IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006055

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:	Jessica Geddes
Date of birth:	3 January 1993
Date of death:	6 November 2020
Cause of death:	1(a) Complications of multiple blunt force injuries
Place of death:	27 Haverstock Hill Close, Endeavour Hills, Victoria, 3802
Keywords:	Family violence; intimate partner homicide; mental illness, begging; homelessness

INTRODUCTION

1. On 6 November 2020, Jessica Geddes was killed by her partner, Robert Rickerby. Jessica Geddes was 27 years old when she passed and is survived by her daughter, parents and siblings.

2. Jessica was born and raised in Queensland and was described as being "*very very bright*" and had dreams of studying medicine. She loved music and taught herself to play the guitar and piano. She also loved animals and was well-connected to her community in Queensland.

3. From 2013 to 2017, Jessica experienced housing instability and mental health issues, and her use of illicit substances escalated. She experienced several inpatient admissions during this time, and her daughter was placed in her mother's care.

4. Robert was 26 years old at the time of the fatal incident. He was primarily raised in Victoria and began using illicit substances from the age of 14. Robert regularly used methylamphetamine and both Robert and Jessica used methylamphetamine throughout their relationship. Robert's only criminal history prior to the fatal incident was a 12-month community corrections order (**CCO**) for reckless conduct and driving with a suspended licence.

Relationship history and history of family violence

5. Jessica met Robert via an online dating application in September 2017 and commenced a relationship. Several days after meeting, they relocated to Victoria together, to live with Robert's father. Robert's father left the property, and the couple lived together until the time of the fatal incident. The house had no electricity or gas and was noted to be "*completely squalid and largely unfit for habitation*" at the time of Jessica's passing.

6. Evidence available to the Court suggests that Robert was coercively controlling and physically, emotionally, financially and verbally abusive towards Jessica throughout their relationship. After moving to Victoria, Jessica became isolated from her friends and had limited contact with her family. Jessica's mother, Saasha Hughes, reported that Jessica was only permitted to call her with Robert present. Jessica told her mother that she was extremely fearful of Robert and would not provide her address to her mother, as Robert forbade her from doing so.

7. Jessica disclosed to some of her neighbours that Robert was violent towards her but declined support. She was often observed with injuries to her face and body. Some of these injuries were so severe that they impacted her ability to walk.

8. Both Jessica and Robert received Centrelink payments, however Jessica's payment was diverted to Robert's bank account from 2017. Witnesses reported seeing Jessica begging in the neighbourhood and on social media for food and money. She alleged that Robert would "*beat her up*" if she was unable to "*get Robert what Robert was after*".

9. In August 2019, Jessica was admitted to hospital on a temporary treatment order due to poor mental health. During this admission, she advised staff that Robert was physically abusive towards her. She left hospital on the day she was admitted, and a missing persons report was filed. In September 2019, Jessica was taken to hospital with deep lacerations to her forehead after Robert assaulted her with a hammer and police sought a Family Violence Intervention Order in protection of Jessica. Concerns were also noted for Jessica's safety in October 2019 when she presented to hospital with facial injuries, however she left before being treated.

10. In January 2020, Jessica attended her neighbour's home and requested assistance. She was observed to be scared and advised her neighbour that she did not want to return home as Robert would assault her if she did not return with "*what he wants*". The neighbour observed that Jessica had a torn shirt, was dirty and had urinated on herself. The neighbour contacted police, however Robert arrived at the property and asked Jessica to leave with him. The neighbour observed that Jessica appeared fearful, hid from Robert and urinated on herself again, telling him she was scared. She eventually left in Robert's car before police arrived.

11. In February 2020, Jessica posted on social media depicting a large portion of hair missing from her head. She disclosed to her mother that Robert had become angry at her for taking photos of herself and had used a pair of scissors to cut off her hair.

12. In May 2020, Jessica sent her father a text message advising that she had discovered Robert was in a relationship with another woman. She told her father that she was "*probably going to get murdered now just for talking to [him]*". She later sent a message to her father asking if he realised how much she was being *"bashed"*.

13. In September 2020, Saasha received a call from her daughter. She reported that Jessica was crying during the phone call and was begging her to buy them some food. Saasha alleged that Robert said that if she did not assist them, he would send Jessica "*home in a fucking body*

bag". Saasha recalled that her daughter frequently called her requesting that she order pizza for her and Robert. During these calls, Saasha overheard Robert verbally abusing Jessica and on one occasion, heard Jessica asking him to "*stop hitting her*", with screaming and banging also heard.

14. In the lead-up to the fatal incident, witnesses advised that Jessica's appearance and health had significantly declined. Various witnesses noted that she looked unkempt and had lost a significant amount of weight.

THE CORONIAL INVESTIGATION

15. Jessica'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.

16. 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.

17. 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.

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

19. This finding draws on the totality of the coronial investigation into the death of Jessica Geddes 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

20. On 6 November 2020, Jessica Geddes, born 3 January 1993, was visually identified by her partner's father, David Rickerby.

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

Medical cause of death

22. Forensic Pathologist Dr Linda Iles, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 7 November 2020 and provided a written report of her findings dated 9 April 2021. Dr Iles prepared a supplementary report dated 16 July 2021, after reviewing further material supplied by police.

