natural disease that may have caused or contributed to death. There was no evidence of trauma or injury that may have caused or contributed to death.

16. Toxicological analysis of post-mortem samples identified the presence of ethanol (0.11 g/100mL), diazepam and its metabolite and olanzapine.

17. Dr Baber provided an opinion that the medical cause of death was *drowning whilst inebriated (ethanol).*

18. I accept Dr Baber's opinion as to the medical cause of death.

Circumstances in which the death occurred

19. On 28 March 2020, FCP travelled to New South Wales to stay with a friend she had met online through a Facebook group. FCP's relationship with this friend, as well as her mental health, appeared to decline rapidly. She reported paranoid thinking, including that her friend would sell her into sexual slavery. On 1 April 2020, FCP took an overdose of medications, and she was admitted to Grafton Hospital for mental health assessment and treatment.

20. FCP was discharged on 7 April 2020 and drove back to her home in Kilmore East. LFQ reported that FCP appeared to be in good spirits upon her return home. She remained in this good mood until 10 April 2020, when she spoke to her mother on the phone. FCP's mother, CVB, noted that during the phone call, FCP disclosed family violence and stated " *[that CVB] didn't believe her and [she] asked [FCP] if she had been to the hospital*". FCP was reportedly distressed after the phone call and was upset that her mother allegedly accused her of breaking into her house. LFQ noted that FCP appeared paranoid and stressed after the phone call.

21. On the morning of 11 April 2020, FCP awoke and "*did her usual routine*". When LFQ awoke at 9.30am, he observed FCP sitting on the edge of the bed. LFQ asked her to come back to bed as it was cold, however she said she wanted to have a cigarette. LFQ noted that FCP

would ordinarily have one cigarette and then return inside to make a coffee, before going back outside for a second cigarette.

22. LFQ explained that he fell back asleep and awoke sometime later to the sound of dogs barking. He thought that FCP might have called an ambulance, which was her usual practice when her mental health had deteriorated, or she was in pain. When he left bed later that morning, he made a coffee and looked around the house for FCP, however, was unable to find her. He became concerned when he realised that her phone and handbag were still in the house, so he decided to call the Northern Hospital to see if she had been transported there earlier that morning. The hospital advised that FCP was not there and suggested that she might still be in transit and to call back in half an hour.

23. LFQ also realised that their dog, Willow, was missing, and thought she may have followed the ambulance, so he and his children started searching for her. LFQ walked to the top of the hill near his neighbour's property and observed something near the dam on his property. He also observed his horse standing still and looking at the dam, which was unusual.

24. LFQ jumped onto his bike and located Willow, however, was still unable to find FCP. He rode to the top of the hill on the other side of the dam and observed FCP in the dam, floating amongst the reeds. LFQ ran down to FCP and called the Kilmore Police Station, who told him to call 000. LFQ pulled FCP out, dragging her out by her jacket, and observed that she had a plastic bag over her head. The 000 call-taker instructed LFQ to remove the plastic bag, which he did. The call-taker asked LFQ to commence cardiopulmonary resuscitation, however LFQ refused as he believed FCP had already passed away.

25. Emergency services arrived on scene shortly thereafter. Paramedics confirmed FCP had passed away some time earlier and therefore did not attempt resuscitation. Police investigated the scene and located an empty bottle of wine, an empty blister pack of diazepam and cigarette butts nearby. Police did not identify any suspicious circumstances or signs of third-party intervention in connection with FCP's death.

FURTHER INVESTIGATIONS AND CPU REVIEW

26. As FCP's death occurred in circumstances where there was a reported history of family violence, I referred her case to the Coroner's Prevention Unit (**CPU**)[2] Family Violence Team and requested they examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3] I also asked the CPU's Mental Health team to review the mental health treatment provided to FCP proximate to her passing.

Family violence incidents between FCP and LFQ

March 2019

27. The first incident reported to police occurred on 6 March 2019, with two separate incidents occurring on this date. At about 4.00pm, a police patrol car located a vehicle parked on the side of the road with FCP and her partner's son inside the car. FCP approached the officers, "*waving her arms in hysterics*" and alleged that she had been threatened by family members and was forced to leave her home. A second car arrived shortly thereafter, containing LFQ's three daughters who stated that FCP had taken their brother. They accused FCP of being psychologically and emotionally abusive towards the children. LFQ also attended the scene, and all parties were separated and spoken to individually.

28. LFQ described a challenging situation at home where the children had lost their mother to cancer, and they were not happy with LFQ's relationship with FCP. FCP was identified as the respondent in this incident and police made formal referrals for all parties.

