IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 007005

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Ms HRZ
Date of birth:	[redacted]
Date of death:	25 December 2020
Cause of death:	1a: NECK COMPRESSION 1b: HANGING
Place of death:	Melbourne, Victoria
Keywords:	Family violence; sexual abuse; physical abuse; culturally and linguistically diverse persons; human rights; Convention on the Elimination of All Forms of Discrimination Against Women

INTRODUCTION

1. On 25 December 2020, Ms HRZ was 48 years old when she died in circumstances consistent with suicide. Ms HRZ was born in Turkey and moved to Australia with her husband in about 1993. She is survived by her daughter and son, who were aged 23 and 16, respectively, at the time of her passing. Ms HRZ was described by her daughter, Ms YBH, as "*an amazing mum*" and was "*like [her] best friend*".

Background

2. Ms HRZ reportedly experienced significant physical and verbal violence in her marriage. This led to the breakdown of her marriage, with Ms HRZ and her husband separating in early 2015. Ms HRZ experienced symptoms of depression and anxiety due to the abuse, for which she received mental health support. Ms HRZ expressed concern that the Turkish community might judge her for her divorce.

3. In about 2016, Ms HRZ met a (then) 68-year-old married man named Mr IPK while picking fruit from his garden. There is conflicting evidence regarding the nature of the relationship between Ms HRZ and Mr IPK. In Victoria Police records, Mr IPK was referred to as an intimate partner, whilst in other records, Ms HRZ indicated that she did not regard him in this way and only engaged with him due to his coercive behaviour and threats to shame her.

4. After meeting Mr IPK, evidence available to the Court suggests that Mr IPK coerced Ms HRZ into having regular contact with him and reportedly perpetrated abuse towards her including sexual coercion, sexual assault, psychological abuse, stalking, threats to kill, physical abuse including strangulation, drugging and filming her naked without consent and then using this material to blackmail and coerce her. Mr IPK allegedly threatened to shame Ms HRZ in the Turkish community for attending his house alone and having a sexual relationship with her, in order to further coerce her to continue to visit him. Ms HRZ found this behaviour extremely distressing.

5. Due to the COVID-19 restrictions implemented in early 2020 in Victoria, Ms HRZ had less contact with Mr IPK. It appears that in the latter part of 2020, Ms HRZ was trying to separate from and escape Mr IPK.

THE CORONIAL INVESTIGATION

6. Ms HRZ'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 an officer to be the Coronial Investigator for the investigation of Ms HRZ's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. Then-Coroner Katherine Lorenz initially held carriage of this investigation until it came under my purview on 19 October 2023 for the purposes of finalising the investigation and handing down findings.

11. This finding draws on the totality of the coronial investigation into the death of Ms HRZ 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]

[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.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Police interaction in October 2020

12. On 14 October 2020, Mr IPK attended his local police station to make a report that his ex-partner, Ms HRZ, was trying to blackmail him. Initially, he reported that he had given her money and gifts, and had become "*suspicious of other males*" in her life, and that as a result, he "*would follow her to shopping centres*". While making his report, Mr IPK's narrative reflected that he had been exhibiting "*controlling behaviours*" towards Ms HRZ and did not initially report "*any criminal offences or untoward behaviour*" by Ms HRZ, with police noting that it "*sounded as though they had a break down in their relationship and he had spent money buying her gifts*". At this point, Mr IPK's story changed, and he reported that each time he gave Ms HRZ a gift or money, she would "*say if he didn't continue she would tell his wife and children*" about their relationship. Police documented that they did not hold any concerns for Mr IPK's welfare or safety, however Mr IPK stated that he was "*afraid [Ms HRZ] will tell [his wife] of their affair"*.

13. Police commenced a criminal investigation into Mr IPK's allegations of blackmail and completed a family violence risk assessment (**FVR L17**), which listed Ms HRZ as the respondent and Mr IPK as the affected family member (**AFM**). This triggered specialist family violence referrals for both parties on that basis. Police did not seek a Family Violence Intervention Order (**FVIO**) in protection of Mr IPK.

14. Ms HRZ attended the police station on 16 October 2020 where she was arrested and interviewed in relation to Mr IPK's allegation of blackmail. She denied the allegations and disclosed significant abuse allegedly perpetrated by Mr IPK towards her. Police completed another FVR L17, this time recording Ms HRZ as the AFM and Mr IPK as the respondent. Police also applied for an FVIO in protection of Ms HRZ, against Mr IPK. An interim FVIO was granted in full non-contact conditions and was served on Mr IPK on 21 October 2020. The uniform police members initially handling the investigation transferred it to the Sexual Offences and Child Abuse Investigation Team (**SOCIT**) for further investigation. Ms HRZ made a statement to police over three appointments in October and November 2020 in which she outlined the abuse she suffered. This process was reportedly extremely distressing for Ms HRZ.