23. The post-mortem examination revealed extensive blunt force injuries that were acute, subacute and chronic in nature. There was bruising to the periorbital regions bilaterally, a laceration around the right eye, bruising to the chin, mid face and lacerations to the oral mucosa along with four scalp lacerations associated with underlying subscapular bruising. There was no associated intracranial haemorrhage or skull fracture. There was evidence of focal traumatic axonal injury, some of which was subacute.

24. The deceased had multiple bilateral rib fractures, some of which demonstrated features of recent haemorrhage through old fracture lines, and some of which show features of well-established healing. These were associated with small volume bilateral haemothoraces. Given limited attempts at resuscitation, any fresh antero-lateral rib fractures (and the sternal buckle fracture) could be accounted for by this mechanism.

25. There were extensive predominantly healing and malunited fractures of the limbs. There was variable and focally extensive soft tissue haemorrhage, fat necrosis and focal muscle necrosis of the limbs, most notably around the right arm.

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[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.

26. There was soft tissue haemorrhage around the scapulae bilaterally, in the lumbar region and about the buttocks. This was associated with a lumbar transverse process fracture and with haemorrhage about the soft tissue surrounding the right kidney. These changes were associated with notable cortical pallor in the kidneys, thyroid and brain, and limited (but not absent) posterior lividity. These signs were suggestive of hypovolemia/anaemia, however, were not necessarily quantifiable or reliable.

27. There was very focal early bronchopneumonia present, on a background of features of fat embolism within the lungs. Fat embolism is a recognised complication of soft tissue trauma and bone fractures and may have caused or contributed to the death. Fat embolism syndrome, however, is a clinical diagnosis, and can be difficult to diagnose post-mortem, particularly in the setting of attempted cardiopulmonary resuscitation.

28. There was evidence of rhabdomyolysis with markedly elevated post-mortem creatinine kinase. There were focal myoglobin deposits within the kidneys, however there were no post-mortem biochemical features of acute renal failure. Rhabdomyolysis is a complication of blunt force injury with muscular trauma. It is frequently associated with hyperkalaemia, which can be lethal, but hyperkalaemia cannot be measured accurately after death.

29. Based on these findings, Dr Iles opined that the cause of death was the consequence of multiple blunt force injuries. There was no one specific injury that precipitated the death and it appeared to be due to the secondary consequences of multiple blunt force injuries (i.e., soft tissue bruising, unquantifiable blood loss, fat embolism, fat necrosis and muscle necrosis). Death via this mechanism is well-recognised.

30. In addition to the above injuries, there were extensive fractures that showed features of malunion and non-union, indicative of no treatment being sought or rendered for these injuries, in particular, long bone fractures. There were multiple scars on the scalp and there was prominent scarring and deformity of the left ear, indicative of previous injury.

31. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine, hydroxyrisperidone and cannabis.

32. Examination demonstrated both acute, subacute and chronic injuries, many of which showed no evidence of having been treated in a conventional fashion. The totality of the injuries, and evidence of lack of treatment, was inconsistent with accidental injury. Whilst there was evidence of scarring on the forearms, which is typical of past episodes of self-harm with a

sharp implement, the pattern of extensive blunt force injuries that have occurred over days, weeks and months, and quite possibly years, was not that of self-inflicted injury. It was quite clear that treatment has not been rendered for a number of these very significant bony injuries.

33. Dr Iles provided an opinion that the medical cause of death was *1(a) complications of multiple blunt force injuries.*

34. I accept Dr Iles' opinion as to the medical cause of death.

Circumstances in which the death occurred

35. On 6 November 2020, Robert attended an online meeting with Relationships Australia's LINCS program. He was mandated to attend this program as part of his CCO. The program commenced at about 9.45am and was scheduled to finish at about 3.00pm.

36. During the morning, while Robert was attending the LINCS program, Jessica walked from their home to the local 7-Eleven service station on the corner of Heatherton and Power Roads in Endeavour Hills. Jessica regularly attended this 7-Eleven to purchase items and beg for money, food or petrol, sometimes multiple times per day. She left home at 11.19am and arrived at the 7-Eleven at 11.28am.

37. Jessica entered the store, made a coffee from the self-serve coffee machine, and selected a sandwich. While in the store, she loitered for some time, took a 'selfie' with her phone, then paid for her items. She continued loitering in the store and appeared to be behaving strangely, so the store owner called 000. The store owner knew Jessica well, as they had seen and interacted with her for many years at the store.

38. From 11.31am to 11.35am, while inside the 7-Eleven, Robert attempted to call Jessica eight times, however she rejected every call. Robert sent text messages to Jessica asking her to call him. As Robert was participating in the LINCS program at the time, he asked the facilitator if he could take a break. The break was granted, and Robert drove to the 7-Eleven.

39. When Robert arrived at the 7-Eleven, he appeared to be frustrated and angry with Jessica. He called her over to him and stated that he risked going to jail if she did not hurry. Jessica walked over to Robert and showed him a $5 note in her hand. He snatched the note off her and used it to purchase a sandwich. Robert then rushed back to his car; however, Jessica did not immediately follow him; instead, she returned inside the store. She appeared to be distressed and told witnesses in the store that she was scared.