29. Later that day at about 11.50pm, FCP called 000 and reported an assault in which she suffered a dislocated shoulder. The computer-aided dispatch (**CAD**) notes were documented as follows:

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

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30. When the first two police units arrived on scene, the first notes in the CAD Event Report were "*F LAYING ON BEDROOM FLOOR IN DISCOMFORT, A BIT EMOTIONAL*". The next notes added to the CAD Event Report (beyond those referring to the ETA of paramedics) was as follows:

> *S/T FCP & LFQ separately ekm311 speaking with LFQ. AV attended FCP to northern hospital with shoulder injury. FCP to be Resp. Further details with ekm311.*

31. The next substantive notes were:

> *AfM LFQ stated defacto resp FCP has drinking problem was heavily affected by alcohol and Valium tonight. She was in a texting war with LFQ's niece in Kilmore and has been having issues with LFQ's two teenage daughters who live with them. AfM went to bed and tried to sleep to avoid the situation but resp has wanted to continue discussions about the niece and the text messages. The resp has poked and kicked the AfM and has slapped him across the face. He asked her if that made her feel good and told her to do it again. The resp punched the AfM to the face. The AfM then pushed the resp off the bed causing her to fall heavily and hurt her shoulder. The resp called police and ambulance. Both attended. Resp taken to northern hospital. Statement taken from AfM. He does NOT want criminal charges issued.*

32. As indicated above, attending officers took a statement from LFQ, while paramedics transported FCP to the Northern Hospital for medical attention. Police applied for a Family Violence Intervention Order (**FVIO**) via a complaint and warrant against FCP. When they attended the Northern Hospital, FCP was interviewed in relation to the incident and was later bailed to the Seymour Magistrates' Court on 8 March 2019. On that date, an interim FVIO was granted in limited conditions (not to commit family violence and not to damage property).

33. Whilst at the Northern Hospital, FCP told medical staff and a social worker a different story, namely, that LFQ allegedly held her arm and twisted it, before pushing her into a wall, which resulted in the dislocated shoulder. She also disclosed to hospital staff that LFQ had threatened her to take the blame for the incident, and she was fearful of repercussions if she did not. The

social worker completed a risk assessment and identified FCP as a victim-survivor of family violence. They provided appropriate supports and referrals in the form of clothes, toiletries, and referrals to emergency housing and family violence services.

34. I note the *Code of Practice for the Investigation of Family Violence* (**the Code of Practice**) in place at the time of the incident. Pursuant to the Code of Practice, police attending a family violence incident are required to consider the following factors when determining which party should be considered the respondent:

    a) Respective injuries

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

    c) Whether either party has defensive injuries

    d) Which party is more fearful; and

    e) Patterns of coercion, intimidation and/or violence by either party.[4]

35. In this case, FCP sustained the more significant injury, was the one who called 000, and was "*in discomfort*" and "*a bit teary*" at the time of police arrival. There were no notes documenting any injuries to LFQ and he did not require medical attention or treatment. FCP was initially allocated as the complainant by the 000 call-taker, however at some point after police arrived, she was determined to be the respondent.

36. In their submissions to the Court, Victoria Police noted that there were no statements from the members who attended on the evening and urged me not to find that she was misidentified as the predominant aggressor, nor that there was a deficient police response by the members who attended that evening.

37. I accept that there is limited available evidence to determine why she was considered the predominant aggressor. I am also of the view that obtaining statements from members five and a half years after the incident would be of limited forensic benefit. Furthermore, I do not make any criticism of the members involved.

38. However, based on the evidence that *is* available, it is unclear how the decision was reached. Based on the CAD Event Report, at some point during the evening, police assigned FCP as

[4] Code of Practice for the Investigation of Family Violence Edition 3 V3 2017, 17.

the respondent, but the reasoning for this decision is not documented anywhere. Given the level of injury she sustained (in comparison with LFQ), I am of the view that police should have documented their decision-making process. The members *did* document their conversation with LFQ but did not document their conversation with FCP. In circumstances where she sustained an injury that required hospitalisation, the absence of that documentation is problematic.

39. This documentation would have been of benefit to any future members who may attend a further incident of family violence and/or who may wish to familiarise themselves with the prior history to understand why a particular decision was made in the past. Furthermore, should an incident arise in the future where police are trying to determine whether a previous incident of misidentification has occurred, they would have the appropriate documentation to assist in their investigation.