15. As a result of the second FVR L17, new referrals to specialist family violence services were generated. Mr IPK's referral to DPV Health was closed without contact as police had not

discussed the referral with him. Ms HRZ was referred to Berry Street, a family violence crisis and support service. A Berry Street staff member attempted to call her on 22 October 2020. Ms HRZ was unable to speak to Berry Street at the time, as she was meeting with police when they called. Berry Street sent a text message to Ms HRZ, inviting her to call back, however she did not return the call and Berry Street closed its referral.

Deterioration in mental health

16. After making a statement to police in relation to her experience of sexual and other violence, Ms HRZ's mental health deteriorated rapidly, and she experienced significant guilt, shame, and anxiety which she was "*unable to contain*". She reportedly became paranoid and believed that Mr IPK had told the Turkish community about their 'relationship'. She regularly appeared distressed, she started smoking cigarettes and drinking coffee constantly, her appetite was reduced and she struggled to sleep.

17. Ms HRZ presented to her general practitioner (**GP**) on 20 October 2020 and completed a mental health care plan (**MHCP**) for a referral to a psychologist whom she had intermittently seen since 2015. The referral noted that Ms HRZ required support due to being "*a victim of sexual abuse and ransom*". Ms HRZ was distressed while speaking to her GP. She consulted with her psychologist later that day and reported that Mr IPK allegedly told her "*I'll only leave you alone when I die*" and "*I will kill you if you ever leave me then kill myself*".

18. Ms HRZ had a further five appointments with her psychologist, where she spoke at length about the abuse perpetrated against her by Mr IPK. On one occasion, when speaking about her experience, she was so distressed that her psychologist documented that she was "*crying frantically*". The psychologist diagnosed Ms HRZ with an adjustment disorder with mixed anxiety and depressed mood, on a background of "*threats to be shamed in the community*" by Mr IPK.

19. On 27 October 2020, Ms HRZ reportedly contacted a male relative, who was aware of the allegations against Mr IPK. Her relative reportedly told her that she was "*slutting around*", did not need to tell her daughter Ms YBH about the allegations and then hung up the phone. Ms YBH noted that her mother was very distressed after the call, left the house, and called Mr IPK and told him "*I'm going to kill myself and you're the cause of all this*". Ms HRZ was later involved in a minor car accident where she side-swiped another car and rolled to a stop. Ms HRZ was transferred to hospital where she was admitted for one night.

20. In hospital, Ms HRZ was observed to be distressed, however denied that the car accident had been a suicide attempt. She later told her psychologist that she had considered suicide on that evening but had decided against it and the car accident occurred because she was angry and stressed about Mr IPK's abuse. However, Ms YBH noted that when she visited her mother in hospital, she overhead Ms HRZ say, "*I couldn't do it, I will try again*".

21. While in hospital, Ms HRZ saw a social worker and a mental health nurse, disclosed the abuse she had been experiencing and explained that she had started to self-isolate due to fear and shame. She stated that she was "*unable to look people in the eye*", believing that "*they kn[ew] about [her]*" and were judging her. She also reported stress from her ongoing divorce from her husband. The social worker observed Ms HRZ was highly emotional and "*rocked continuously*" and repeatedly stated that she "*will be/is ostracised by the Turkish community*". Hospital staff provided Ms HRZ with information about family violence services, including inTouch, a specialist family violence service for refugee and migrant communities. The social worker also spoke with Ms HRZ's psychologist (with her consent) and confirmed she had an appointment scheduled for 29 October 2020.

22. After her hospital admission, Ms HRZ told Ms YBH that Mr IPK would not leave her alone, would follow her everywhere, and continued to threaten to expose her so that she would *"walk in shame for the rest of her life*".

FVIO cross-application

23. On 28 October 2020, Mr IPK applied to the Magistrates' Court of Victoria for an FVIO against Ms HRZ. He stated that someone had put nails in his car tyres and although he did not see who did this, believed Ms HRZ was responsible. He alleged that she followed him home from the shops, had sent her nephew to his house, had threatened to "*get rid*" of his family, and called him on 27 October 2020 stating that she would kill herself. An interim FVIO in full non-contact conditions was granted for Mr IPK's protection on 28 October 2020 and was served on Ms HRZ the following day.

Events proximate to Ms HRZ's passing

24. Ms HRZ had her final appointment with her psychologist on 21 December 2020. She reported her biggest fear was that the intimate video recordings possessed by Mr IPK would be distributed and shared in the community and she would be shamed by them.