40. Robert followed Jessica back inside the store, where they hugged, and he knocked the hat Jessica was wearing off her head. He yelled at her, then left the store, leaving Jessica visibly upset. Jessica yelled and cried at the counter for about a minute, before Robert re-entered the store and hugged her again. Robert insisted that they needed to leave and partially carried her out of the store. The pair left together in Robert's vehicle and returned home at 11.46am.

41. After returning home, Robert recommenced his LINCS program. Throughout the early afternoon, while Robert was on his videoconference, Jessica sent several nonsensical text messages to a non-existent mobile number. She sent six messages from 12.23pm to 12.28pm and a further three messages from 2.37pm to 2.49pm. The message at 2.49pm was the last known communication from Jessica.

42. Robert finished his LINCS program at about 2.40pm. The events that occurred after 2.40pm are not entirely known, with Robert providing differing versions of events to police.

43. In his first record of interview, Robert stated that he was asleep from 3.00pm to 5.00pm. However, Robert's phone records demonstrated that he attempted to call his father numerous times, commencing at 2.43pm. Robert was captured on CCTV walking out the front of his house at 5.16pm, walking to his vehicle which was parked on the street, opening the door, and sitting inside the car. After sitting in his car for about two minutes, Robert walked back inside.

44. Robert reappeared on CCTV at 5.24pm when he attended his neighbour's home. He walked up to the front door and knocked, waited about 30 seconds, then walked back towards his home. He walked over to his car, leaned on the driver's side door and remained there for a further minute and a half, before walking back towards his house.

45. Over the course of that afternoon and early evening, Robert made 31 calls to his father, David, between 2.43pm and 6.38pm and sent three text messages to David (5.42pm, 5.52pm, and 6.21pm). Robet received two incoming calls from his father at 6.32pm and 6.36pm, and one incoming text message at 5.51pm. During a phone call with David at 5.33pm, Robert asked his father to place an order for pizza at the nearby Dominos in Endeavour Hills.

46. Robert left home in his car at 5.55pm and drove to the Endeavour Hills Shopping Centre where he purchased a drink and then collected the two pizzas from Dominos. Robert returned home at 6.08pm. Robert was home for about nine minutes before he placed a call to David at 6.17pm. Robert called David, received a call from David, or sent a text message to David 19 times from 6.17pm to 6.38pm. During this time, Robert also called his mother.

47. Robert told his parents that he came home after collecting the pizza and found Jessica unresponsive on the floor. During the phone call with his mother, Petra, at 6.27pm, she instructed him to hang up and call for an ambulance. David also told Robert to hang up and call an ambulance during their first call and subsequent phone calls.

48. Robert eventually called 000 at 6.41pm and requested an ambulance for Jessica. He told the 000-operator that when he came home, he found Jessica unconscious on the bed. The 000-operator instructed Robert to remove Jessica from the bed and commence cardiopulmonary resuscitation (**CPR**). David arrived at the scene at 6.46pm, followed by paramedics two minutes later. Paramedics confirmed that Jessica was deceased. They also observed visible injuries to Jessica, so they called police, who established a crime scene.

49. Police spoke to Robert at the scene, who originally stated that when he left home to get the pizza, Jessica was in the bathroom, talking to someone who was not there, and she reported feeling dizzy. When he returned home, he located Jessica lying face-down, trying to say something, and she still had a pulse. He tried to move her onto the bed to resuscitate her, then called 000.

50. Robert was transported to the local police station where he was cautioned, photographed, and his clothing and personal effects were seized. In this first interview, Robert denied all involvement in or knowledge of Jessica's death. He noted that Jessica had mental health and substance abuse issues and had self-harmed in the past. Robert was released from custody pending further investigations.

51. Police reviewed the CCTV footage of the 7-Eleven from Jessica's attendance on 6 November 2020. In that footage, she did not have bruising to her right eye, did not have a large open wound to her right eye, did not have lacerations to her lips, did not have bruising to her right hand, left eye, chin or face, did not have four lacerations to the back of her head, and appeared to have relatively free movement of her legs and arms. The fractures to her right superior glenoid, base of the right first metacarpal, lumbar transverse process and left medial femoral condyle were all not present. Dr Iles opined that these injuries must have been sustained sometime after Jessica's attendance at the 7-Eleven.

52. Police interviewed Robert for a second time in October 2021. He again stated he did not have any involvement with Jessica's death and that there was never any violence in their relationship. He reported that she self-inflicted some injuries but could not explain how Jessica sustained some of the other injuries located during the post-mortem. Robert was eventually

arrested on 5 April 2022 in Queensland and was extradited back to Victoria. Robert was charged with Jessica's murder and later pleaded guilty to her manslaughter. He was sentenced to 15 and a half years' imprisonment, with a non-parole period of 11 years.

FURTHER INVESTIGATIONS AND CPU REVIEW

53. As Jessica's death occurred in circumstances of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[3]

54. I make observations concerning service engagement with Jessica as they arise from the coronial investigation into her death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and Jessica's death.

55. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour, and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[4] I make observations about services that had contact with Jessica to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Contact with Victoria Police

56. Between March 2018 and November 2020, there were 53 events logged by the Emergency Services Telecommunications Authority (**ESTA**) in relation to Jessica. These included:

    a) Eight events from 16 August 2019 to 31 August 2019 requesting a welfare check on Jessica or reporting her as a missing person. Seven of these events were generated by a police member due to an unserved Community Treatment Order (**CTO**).

    b) Two events related to an incident of family violence on 13 September 2019.

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[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.

[4] *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

c) Seven events from 30 September 2019 to 6 November 2020 relating to Robert's breach of the Family Violence Intervention Order (**FVIO**) or reporting an assault by Robert.

d) 36 events from 3 May 2019 to 6 November 2020 relating to public order, with a large portion of these events being reported by 7-Eleven employees due to Jessica begging on the premises or being there in breach of a banning notice.

Family violence incident on 13 September 2019

57. On 13 September 2019, Robert allegedly verbally abused and assaulted Jessica by repeatedly hitting her with a hammer, causing a significant laceration to her skull. After the assault, Jessica left the address and attended a neighbour's home where emergency services were called. Police and paramedics attended and spoke to Jessica, who disclosed that Robert had allegedly caused the injuries and that he had previously assaulted her.

58. Paramedics conveyed Jessica to hospital where she provided a statement, recounting the events that had occurred. She also disclosed that Robert had been violent towards her in the past, she wanted to end their relationship and that she was "*very scared of him*". Robert attended hospital to visit Jessica, and police observed that he had blood on his hand. He was arrested and served with a Family Violence Safety Notice (**FVSN**) in protection of Jessica. Both parties were referred to relevant family violence support services.

59. During his interview, Robert denied assaulting Jessica and stated that Jessica had a history of self-harm, including hitting herself in the head with objects. Police canvassed witnesses in the area but were unable to find any witnesses for same. The brief of evidence against Robert was not authorised for prosecution, as it was deemed there was no reasonable prospect of conviction.

60. An FVIO was issued against Robert on 16 September 2019 with full conditions and was served on Robert on 20 September 2019. Jessica later applied to have the order revoked, and on 9 January 2020, the order was varied to a limited order.

Police response to other family violence incidents

61. Of the seven reports made to police regarding family violence, at the time of Jessica's death, police were only aware of her involvement in five of those reports. The other two instances were able to be linked to Jessica after her passing. The following is a summary of those events where police had contemporaneous knowledge of Jessica's involvement:

a) 1 October 2019 – two calls were placed by Dandenong Hospital stating that Jessica had attended with injuries to her face and had left before being seen. Staff reported concerns for Jessica's welfare due to historical family violence. Police attended Jessica's home, tried to call her and tried to call a friend of hers, however, were unsuccessful. No further action was taken in response to this event.

b) 10 December 2019 – Corrections Victoria requested a welfare check on Jessica and reported that Robert had contravened the FVIO against him. Police attended Robert and Jessica's home and attempted to call Jessica, however, were unable to speak to her. Police advised Corrections Victoria of same and were advised by police that they were meeting with Robert later in the week to discuss the matter. No further action was taken in response to this event.

c) 19 January 2020 – Robert and Jessica's neighbour called 000 to advise that Robert allegedly assaulted Jessica. Police attended their home and attempted to contact Jessica without success. They attended the house again twice on 20 January 2020 and again could not locate Jessica. They were later able to speak to Jessica via phone, however she denied that any violence had occurred, and she only had an argument with her neighbour about cigarettes. No further action was taken in relation to this incident.

d) 15 May 2020 – An anonymous caller reported seeing Jessica begging for food and advised that she had bruises to her body. Police attended Jessica's home and made three unsuccessful attempts to contact her via phone. Jessica called police that day and advised that she was well and living in Rowville. No further action was taken.

Family violence related death service delivery review

62. Following Jessica's death, Victoria Police completed a Family Violence Related Death Service Delivery Review (**FV-SDR**). The FV-SDR identified several areas of concern regarding the police management of Jessica and Robert prior to the fatal incident. I note that the FV-SDR is a desktop review and is completed in a vacuum absent of the ordinary pressures and competing priorities facing members when responding to a family violence incident, and therefore the findings should be considered within that context. In relation to the 13 September 2019 assault, the FV-SDR found that:

a) Some evidence was not gathered by informants which may have impacted on the decision not to authorise the brief of evidence.

b) There was information to suggest that it may have been appropriate for this case to be overseen by the Family Violence Investigation Unit (**FVIU**).

c) Inadequate and inaccurate information was provided in the brief of evidence, including insinuations of victim credibility.

d) Information contained within the brief of evidence appears to have pursued a non-authorisation outcome.

e) Victoria Police prosecutors did not adequately provide evidence to the court indicating Jessica's risk during the FVIO variation hearing on 9 January 2020.

63. In relation to the further reports of family violence, the FV-SDR found that:

a) Most of these events occurred while the full FVIO was in place and did not attract a family violence review.

b) Police members did not submit family violence reports as required.

c) Police members did not undertake rigorous investigations or use entry powers to enter the residence to ensure Jessica's welfare.

d) Opportunities to locate and prosecute Robert for contravention of the FVIO were not pursued.

e) The family violence incidents were treated in isolation and the responses were siloed, with no mechanism to link these incidents together.

f) A large portion of members in the area had not completed family violence training at the time of the fatal incident.