40. I therefore intend to make a recommendation that when police attend a family violence incident and the roles of affected family member (**AFM**) and respondent are not clear, police must document the reason for their decision to assign the roles. This would permit any other investigator or member in the future to quickly and easily identify how and why the roles were assigned. Furthermore, if in the future, police are trying to understand whether a person might have been previously misidentified, then there is clear documentation to assist with their investigation.

<u>September 2019</u>

41. On 10 September 2019, FCP attended Wallan Police Station to report that her phone had been hacked. She explained that she received a phone call from a female caller at her children's school regarding some court documents and stated that she then received an email that had wiped the record of the call. Police provided FCP with general advice.

42. In the early hours of 11 September 2019, FCP presented to the Kilmore District Hospital emergency department (**ED**) and disclosed "*plausible significant family violence but also present[ed] as erratic and paranoid*". Police were called to the hospital and FCP provided the same account regarding her phone being hacked to the attending officers. FCP also reported the following incidents:

    a) She had transferred all of her money to LFQ, and that he would only provide her with small amounts at a time.

b) When LFQ allegedly injured her shoulder in March 2019, he threatened her to "*take responsibility for the incident or there would be [unspecified] consequences*".

c) LFQ had taken all the batteries out of all the smoke detectors, and he had intentionally left the gas on in the house.

d) LFQ was tampering with or restricting access to water at the home.

e) That LFQ was allegedly emotionally abusive and gaslighting her.

43. The attending police officers transported FCP to the Northern Hospital for a voluntary mental health assessment (as Kilmore District Hospital did not have the capacity for this assessment). The attending police then attended FCP's home to investigate her allegations. Police spoke with LFQ, and police reported that they "*could not confirm that any form of controlling behaviour or gaslighting was being committed*" as LFQ was able to provide plausible explanations for each situation reported by FCP. Police noted the FVIO already in place, where FCP was the respondent.

44. I note that despite FCP's disclosure that she was threatened into taking the blame for the March 2019 incident of family violence where she was identified as the respondent, police did not consider whether the FVIO against her was still appropriate. It also did not appear that police considered whether FCP was misidentified in the previous incident. The Family Violence Reform Implementation Monitor (**FVRIM**) December 2021 report *Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor* (**'the FVRIM report'**) appears to be relevant here and highlights how some perpetrators actively manipulate police and other systems for their own advantage.

45. In their written submissions to the Court, Victoria Police noted that there were no statements from the members who responded to this incident and therefore it was purely speculative to suggest what actions police did/did not take and what they considered at the time.

46. Again, I accept that this is true. There is indeed no documentation regarding the conversations that police had with LFQ, other than to note that police could not substantiate FCP's claims. However, I am of the view that this is problematic, as detailed above. When a person alleges significant family violence in the form of financial abuse, threatening behaviour and tampering with household utilities, I am of the view that this should be thoroughly investigated *and* documented. This would not only be of assistance to an investigating entity such as the Court but more importantly, would assist other members who may review the LEAP records

in the future, to fully understand what has occurred in the past. This is particularly pertinent given the long-term patterns of violence and coercion that are exhibited with family violence offenders and the need for police to consider the broader picture, rather than merely an isolated incident. I am not of the view that this would need to be particularly onerous; rather a few additional lines in the LEAP record such as "*spoke to independent witness X, have obtained a statement which corroborates Y's story*". I therefore intend to make a recommendation to that end.

47. The submissions do not consider the issue of FCP's disclosure that she was threatened into taking the blame for the March 2019 incident. FCP's disclosure should have given rise to police reconsidering the appropriateness of the FVIO in place against her, given that it originated out of that incident. I note that Victoria Police are undertaking a program of work to clarify what members are required to do in situations such as this one. This issue is explored in further detail in this finding.

<u>December 2019</u>

48. Police were requested to perform a welfare check on FCP on 24 December 2019. She told police that she was upset because LFQ did not acknowledge her birthday, and she felt isolated and lonely. She began drinking alcohol, filled her bath with water and called her friend to advise that she was going to take her own life. The attending officers noted her suicidal ideation and transported her under section 351 of the *Mental Health Act 2014* (Vic) to the Northern Hospital for a mental health assessment. I have not identified any opportunities with respect to this incident.

<u>February 2020</u>

49. FCP attended Wallan Police Station and reported that she had an argument with LFQ over his refusal to show the account details for the money she had put into his trust account. The LEAP records noted that FCP "*appeared erratic and possibly substance affected*". Police contacted LFQ, and FCP returned home with the agreement that LFQ would review the bank statements with her. I have not identified any issues with respect to the police contact on this occasion.