25. On 24 December 2020, Ms HRZ and her son visited their relative's home for a family BBQ. While the family were eating and making jokes, Ms HRZ was quiet, and did not laugh or talk to anyone. Ms HRZ's son thought this behaviour was unusual as she normally liked to laugh and joke around with her family. While at the family gathering, Ms HRZ observed a photo of Mr IPK on the phone of a relative's partner. Ms HRZ grabbed the phone and said (in Turkish) "*you're the reason why I am going through this*", swore at the photo, and gave the phone back to the partner. Ms HRZ's son believed that when she made this comment, she was referring to ending her own life, but did not think anything of this comment at the time.

26. When they left the gathering, Ms HRZ drove two laps around her suburb before going home. Her son did not think this was abnormal as he liked to go for drives with his mother. When they arrived home, Ms HRZ said goodnight to her children in their rooms and told them she was going to sleep. However, Ms HRZ did not go to bed and stayed up all night. Her son saw her in the kitchen at about 3.00am on 25 December 2020, which was unusual behaviour for her.

27. At about midday on 25 December 2020, Ms HRZ was last seen alive by her son when she asked him for the keys to the garage. He gave her the keys, then did not see her for 30-60 minutes. At about 1.30pm, her daughter Ms YBH woke up and heard her mother's phone ringing. By the time she reached the phone in Ms HRZ's bedroom, the phone stopped ringing. Ms YBH noticed that her uncle had called, and there was an envelope full of money and gold jewellery on her mother's bed. Ms YBH called her uncle back, and he asked about Ms HRZ. Ms YBH explained her mother was not there, so she started looking around the house.

28. Ms YBH noticed the car keys were on the hallway table, so she assumed her mother was outside gardening. Ms YBH entered the garage and observed her mother hanging from some fabric that was secured to the garage rafters. She immediately called her uncle, who was nearby, then called 000 for assistance. The uncle assisted Ms YBH to cut the fabric and placed Ms HRZ on the ground.

29. Paramedics attended and confirmed that Ms HRZ had passed away. Police also attended and investigated the scene. Police did not identify any suspicious circumstances or signs of third-party intervention in connection with her death.

Police investigation after Ms HRZ's passing

30. Following Ms HRZ's passing, her nephew stated that he discovered a notebook with notes in Turkish "*describing stuff that had happened to her sexually from Mr IPK*" and included dates and times that Mr IPK followed her. He explained that he provided this notebook to Victoria Police on 27 January 2020.

31. Victoria Police provided copies of the notebook to the Court, which were translated. The diary entries did not contain any information about sexual abuse, or a cohesive narrative of family violence, however, it did include repeated references to blackmail, and a narrative about someone following Ms HRZ on 23 December 2020.

32. Police obtained a search warrant to investigate the report that Mr IPK had recorded Ms HRZ undressed, without her consent or knowledge in January 2021. They seized multiple electronic devices from Mr IPK's home and reviewed the images and videos and images contained therein but were unable to find any that depicted Ms HRZ. There are no police records to suggest that they analysed Mr IPK's text messages or calls for possible breaches of the FVIO or other offences.

33. After searching his address, police interviewed Mr IPK regarding charges of rape, sexual assault, blackmail and possession of a prohibited weapon, after finding a crossbow at his home. He denied all allegations and explained that he had taken a video of Ms HRZ at her request and with her consent, however deleted it the next day. Police advised the Court that they did not identify any other evidence to support the alleged offending and did not prepare a brief of evidence against Mr IPK. There are no findings of guilt against Mr IPK for any of the alleged incidents described by Ms HRZ.

IDENTITY OF THE DECEASED

34. On 25 December 2020, Ms HRZ, born [redacted], was visually identified by her brother-in-law, Mr MLB, who completed a Statement of Identification to this effect.

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

MEDICAL CAUSE OF DEATH

36. Forensic Pathologist Professor Noel Woodford (**Prof Woodford**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 28 December 2020 and provided a written report of his findings dated 15 January 2021.

37. The post-mortem examination revealed no injuries (other than the ligature marks on the neck) of a type likely to have caused or contributed to the death.

38. A post-mortem CT scan showed the presence of gas within the liver. There were no acute changes within the head and the neck skeleton appeared intact.

39. Toxicological analysis of post-mortem samples did not identify the presence of alcohol or other common drugs or poisons.

40. Prof Woodford provided an opinion that the medical cause of death was 1(a) *neck compression* secondary to 1(b) *hanging*.