64. In response to the findings of the FV-SDR, several recommendations were made:

a) Amendments to policies and procedures aimed at improving the quality of briefs of evidence for family violence matters. Victoria Police advised that the intent of this recommendation is being addressed through a holistic review and development of the Family Violence Liaison Officer (**FVLO**) and Family Violence Court Liaison Officer

(**FVCLO**) roles and responsibilities. A comprehensive examination of the Family Violence Response Model is also underway which includes an examination of the role, responsibilities and capabilities of FVCLOs/FVLOs.

b) Amendments to practice guidelines aimed at ensuring that relevant supervising personnel have adequate family violence training. Victoria Police advised that the intent of this recommendation is being implemented via the approached outlined for the first recommendation (above).

c) Training for FVLOs aimed at enhancing police responses to family violence. Victoria Police advised that a training needs analysis for the FVLO role has been jointly completed between Victoria Police and Monash University. As a result, the training needs will be addressed and incorporated into the FVLO training package, which is in production and due for endorsement in 2025.

d) The development of a mechanism which allows ESTA to identify to repeat reporting trends so that Victoria Police may target a response. Victoria Police advised that an analytical tool has been developed to identify trends in ESTA reports. However, it is unclear whether this tool has been implemented.

e) Amendments to policies and procedures aimed at encouraging greater consideration of victim risk in applications to vary or revoke a FVIO. This intent of this recommendation is being implemented via the same piece of work referred to in the first two recommendations (above).

65. I note the findings and recommendations of the FV-SDR, and I agree with same. However, the deficiencies in the police response cannot be understated. By not investigating Robert's alleged FVIO breaches, there were missed opportunities to hold him to account for his offending and intervene in his relationship with Jessica. Due to Jessica's isolation, Victoria Police were the only agency that were involved with Jessica and Robert, and therefore was the only agency who could potentially intervene. This is not to say that Jessica's death was preventable, if the Victoria Police response was different, however I am of the view that there were missed opportunities to intervene.

66. I also note a possible reliance on Jessica's mental illness in Victoria Police's decision-making. The brief of evidence in relation to the 13 September 2019 incident was non-authorised, citing (amongst other issues) that Jessica had "*major credibility issues*". There also appeared to be

reliance upon Robert's account that Jessica had a history of self-harm, including hitting herself on the head with rocks to cause injury.

67. Police guidance in place at the time of this incident acknowledged mental illness as a known risk factor for family violence and recognised that mental illness can be triggered or exacerbated by family violence. The reliance on Jessica's mental illness would appear to be contrary to police guidance in place at the time.

68. It is well established that victims of crime are often measured against an idealised standard of victimhood, typically to the detriment of those who are seen to depart in significant ways from notions of the ideal.[5] Women who are victims of family violence often "*encounter conditional help*"[6] which disadvantages many women, especially those who fight back, have a criminal history, abuse alcohol or other drugs, or are seen as less than ideal parents.[7]

69. Police responses to violence directly impacts on a victim-survivor's trust of police and their capacity to protect their safety. These policing responses can increase a victim's level of fear and hesitation in reporting experiences of violence in the future, having an impact on their capacity to access support and manage their safety. Poor responses to family violence also provides messaging to victims and the community in general that violence is acceptable. It may also embolden perpetrators to continue perpetrating violence, believing that they are righteous in their use of violence and that their victims will not be believed. It is therefore imperative that police and family violence services provide a tailored and trauma-informed response to all victim-survivors.

70. In response to correspondence from the Court to Victoria Police, Victoria Police advised that it did not wish to respond to the proposed comments above. Victoria Police reiterated its ongoing work to improve its responses to family violence, including the partnership with Monash University. Given Victoria Police's ongoing work in this space, I am satisfied that I do not need to make a further recommendation with respect to this particular issue.

Opportunities to improve police responses to family violence

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5 Julie Stubbs and Jane Wangmann, 'Competing conceptions of victims of domestic violence within legal processes' in D Wilson and S Ross (eds) Crime, victims and policy (Palgrave Macmillan,2015).

6 Sally Merry, 'Rights Talk and the Experience of Law: Implementing Women's Human Rights to Protection from Violence' (2003) 25(2) *Human Rights Quarterly*, 353.

7 Ibid.

71. Co-responder programs involve the presence of a family violence specialist worker during police attendance at family violence incidents to provide a collaborative response. Research has identified key benefits to co-responder programs, including higher satisfaction of victims with police, increased willingness of victims to contact police in future, more information sharing and coordination of services for victims, greater understanding of family violence by police, and a perceived increase in the accountability taken by police in responding to family violence. Further, co-responder programs are a popular option for reducing rates of misidentification of the predominant aggressor amongst researchers, police, and people with lived experience of family violence.[8] Multiple agencies, including ANROWS, Family Safety Victoria, and Victoria Police have opined that co-response models have the potential to reduce the rates of misidentification of the predominant aggressor.