<u>March 2020</u>

50. FCP reported to police that she was concerned that LFQ had attempted to poison her with gas. She was so fearful that she left the house and slept in her car, before attending Kilmore District Hospital at 6.00am. Hospital staff notified police, who noted that FCP "*detailed an extensive*

history of family violence" which had all "*been previously reported and dealt with*". FCP explained that she wanted to travel to New South Wales to stay with a friend, and asked police to escort her to collect her belongings from the home. Attending police spoke to LFQ separately, and no civil or criminal actions were deemed necessary as police believed that FCP had left the relationship. There did not appear to be any issues with the police contact on this occasion.

Ongoing Victoria Police work in family violence policy and procedure

51. In their submissions to the Court, Victoria Police noted that a Family Violence Predominant Aggressor Practice Guide (**the Practice Guide**) is currently under development. This Practice Guide will be the document that police officers practically refer to in the course of their duties and is aligned with the Multi-Agency Risk Assessment Management (**MARM**) Foundation Knowledge Guide and Practice Guides. Victoria Police also noted that the as part of the development of the Practice Guide, Victoria Police is currently implementing the findings and recommendations from the FVRIM December 2021 report.

52. It further noted that the Practice Guide will:

    a) Make specific reference to factors which may increase the risk of misidentification (including situations where the AFM is a woman and/or has a mental illness);

    b) Require police officers to consider potential biases and how these may contribute to expectations around what a victim is 'supposed' to look like;

    c) Provide guidance as to the potential misidentification of AFMs as predominant aggressors based on their presentation or behaviour in relation to having mental illness, the influence of alcohol or other drugs, and perceived or actual aggression towards police; and

    d) Speak to 'bi-directional' violence and require police officers to consider where the use of violence may be in the context of self-defence or violent resistance (noting this is distinct from violence driven by ongoing, coercive or controlling behaviour perpetrated by the predominant aggressor).

53. Victoria Police also noted its recent Identification of the Predominant Aggressor Trial (**'the Trial'**) in the North-West Metro Region Division 5 in 2022 and further work to review its IT

platforms to determine potential enhancements, and the development of a training package for police supervisors to support the above policy and guidance changes.

Conclusion regarding family violence service interaction

54. This case highlights the complexities and ambiguities of understanding the interaction of trauma/mental health, substance use, and family violence issues in identifying and responding to the perpetrator and victim-survivor of family violence. It indicates the need for a systemic approach where police have clear guidance and clear access to the expertise and support of family violence services when needed in complex cases. The CPU suggested that I consider making the following recommendations:

   a) Endorse all recommendations made in the FVRIM report, particularly recommendations four to eight.

   b) That Victoria Police amend the Code of Practice to provide further information on the specific risk of misidentifying women with mental illness as primary aggressors when they do not present as 'ideal victims' due, for example, to:

      i. Perceived aggression, agitation or erratic behaviour

      ii. Substance use or lack of calm cooperation with police

      iii. Use of violent resistance, including self-defence.

<u>Recommendation a)</u>

55. In their submissions to the Court, Victoria Police noted that the Practice Guide is currently implementing the findings and recommendations from the FVRIM December 2021 report, and therefore recommendation a) is not necessary.

56. However, I note that recommendation 5 of the FVRIM was for Victoria Police to "*Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possible for other targeted cohorts) before it is committed to Victoria Police's LEAP database.*" Victoria Police submitted that they have satisfied this recommendation as a result of the Trial in 2022, and that the Family Violence Command consulted with a wide range of stakeholders to inform this work, including specialist family violence agencies. Specialist family violence agencies were *not* involved in

the actual reviews of Family Violence Reports where a woman is identified as a respondent, they were only consulted as part of the design process.

57. Although Victoria Police has theoretically completed this recommendation, I note that specialist family violence agencies were not involved in the reviews of actual family violence reports. As highlighted by the FVRIM, "*one recurring suggestion during [their] consultations was for a stronger partnership between Victoria Police and the family violence sector to review cases where there is a high risk of misidentification or other uncertainty about the dynamics in the relationship*".[5] The present case is a good example of the difficulties faced by frontline members when attempting to determine the predominant aggressor. I am therefore of the view that it would be beneficial for Victoria Police to implement FVRIM recommendation 5 in the spirit in which it was intended, that is, where police *and* specialist family violence workers review Family Violence Reports where a woman is identified as a respondent, prior to committing the report to LEAP. I intend to make a recommendation to that effect.