41. I accept Prof Woodford's opinion.

FURTHER INVESTIGTIONS AND CORONER'S PREVENTION UNIT REVIEW

42. For the purposes of the *Family Violence Protection Act 2008*, the available evidence suggests that Ms HRZ experienced '*family violence*'[2] in the lead up to the fatal incident. In light of this death occurring in connection with circumstances of family violence, it was requested that the Coroners Prevention Unit (**CPU**)[3] examine the circumstances of Ms HRZ's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[4]

43. I make observations concerning service engagement with Ms HRZ 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 Ms HRZ's death.

44. 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*".[5] I make observations about services that had contact

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[2] *Family Violence Protection Act 2008*, section 5.

[3] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

[4] 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.

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

with Ms HRZ to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Systems abuse

45. In the months prior to the fatal incident, Mr IPK took actions that appeared to constitute systems abuse against Ms HRZ, which may have influenced or impacted her suicidal ideation and mental health. Systems abuse is used by perpetrators to "*manipulate actions or decisions of professionals in the system as a method to further coerce and control victim survivors*" to cause further harm.[6]

46. Mr IPK's report to police on 14 October 2020 can be characterised as a form of systems abuse. Police records indicate that police suspected Mr IPK was using the report to perpetrate abuse against Ms HRZ, however she was still labelled as the respondent, and he was recorded as the AFM on the FVR L17. As a result of these allocations, Ms HRZ was referred to specialist family violence services as a perpetrator, rather than as a victim. Although Ms HRZ did not engage with the services, Mr IPK received a victim's information pack in the mail, which may have emboldened him to continue to perpetrate systems and other abuse against Ms HRZ.

47. As a result of Mr IPK's report on 14 October 2020, Ms HRZ was arrested and interviewed by police, despite Mr IPK demonstrating controlling and jealous behaviours and disclosing that he had been following her. Upon being arrested, Ms HRZ made disclosures about Mr IPK's alleged longstanding family violence. It is not known why she chose to make these disclosures at that time; however, it is possible that she felt compelled to do so to protect herself from the possible ramifications of Mr IPK's report to police. The available evidence suggests that Ms HRZ's disclosures caused her significant distress, and her mental health and wellbeing deteriorated rapidly in the weeks and months that followed.

48. By identifying Ms HRZ as the respondent on 14 October 2020, despite Mr IPK's own disclosures and controlling behaviour, it appears that Ms HRZ was misidentified as the predominant aggressor. This was confirmed once Ms HRZ spoke to police and made significant disclosures about ongoing family violence.

49. The term 'predominant aggressor' may be substituted for the term 'primary aggressor' and:

[6] Family Safety Victoria, *MARAM Practice Guides: Foundation Knowledge Guide –Guidance for Professionals Working with Child or Adult Victim Survivors, and Adults Using Family Violence* (February 2021), 125.

seeks to assist in identifying the actual perpetrator in the relationship, by distinguishing their history and pattern of coercion, power and controlling behaviour, from a victim survivor who may have used force for the purpose of self-defence or violent resistance in an incident or series of incidents. The predominant aggressor is the perpetrator who is using violence and coercive control to dominate, intimidate or cause fear in their partner or family member, and for whom, once they have been violent, particularly use of physical or sexual violence, all of their other actions take on the threat of violence.[7]

50. Police misidentification of women as primary aggressors is an ongoing issue in Victoria and other Australian jurisdictions and has serious repercussions for victims.[8] Migrant and refugee women are at an increased risk of being misidentified, with inTouch (a family violence support service for migrant and refugee women and their communities) estimating that this affects as many as one in three of their clients.[9] Misidentification can also lead to specific negative ramifications for migrant and refugee women.[10]

51. Research indicates that when women use violence in heterosexual intimate relationships, the violence tends to be a consequence of their own victimisation and as a violent resistance to a pattern of controlling, coercive and violent behaviour used against them.[11] Therefore, it is important that the primary aggressor is identified on the basis of a pattern of coercive and controlling behaviour, rather than on the basis of an incident-based approach to investigation, which does not take patterns of coercion and control into account.[12]

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[7] Family Safety Victoria, MARAM Practice Guides: Foundation Knowledge Guides (February 2021), 124.

[8] Women's Legal Service Victoria, 'Snapshot of Police Family Violence Intervention Order Applications' (2018) 1; Women's Legal Service Victoria, "*Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family violence incidents in Victoria* (Policy Paper One, July 2018), 1; No To Violence, Predominant Aggressor Identification and Victim Misidentification (Discussion Paper, November 2019), 6; FVRIM, *Monitoring Victoria's family violence reforms Primary prevention system architecture* (Report, 2022) 10-1; Parliament of Victoria Legislative Council, Legal and Social Issues Committee Inquiry into Victoria's Criminal Justice System Volume 1 (March 2022), 243 < lclsic-59-10-vic-criminal-justice-system.pdf (parliament.vic.gov.au)>.