72. The Alexis Family Violence Response Model is a co-responder model which operates across Prahran, Bayside and Sommerville Family Violence Units. Evaluations of the program have found many positive effects, including a reduction in family violence recidivism by 85%,[9] increased reporting,[10] and the transfer of skills and knowledge between police and specialist family violence workers.[11]

73. Workforce capacity and funding are noted to be the most significant barriers to the implementation of co-responder models in Victoria, given that these programs are considered to be relatively resource intensive. However, I am not of the view that these barriers are insurmountable. The diversion of resourcing and fundings from the current referral pathways into co-responder programs may effectively engage more victim-survivors, whilst also reducing police misidentification of the predominant aggressor and introducing all of the benefits discussed above.

74. I cannot determine that the existence of a co-responder model would have improved Jessica's engagement, however given her isolation and degree of vulnerability, a police response guided by a specialist family violence worker may have assisted engagement and may have offered Jessica an alternative option for safety and support.

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[8] Nancarrow, H., Thomas, K., Ringland, V., & Modini, T. (2020). Accurately identifying the "person most in need of protection" in domestic and family violence law (No. ANROWS Research Report 23) 21, 96.

[9] Dr Lisa Harris, Dr Anastasia Powell and Dr Gemma Hamilton, Alexis – Family Violence Response Model (Evaluation Report, 2017) 28.

[10] Hamilton, G., Harris, L., & Powell, A., 'Policing Repeat and High-Risk Family Violence: Police and Service-Sector Perceptions of a Coordinated Model' (2021) 22(3) Police Practice and Research, 145.

[11] Ibid, 145-152.

75. I noted the potential benefits of a co-responder model in my finding into the death of Carolyn James and made the following recommendation in my finding into the passing of Noeline Dalzell:

> *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.*[12]

76. In response to the above recommendation, Victoria Police advised that it consulted with DFFH (the department with oversight of The Orange Door) and explained that Victoria Police would work with DFFH to consider the options and to identify funding for such pilots. Victoria Police advised that it was unable to fund this recommendation and the implementation of any such pilot would require Victorian Government funding decisions. DFFH provided a similar response, noting that it required funding to implement same. Given that DFFH and Victoria Police are not opposed to this recommendation, however, are unable to fund same, I intend to make a recommendation to the relevant minister that funding should be made available to pilot to embed an advanced family violence practitioner within a FVIU.

Victoria Police response to non-family violence incidents

77. As noted above, police received 36 public order reports related to Jesssica from 3 May 2019 to the time of her death. Most of these incidents were in relation to Jessica begging and she usually left the scene prior to police arrival. In the instance where police *did* engage with Jessica, they advised her not to return and told the complainant to contact police if she did. These public order reports were reported to police in between report of suspected family violence and concerns for Jessica's welfare. It appears that each incident was considered individually, rather than considering the reasons why Jessica was begging, and the underlying issues she was facing. This is not a criticism of Victoria Police as they were compliant with

[12] Coronial Finding into the passing of Noeline Dalzell COR 2020 0670.

their own policies in relation to begging; rather it is an observation of the way begging is responded to by society.

78. In the evidence available to the Court, it appears that Robert forced Jessica to beg for food, cigarettes and money as an act of family violence, as she advised her neighbours that Robert would "*beat her up*" if she did not return with what he wanted (food, cigarettes). Jessica's Centrelink payments were being diverted into Robert's bank account, which suggests that she may have also been begging as she was unable to provide for herself.

Begging as a criminal offence

79. In Victoria, begging is a criminal offence under the *Summary Offences Act 1966* (Vic) and can attract a fine or a sentence of up to 12 months' imprisonment. This is despite research that demonstrates that begging is widely recognised as a symptom of poverty that often intersects with a range of other issues.[13] In a 2018 survey of people charged with begging offences in Victoria, researchers found that 87% had a mental illness, 77% were experiencing drug or alcohol dependence, and 33% had experienced family violence. Legal and community support organisations have called on the Victorian Government for legislative reform to decriminalise begging in recognition that such acts are most often in direct response to financial hardship and poverty.[14]

80. Moral issues aside, there appears to be limited evidence to support criminalisation of begging, as police and court resources are usually directed towards a law-and-order approach, rather than addressing the underlying drivers. From 1 July 2020 to 30 June 2023, 167 charges for begging or gathering alms were sentenced in Victoria.[15] In 60.5% of these cases, the charges were either dismissed or discharged. These numbers obviously do not capture individuals such as Jessica who leave the area before police are able to apprehend them.

81. Victoria Police have demonstrated an appetite to consider alternative approaches to begging and previously established a protocol with the City of Melbourne to encourage members to

[13] See, eg, Michael Horn and Michelle Cooke, *A Question of Begging: A study of the extent and nature of begging in the City of Melbourne* (Hanover Welfare Services, June 2001); Philip Lynch, *Begging for Change: Homelessness and the Law* [2002] Melbourne University Law Review 35; Philip Lynch, *Understanding and Responding to Begging* [2005] Melbourne University Law Review 16; PILCH Homeless Persons' Legal Clinic, *We Want Change: Public Policy Responses to Begging in Melbourne* (June 2005); PILCH Homeless Persons' Legal Clinic, *We Want Change! Calling for the abolition of the criminal offence of begging* (November 2010); City of Melbourne, Begging Engagement Pathways and Support Program Evaluation Report (June 2015). Justice Connect Homeless Law, *Asking for Change: Calling for a more effective response to begging in Victoria* [2018].