Recommendation b)

58. Victoria Police explained that the new Practice Guide will address (amongst other matters), the following:

    a) Supporting officers to identify the predominant aggressor before beginning the risk assessment (per FVRIM recommendation 4).

    b) Clear differentiation between use of the risk assessment and applying for civil protection orders for protection purposes and responding to criminal offences (per FVRIM recommendation 4).

    c) A process for reviewing the identification of AFMs and respondents, when there is new information that suggests misidentification may have occurred (per FVRIM recommendation 7).

    d) When misidentification is determined to have occurred, processes for rectification (per FVRIM recommendation 7), including, where appropriate, withdrawal of resulting

[5] Family Violence Reform Implementation Monitor, State of Victoria, Monitoring Victoria's Family Violence Reforms: Accurate Identification of the Predominant Aggressor (Report, December 2021), 21.

family violence intervention order applications or criminal charges (per FVRIM recommendation 8).

59. With respect to recommendation b), Victoria Police agreed to update their policy to provide further information about the specific risks for misidentifying women with mental illness as the predominant aggressor. Victoria Police proposed that these amendments should be incorporated into the new Practice Guide, rather than the Code of Practice. Victoria Police explained that the Practice Guide will be the document that police officers practically refer to in the course of their duties, whilst the purpose of the Code of Practice is to communicate to the public what they can expect from police relating to family violence.

60. I am of the view that this information should be incorporated into *all* Victoria Police policy and procedure documents, including the Victoria Police Manual (**VPM**), the Code of Practice and the new Practice Guide, when it is launched. In their submissions, Victoria Police did not provide a timeframe for when the Practice Guide was likely to be launched. However, given the importance of ensuring police provide victim-survivors with comprehensive and timely responses to family violence, I do not believe that these changes need to wait until the Practice Guide is launched. I therefore intend to recommend that Victoria Police amend *all* of its policy and guideline documents accordingly.

Review of mental health treatment

61. FCP had a history of fluctuating mental health since at least 2016, when she appeared to experience an acute decline and an episode of psychosis. From 2016 to the time of her death, FCP received mental health treatment from several mental health service providers including Mercy Health, Northern Health and Goulburn Valley Health. In the weeks before her passing, she also presented to the Grafton Hospital in New South Wales.

<u>Goulburn Valley Health</u>

62. FCP's most recent engagement with Goulburn Valley Health was in March 2019 for a mental health assessment and treatment. Concerns for her mental state were identified during that time and a psychiatric review was requested. The psychiatry team reviewed FCP and documented some concerns, although no imminent risk was identified. She was referred for community mental health follow-up, following discharge.

63. On 24 March 2019, FCP called the Goulburn Valley Health mental health triage number and requested they collect her. Her communication was vague, and she was unable to identify any

specific concerns. She denied suicidality, reported feeling safe, was agreeable to returning to bed and agreed to a follow-up call the next day.

64. On 25 March 2019, a Goulburn Valley Health clinician called FCP as previously organised. At that time, FCP again denied active suicidal thinking or plans. She was aware of the number for psychiatric triage if she needed to call again and indicated that she was engaged with a private psychologist in the community.

Mercy Health

65. FCP's last engagement with Mercy Health occurred in September 2019, when she was admitted to Wyndham Private Hospital from 17 to 27 September 2019. On admission, she presented as paranoid and appeared to be displaying early signs of psychotic relapse. She displayed good insight into her need for treatment and was agreeable to an admission to Wyndham Private Hospital. She engaged well in programs and psychological treatment and received an anti-psychotic medication.

66. Upon her discharge on 27 September 2019, FCP's mental state was reportedly stable. She was not displaying psychotic symptoms and was denying suicidal ideation, thoughts, plans or intent. The plan upon discharge was for FCP to engage with her private psychologist, and to escalate to area mental health triage if her mental health declined or if she required more urgent or acute assistance. She had previously demonstrated good help-seeking behaviours and a willingness to escalate to mental health triage as required.

Northern Health

67. FCP's last documented engagement with Northern Health in relation to her mental health occurred in December 2019. She also presented to the ED on 7 March 2020, however this was in relation to a physical health issue. There were no concerns for her mental health during that presentation.

68. In December 2019, FCP indicated suicidality to a friend in the context of feeling neglected by her partner. She was transported by police to the Northern Hospital ED, where she denied suicidal intent and advised that she was attention seeking and had no intention of ending her life.