[9] InTouch, Submission 84 to Standing Committee on Social Policy and Legal Affairs, Parliament of Australia, *Inquiry into Family Violence Orders* (August 2024) 12; InTouch, Submission to ALRC, *Inquiry into Justice Responses to Sexual Violence* (June 2024) 10.

[10] InTouch, Submission to ALRC, *Inquiry into Justice Responses to Sexual Violence* (June 2024) 11.

[11] Women's Legal Service Victoria, "*Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family violence incidents in Victoria* (Policy Paper One, July 2018), 2-3; Family Safety Victoria, MARAM Practice Guides, Foundation Knowledge Guide: Guidance for Professionals Working with Child or Adult Victim Survivors, and Adults Using Family Violence (2021) 112.

[12] Heather Nancarrow et al, 'Accurately Identifying the "Person Most in Need of Protection" in Domestic and Family Violence Law' (Research Report Issue 23, ANROWS, November 2020), 27; Women's Legal Service Victoria, *"Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family violence incidents in Victoria* (Policy Paper One, July 2018) 4.

52. One of the key issues that may have influenced the misidentification of the predominant aggressor in this case is the police system which encourages or requires pre-emptive commitment of data to the Law Enforcement Assistance Program (**LEAP**),[13] which may be based on incomplete assessments. In this case, police committed the FVR L17 to LEAP before speaking to Ms HRZ, despite their concerns about Mr IPK's report and the absence of any clear risks or an urgent necessity to commit the FVR L17 report to LEAP. This triggered referrals to specialist family violence services based on an inaccurate and incomplete assessment. After speaking to Mr IPK only, police did not (and could not) have a complete understanding of what was occurring. This is not a criticism of the members involved, as they were complying with Victoria Police guidelines, and were working from the limited information available. However, the system in which these members currently work does not encourage them to be flexible and/or obtain the full story, before committing the data to LEAP.

53. There was nothing particularly urgent about Mr IPK's report such that it required immediate commitment to LEAP, and I note that police spoke with Ms HRZ two days later, where full details of the relationship between the pair became evident. If the FVR L17 report's commitment to LEAP was delayed until after speaking with Ms HRZ, this could have avoided her being misidentified as the predominant aggressor and thus receiving incorrect referrals to specialist family violence services.

54. Victoria Police acknowledged the above concerns, in its correspondence to the Court, and stressed that exploration of the appropriate timing and process of committing information to LEAP is continuing. Since Ms HRZ's passing, Victoria Police has undertaken work to address the issue of police misidentification of the predominant aggressor, with updated and improved guidance on identifying the predominant aggressor in line with the Multi-Agency Risk Assessment and Management (**MARAM**) framework.[14] Victoria Police commenced its 'Predominant Aggressor Program of Work' in December 2022, which includes a long-term goal of determining a "*time threshold for delaying the upload of family violence reports to allow further time to obtain additional information to assist correct identification*".

55. I support and strongly encourage the continuation of this work. The Court wrote to Victoria Police with a proposed recommendation, namely, that "*Victoria Police should develop and*

[13] LEAP is an electronic database which stores information about members of the public whom the police have had interactions with.

[14] Victoria Police, Victoria Police Manual - Family Violence (2022), 10-1; Family Safety Victoria, MARAM Foundation Knowledge Guide (2021), 113.

implement a process for delaying the upload of family violence risk assessments in appropriate cases".

56. Victoria Police responded by confirming its commitment to preventing misidentification of the predominant aggressor, however, it was concerned that such a recommendation might have risks and/or unintended consequences. I accept that this is a complex issue and requires input from various entities within the specialist family violence sector. Victoria Police explained that it is currently participating in a whole-of-Victoria-Government working group, which has been convened to improve sector-wide responses to misidentification of the predominant aggressor. Victoria Police submitted that this working group would be best placed to explore the workflow and flow-on effects of the FVR L17 and will ensure sector-wide consultation. I accept this would be an appropriate forum for such a discussion and will direct a copy of this finding be provided to Victoria Police, to consider as part of this working group.

FVIO cross-applications

57. After making his report to police on 14 October 2020, Mr IPK applied for an FVIO against Ms HRZ at the Broadmeadows Magistrates' Court on 28 October 2020, which was granted. With the benefit of hindsight, his application can be characterised as a further form of systems abuse, initiated to cause further harm to Ms HRZ.