[14] Ibid.

[15] Sentencing Advisory Council, 'Beg or gather alms', https://www.sentencingcouncil.vic.gov.au/sacstat/magistrates-court/7405-49a-1-beg-or-gather-alms-mc.html#:~:text=Charge%20data,count%20of%20a%20sentenced%20offence.

use discretion when issuing public order offences relating to homelessness.[16] As part of this protocol, the City of Melbourne committed to connecting homeless people with support services.[17] I welcome this change, however I note that this only applies to people begging in the City of Melbourne. Furthermore, this protocol may have been overshadowed by a recent move to use private security guards to respond to begging and public order offences.[18] It also relies on the use of police discretion and the capacity of members to liaise with support services.

82. As argued by legal and community advocacy networks, criminal responses to symptoms of poverty fail to address the root cause and instead criminalises people's attempt to care for themselves and access shelter, food and water. This further marginalises people who are already significantly isolated from mainstream society. Criminalisation may also increase a person's mistrust or fear of police and services and therefore limit a person's willingness to engage with community or support services, further impeding their access to safety.

83. A community-based response to Jessica's begging (rather than the threat of criminalisation) may have promoted positive engagement and fostered greater interpersonal connection, which can be a significant protective factor against violence and the negative impacts of violence.[19] Instead of being afraid of getting in trouble from police, Jessica could have received referrals to get assistance with housing, substance use, mental/physical health and family violence.

84. Given the rates of family violence among people who beg, and marginalisation of these populations in our community, it is critical to divert resources away from further criminalising people who beg and seek alms and invest in opportunities to provide support and safety. I therefore intend to recommend that the Victorian Government work with Victoria Police to develop welfare-oriented approaches to responding to people who beg.

Service contact with WAYSS

[16] Parliament of Victoria, Legislative Council Legal and Social Issues Committee, 'Inquiry into homelessness in Victoria: Final report' (2021), https://www.parliament.vic.gov.au/4af5e8/contentassets/0c6d61c7d86d4971bf50c2573cb534b2/inquiry-into-homelessness-in-victoria---final-report.pdf, 190.

[17] Ibid.

[18] The Age, 'Nick Reece spruiked a crack squad to clean up the CBD. So far, it's two security guards', Cara Walters (31 January 2025).

[19] Plazaola-Castaño, Juncal & Ruiz-Pérez, Isabel & Montero, Isabel. (2008). 'The protective role of social support and intimate partner violence'. Gaceta sanitaria / S.E.S.P.A.S. 22. 527-33; Centre for Disease Control, 'Intimate Partner Violence Prevention: Risk and Protective Factors' (2024), https://www.cdc.gov/intimate-partner-violence/risk-factors/index.html; Family Safety Victoria, 'Multi Agency Risk Assessment and Management Framework – Practice Guides: Responsibility 7: Comprehensive Risk Assessment', .

85. Following the 13 September 2019 incident of family violence, Jessica was referred to WAYSS specialist family violence service. Upon receipt of the referral, WAYSS contacted Victoria Police to request a welfare check on Jessica. During their engagement with police, WAYSS were advised that Jessica did not have a mobile phone or other means of contact. WAYSS coordinated with Victoria Police to arrange to have a phone delivered to Jessica. On 2 October 2019, Jessica contacted WAYSS and advised them that she had relocated to Queensland and no longer required support.

86. It appears that WAYSS appropriately assessed Jessica's risk, took proactive steps to contact her and advocated with police to provide her with support. I am satisfied that there are no prevention opportunities arising from Jessica's contact with WAYSS and I commend them for their comprehensive and proactive work with Jessica.

Contact with Community Correctional Services

87. As noted above, Robert was sentenced to a 12-month CCO, commencing on 22 March 2018. He was non-compliant with the conditions of this order and contravention proceedings were initiated. In discussions with Community Correctional Services (**CCS**), Robert advised that he struggled to comply with his CCO as his partner was "*clingy and suffering mental health concerns*" but otherwise reported his relationship to be stable. He was offered another opportunity to comply with his CCO beginning in November 2019.

88. On 21 November 2019, Robert's supervising officer was advised that Robert had attended court for his CCO in the presence of Jessica, despite there being an FVIO in place to protect her. Robert attended an introductory supervision session with CCS and listed Jessica as his emergency contact, despite the full, no contact FVIO in place at the time. There was no recorded discussion about the FVIO or the breach on this occasion.

89. Robert attended his second supervisory session with CCS on 10 December 2019, where the FVIO was discussed with him. Robert explained that he was not responsible for the injuries that had led to police applying for the FVIO and disclosed that he was residing with Jessica in breach of the FVIO. When Robert was advised that this was a breach of the FVIO and would be reported to police, Robert became upset and noted that he would become homeless if he could not stay with Jessica. CCS offered one night's paid accommodation, which he declined.

90. CCS reported the breach to Victoria Police on 11 December 2019 and requested they perform a welfare check on Jessica. Police later advised that they attended the address but there was no answer. CCS recorded "*no further follow-up [was] to be completed at this stage*".