69. FCP did not display any psychotic symptoms or formal thought disorder and denied any suicidal ideation, plans or intent. She was assessed as displaying some dependent personality

disorder traits and the provisional diagnosis was of a situational crisis in the context of social stressors. She was assessed as not being at acute risk, and she advised that she did not want an admission or crisis follow-up. The hospital agreed with a plan to liaise with her general practitioner regarding her presentation, and for FCP to continue to engage with her private psychologist.

Grafton Hospital (New South Wales)

70. FCP was admitted to Grafton Hospital on 1 April 2020. She made a call to a mental health line, following which an ambulance attended and transported her to hospital. Upon examination, FCP was noted to be intoxicated and had reportedly taken an overdose of benzodiazepines. She presented with paranoid thinking with the belief that people were controlling her social media accounts. Clinicians determined that she was intoxicated and that she required medical alcohol withdrawal treatment. Clinicians thought her mental health symptoms may subside somewhat as she became sober, with the assistance of medication.

71. FCP was admitted to a medical ward with a plan to monitor her alcohol withdrawal. She remained in hospital until 7 April 2020 and during that time she was reviewed by a mental health nurse. She declined admission to the Lismore mental health unit, and the assessment was that she did not meet the criteria for an involuntary admission. She received medications including benzodiazepines for anxiety and an antipsychotic (olanzapine) during her admission.

72. FCP was discharged on 7 April 2020 and was provided with a seven-day supply of medication, with a plan for review by her doctor upon her return to Victoria. She was advised to report to the nearest hospital should she feel unwell or unstable on her return journey home. FCP returned to the home she shared with LFQ, without incident.

Intersection of family violence and mental health treatment

73. I note that at the time of FCP's passing in April 2020, service obligations under the multi-agency risk assessment and management framework (**MARAM**) were underway. The expectation for prescribed agencies such as public mental health services, was that they would gradually implement all MARAM-related requirements and would not immediately align with MARAM. Northern Health, Goulburn Valley Health and Mercy Health were designated mental health services under the MARAM, whilst Grafton Hospital (being in New South Wales) was not prescribed under MARAM.

74. The CPU did not identify any significant concerns or systemic issues in the medical records that would not have been addressed by the ongoing MARAM implementation and alignment. I also noted that during FCP's presentation to Northern Hospital in March 2020, family violence was appropriately identified, with risk assessments completed and appropriate referrals offered.

Summary of mental health treatment

75. I note that FCP presented with a history of fluctuating mental health since an acute episode of psychosis in 2016. A review of her medical records documented several episodes of early signs relapse (psychosis). Her mental health improved (often quickly) following treatment (admission, medication, or both). While she was documented to sometimes present with suicidal ideation during episodes of mental ill health, she did not articulate plans or intent. She demonstrated good help-seeking behaviours and did not meet the criteria for an involuntary admission, and she agreed to engage with voluntary treatment where indicated. The CPU concluded that no prevention opportunities in relation to FCP's mental health treatment were identified. I accept their opinion.

76. I note that it is likely that the various mental health services involved would have further improved and matured their alignment and implementation of the MARAM framework, since the time of FCP's passing. I therefore make no criticism of the health services involved with FCP in the months proximate to her passing.

FINDINGS AND CONCLUSION

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

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

    b) the death occurred on 11 April 2020 at [redacted], from *drowning whilst inebriated (ethanol)*; and

    c) the death occurred in the circumstances described above.

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

RECOMMENDATIONS

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

a) That **Victoria Police** update their policies and documents to require members to document the reason for their decision to assign the roles of AFM and respondent and document the conversation(s) held with the respective parties/other witnesses when attending family violence incidents where the roles of AFM and respondent are not clear.

b) That **Victoria Police** amend the Code of Practice, Victoria Police Manual and the new Predominant Aggressor Practice Guide to provide further information on the specific risk of misidentifying women with mental illness as primary aggressors when they do not present as 'ideal victims' due, for example, to:

    i. Perceived aggression, agitation or erratic behaviour

    ii. Substance use or lack of calm cooperation with police

    iii. Use of violent resistance, including self-defence.

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

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

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

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

LFQ, Senior Next of Kin

CVB

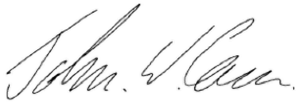
Mercy Health

Northern Health

Victoria Police (C/- Victorian Government Solicitor's Office)

Senior Constable Jodie Fiera, Coronial Investigator

Signature:



Judge John Cain
State Coroner
Date: 31/1/25

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.