58. Mr IPK's application explicitly states that it is a cross-application, however there are no available records to suggest that anyone at the Broadmeadows Magistrates' Court considered whether this application was a form of systems abuse, nor does there appear to be a requirement for staff to make such enquiries when receiving a cross-application. I therefore make no criticism of the staff working at Broadmeadows Magistrates' Court (nor indeed of the magistrate, who granted the cross-application based on the information before them), as it was not incumbent upon them to make such enquiries.

59. I also note that not all FVIO cross-applications are motivated by systems abuse, and some are initiated by a victim who has been previously misidentified by police. However, it appears that more can be done to try to identify those that are. Court applicant and respondent workers have the necessary knowledge and skills to carry out family violence risk assessments, to identify predominant aggressors and to play a supportive role in identifying FVIO applications that might be motivated by systems abuse.

60. In its submission to the Royal Commission into Family Violence (**RCFV**), the Broadmeadows Community Legal Service (**BCLS**), as it then was, recommended that court applicant and respondent workers complete family violence risk assessments where a cross-application is being made to assist magistrates to make the most informed decision possible.[15] The RCFV did not address this recommendation in its final report, but did note that its other recommendations would improve management of the demands placed on the judiciary, court staff, and legal practitioners, and therefore improve their capacity to detect vexatious FVIO applications.[16] However, perpetrators making FVIO cross-applications as a form of systems abuse continues to be a significant issue,[17] including for migrant and refugee women.[18]

61. There appears to be significant merit in BCLS' submission to the RCFV, and it may substantially address this ongoing issue. The Coroners Court wrote to the Magistrates' Court of Victoria (**MCV**) to seek its input on BCLS' recommendation. In response, MCV advised that it did not support this proposed recommendation for several reasons:

    a) Implementation of the recommendation would require an amendment to r 15.01 of the *Magistrates' Court (Family Violence Protection) Rules 2018* (**FV Rules**) which states that a risk assessment is confidential and is not to be used in evidence or disclosed to the respondent. This is to ensure that AFMs can provide frank disclosure.

    b) Engagement with applicant and respondent practitioners is voluntary (except in certain circumstances). Practitioners can provide non-legal advice and support, as well as referrals to other organisations. The practitioners complete risk assessments and provide guidance to court users. The demand for their services already exceeds their capacity.

    c) MCV submitted that the proposed recommendation would profoundly alter the role and purpose of the practitioners. It would change the service from a voluntary service to a court process that uses practitioners as a source of evidence to determine FVIO applications.

[15] BCLC, Submission 791 to RCFV (29 May 2015) 5, 10.
[16] *RCFV: Final Report* (March 2016) Vol 3, 175.
[17] Safe and Equal, Submission 83 to the Legislative Assembly Legal and Social Issues Committee, *Parliamentary Inquiry into the Data on the Profile and Volume of Perpetrators of Family Violence in Victoria* (August 2024) 8.
[18] inTouch, Submission 84 to Standing Committee on Social Policy and Legal Affairs, Parliament of Australia, *Inquiry into Family Violence Orders* (August 2024) 11.

d) If risk assessments were tendered as evidence in proceedings, procedural fairness would require parties to have the ability to cross-examine and scrutinise the practitioners and their assessments. This may lead to AFMs and respondents becoming more reluctant in disclosing information to practitioners.

e) Implementation of this recommendation would require substantial government investment into resourcing, not only for planning and implementation, but to recruit additional practitioners. The current practitioner workforce does not have capacity to undertake this work.

62. I accept that this is a complex issue which likely needs significant stakeholder consultation. It is critical that if any change is made to the role of the court practitioner, that it does not have any unintended consequences. However, I am still of the view that the submission by BCLS is worthy of further exploration. Therefore, I intend to make a recommendation to the Department of Justice and Community Safety, to fully explore and consider this issue in consultation with the specialist family violence sector.

63. I also note the recent report of the Rapid Review of Prevention Approaches, which commented that government systems originally established to support women, children and at-risk communities are being manipulated and abused by perpetrators to control victim-survivors and extend domestic, family and sexual violence (**DFSV**).[19] As a result, the Rapid Review Panel recommended that the Commonwealth, state and territory governments undertake an immediate audit of the ways in which DFSV perpetrators are weaponising government systems, and to respond to these findings.[20] To that end, I endorse recommendation 16 of *Unlocking the Prevention Potential: Accelerating action to end domestic, family and sexual violence* and intend to make a recommendation that the audit considers the use of intervention orders in systems abuse, including through cross-applications.