91. Robert initially disengaged with CCS after this appointment, however returned on 7 January 2020. He explained that he was annoyed after his last appointment and that he disengaged due to a fear that police would attend CCS. CCS commended Robert for reengaging.

92. CCS asked about Robert's relationship with Jessica on one further occasion but noted that he was vague in his response and reported that the relationship was stable.

CCS management of family violence risk

93. CCS undertook a review of their management of Robert's CCO in August 2022. The review concluded that CCS staff initially failed to address the breach of the FVIO, and that staff did not investigate Robert's use of violence after discussions with police on 11 December 2019. It also found that required risk assessment tools were not completed and that offender risk management strategies did not consider Robert's use of family violence or his breach of the FVIO.

94. The review also outlined the work that has been undertaken since this time and advised that an action plan had been drafted to address staff use of perpetrator assessment tools. It was further noted that MARAM training for staff was in development and a recommendation was made to address practice issues unrelated to family violence.

95. I agree with the findings of this review, and I am similarly of the view that CCS did not sufficiently utilise their position to monitor Robert's risk to Jessica. I also note that his CCO contravention report (prepared 28 April 2021) did not mention that Robert was subject to an FVIO or that he breached the FVIO.

96. I note that several practice and logistical reforms have been initiated and implemented in the years that have elapsed since Jessica's passing. As noted in the inquest into the passing of Noeline Dalzell, CSS have been provided with conditional approval by the Department of Families, Fairness and Housing (**DFFH**) to allow CCS practitioners access to the L17 portal.[20] This will enable staff to gain greater information regarding a respondent or victim's history

[20] Finding following inquest into the passing of Noeline Dalzell COR 2020 0670, 36-37.

of family violence, assessed level of risk, the circumstances of violence and the support service that the party was referred to.

97. CCS also advised that upgrades to the department's IT systems are currently under development, with the aim of establishing a single point of reference for family violence information that will be updated in real time. Furthermore, CCS released practice guidelines to support practitioners working with victims and perpetrators of family violence alongside MARAM training for staff on managing adults using violence, scheduled for implementation this year. CCS also established a Family Violence Practice Committee to inform and strengthen their management of adults using and affected by violence and has arranged regular out-posting of The Orange Door staff in CCS offices within the Bayside area.

98. As discussed in my finding into the passing of Noelene Dalzell, since 2022, CSS have employed Family Violence Practice Leads to support staff and the organisation to align with MARAM and respond to those affected by or using violence.

99. Given the changes that have occurred in this space, I am satisfied that I do not need to make any further recommendations.

CCS management of non-compliance

100. The CCS review found that Robert consistently failed to comply with the conditions of his CCO by sporadically attending supervision and failing to attend program appointments. While these absences were discussed with Robert during supervision, contravention proceedings were not initiated until February 2021, after Jessica's death.

101. Delayed contravention proceedings have been a feature of several cases reviewed by the VSRFVD. Current practice guidance to CCS practitioners suggests that non-compliance should be addressed by applying the least interventionist measure possible, for example, by starting with a caution and escalating to contravention proceedings as required.

102. However, contravention proceedings can be considered immediately if the offender absconds, if the CCO conditions will not be completed before it expires, if further offending has occurred, or if the risk to the community becomes too high. In my finding into the death of Joshua Tovey I recommended that CCS update policies to assist practitioners to assess when contravention proceedings should be initiated. I suggested that these policies should provide greater clarity to assist a case manager in determining when a risk to the community has

become too high.[21] In response to this finding, the Department of Justice and Community Safety committed to reviewing practice guidance issued to CCS in accordance with the MARAM framework.

103. Given CCS' commitment to these changes, I am satisfied that further recommendations are not required.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Jessica Geddes, born 3 January 1993;

b) the death occurred on 6 November 2020 at 27 Haverstock Hill Close, Endeavour Hills, Victoria, 3802, from *1(a) complications of multiple blunt force injuries*; and

c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

(i) That **Victoria Police** develop welfare-oriented approaches to people who beg. In doing so, I recommend that the Victorian Government consider investing in a co-responder model which would see police members partner with community welfare practitioners when responding to reports of begging. I also recommend that **Victoria Police** develop a protocol/practice guideline to dissuade members from using a criminal response to people who beg and that encourages members to inquire as to the persons' needs and safety and offer referrals to welfare services.

(ii) That **Victoria Police** and **Department of Families, Fairness and Housing** provide funding to implement Recommendation 5 in my Finding into the passing of Noeline Dalzell, as follows:

> *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*

[21] Finding into the passing of Joshua Tovey COR 2021 0345, 11.

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.

I convey my sincere condolences to Jessica'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:

Saasha Hughes, Senior Next of Kin

Bevan Geddes, Senior Next of Kin

Department of Families, Fairness and Housing

Department of Justice and Community Safety

The Hon. Natalie Hutchins MP, Minister for Prevention of Family Violence

The Orange Door

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

WAYSS

Detective Senior Constable Telen Stanfield, Coronial Investigator

Signature:

Judge John Cain
State Coroner
Date: 24 June 2025

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