Link between family violence and suicide

64. It appears that the family violence perpetrated against Ms HRZ across her lifespan, but more specifically the violence allegedly perpetrated by Mr IPK, was a key contributor in her decision to end her life. This is supported by the evidence available to the Court, including:

[19] Elena Campbell et al, *Unlocking the Prevention Potential: Accelerating action to end domestic, family and sexual violence* (Report of the Rapid Review of Prevention Approaches, August 2024), 69.
[20] Ibid, 71.

a) Ms HRZ's mental health deteriorated in the context of family violence allegedly perpetrated by her ex-husband.

b) Ms HRZ's mental health deteriorated further in the context of the family violence allegedly perpetrated by Mr IPK, specifically after he made allegations of blackmail to police, which led to her arrest and interview. Ms HRZ sought mental health treatment four days after her first contact with Victoria Police.

c) Ms HRZ contacted Mr IPK on 27 October 2020 and stated that she was going to end her life due to his abuse and was involved in a car accident on the same day. When she was taken to hospital, she was extremely distressed and disclosed the violence she experienced from Mr IPK.

d) Ms HRZ regularly spoke to her daughter and psychologist about the abuse, often in a distressed state, and often repeating the same statement multiple times.

e) Ms YBH, her daughter, noted her belief that Ms HRZ "*lost her mind*" because of Mr IPK and his manipulation.

65. There is emerging evidence that intimate partner violence (**IPV**) is a significant risk factor for suicide, suicidal ideation, and self-injury for women,[21] with the Australian Institute of Health and Welfare estimating that IPV is the second leading factor contributing to suicide and/or self-harm behaviours in women over 15 years of age.[22] In the United Kingdom, coroners are increasingly acknowledging the link between family violence and suicide, with one inquest concluding that a victim of IPV had been subject to unlawful killing by her partner after she suicided in the context of this abuse.[23]

66. I note the recent *Investigation into Family and Domestic Violence and Suicide* by the Ombudsman Western Australia, which found that between 1 January 2017 and 31 December 2017, 124 women and children died by suicide and 68 of those people were known to have experienced family violence.[24] The report contained a systemic review of available research,

[21] Agenda Alliance, *Underexamined and Underreported: Suicidality and Intimate Partner Violence: Connecting Two Major Public Health Domains* (Briefing paper, February 2023); Vanessa E Munro, 'From Hoping to Help: Identifying and Responding to Suicidality Amongst Victims of Domestic Abuse', (January 2020) 26(1) International Review of Victimology.

[22] Australian Institute of Health and Welfare, 'Suicide and Self-Harm Monitoring Data' (Web Page, 2023), Suicide & self-harm monitoring data - Australian Institute of Health and Welfare (aihw.gov.au)>.

[23] Sophie Naftalin and Vanessa Munro, 'Investigations into Suicides in the Context of Domestic Abuse' (October 2023) *Legal Action.*

[24] Ombudsman Western Australia, *Investigation into Family and Domestic Violence and Suicide: Volume 1*, Executive Summary, 41.

which found a strong link between IPV and suicidality, and noted that IPV was a significant risk factor for suicidal thoughts and behaviours. The report also noted that the link between family violence and suicide is under-researched.[25] The Coroners Court of Victoria (**the Court**) recently released data related to the relationship between family violence and suicide and noted that increased resourcing for the Court could yield better quality data and analysis of this relationship.[26]

67. The report of the Rapid Review of Prevention Approaches, published August 2024, noted that Australia has yet to include suicides related to DFSV victimisation in homicide data, despite evidence suggesting that suicides related to DFSV victimisation potentially account for at least three times the number of female homicide deaths.[27] The report further noted that the potential to prevent further suicide through DFSV-victimisation is deserving of further investigation,[28] and made the following recommendations:

    a) establishing and uplifting death review panels across all jurisdictions, including with First Nations support units and protocols (state and territory governments);

    b) strengthening national coordination and consistency of DFSV death review processes, and learning and sharing of findings (state and territory governments supported by Commonwealth); and

    c) initiating an urgent inquiry into the relationship between DFSV victimisation and suicide, with a view to developing a methodology for accurate counting of the DFSV death toll (Commonwealth, state and territory governments).[29]

68. In the Court's submission to the Parliamentary Inquiry into the Data on the Profile and Volume of Perpetrators of Family Violence in Victoria, it noted that the Court is currently experiencing barriers in its ability to identify, analyse, and accurately code data relating to family violence-related deaths, particularly suicides. The submission called for increased funding to address these barriers through:

[25] Ibid 30.
[26] Coroners Court of Victoria, *Experience of Family Violence Among People who Suicided*, Victoria 2009-2016 (Data summary, July 2024).
[27] Elena Campbell et al, *Unlocking the Prevention Potential: Accelerating action to end domestic, family and sexual violence* (Report of the Rapid Review of Prevention Approaches, August 2024), 79.
[28] Ibid 80.
[29] Ibid 81.

a) Increased capacity at the Coroners Court to support coroners' investigations in the circumstances of all family violence related deaths, and to provide in-depth analysis of these circumstances;
b) Enhanced functionality of the Court database to provide more comprehensive/multidimensional data on family violence victims and perpetrators, and;
c) Increased capacity at Court to code, analyse and disseminate the data to the coroners and relevant stakeholders.[30]

69. State Coroner Judge Cain echoed and endorsed this submission, in his Honour's recent finding into the death of Thi Minh Phuong Nguyen.[31]

70. I support the Court's submission to the Parliamentary Inquiry, and his Honour's comments.

Primary prevention of family and gender-based violence

71. In Australia, violence against women is "*staggeringly common*" and is overwhelmingly perpetrated by men.[32] Although attitudes regarding violence against women are slowly changing, problematic attitudes in relation to gender equality and violence against women, including attitudes which reinforce rigid gender roles, persist for a concerning number of Australians.[33] To address gender-based violence, more must be done to challenge dominant forms of masculinity, and the harm they do to people of all genders at individual, group and societal levels.[34]

72. Primary prevention aims to change the underlying social conditions that produce and drive violence against women to prevent it from occurring in the first place.[35] This involves working

[30] Coroners Court of Victoria, Submission 59 to the Legislative Assembly Legal and Social Issues Committee, *Parliamentary Inquiry into the Data on the Profile and Volume of Perpetrators of Family Violence in Victoria* (14 June 2024) 7-8.
[31] Finding into death without inquest – Thi Minh Phuong Nguyen COR 2021 000964, 12.
[32] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 12; Australian Bureau of Statistics, Personal Safety Survey – Physical Violence (2023).
[33] Christine Coumarelos et al, ANROWS, Attitudes Matter: The 2021 National Community Attitudes Towards Violence against Women Survey (NCAS) Findings for Australia (Report, 2023) 22-4.
[34] Respect Victoria, *Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament* (Report, September 2022) 113.
[35] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 12.

on actions to address the gendered drivers of violence against women to create generational, cultural and attitudinal change,[36] including:

a) The condoning of violence against women

b) Men's control of decision-making and limits to women's independence in public and private life

c) Rigid gender stereotyping and dominant forms of masculinity

d) Male peer relations and cultures of masculinity that emphasise aggression, dominance, and control.[37]

73. Primary prevention also involves addressing other factors which play a role in influencing the occurrence or dynamics of men's violence against women, including:

a) The condoning of violence in general

b) Experience of, and exposure to, violence

c) Factors that weaken prosocial behaviour, such as neighbourhood-level poverty, disadvantage and isolation, and substance misuse

d) Backlash and resistance to prevention and gender equality.[38]

74. Primary prevention uses a range of mutually reinforcing strategies across a wide range of settings/areas including education, workplaces, sports clubs, health and community services and the media industry.[39] In recent years, Victoria has made progress in building an effective primary prevention system. 'Respect Victoria' was established in 2018 in response to a recommendation by the RCFV, becoming the first agency dedicated to the primary prevention of family violence and all forms of violence against women in Victoria.[40] Under Victoria's

[36] Victorian Government, *Free from Violence: Victoria's Strategy to Prevent Family Violence and all Forms of Violence Against Women - Second Action 2022-2025* (December 2021) 4.
[37] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 36.
[38] Ibid 48, 51; Shaoling Zhong, Ronggin Yu, and Seena Fazel, 'Drug Use Disorders and Violence: Associations with Individual Drug Categories' (2020) 42(1) Epidemiologic Reviews.
[39] Respect Victoria, Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament (Report, September 2022) 6, 114.
[40] Ibid 4.

Free from Violence strategy, several primary prevention initiatives have been funded and rolled out across education, public sector workplaces, local government and sport settings.[41]

75. Achieving lasting change in relation to the underlying social conditions which produce and drive family violence through primary prevention will require large-scale, persistent efforts over an extended period. Current state and federal funding for primary prevention has been criticised in the sector for being insufficient to meet this goal and has predominantly been for relatively short-term activity targeting fairly small cohorts.[42]

76. The Victorian Government is currently developing the *Family Violence Reform Rolling Action Plan 2024-2026*, which was due for release in late-2024, and will set out the Government's priorities in addressing DSFV. The imminent release of this report serves as a timely reminder for the Victorian and Commonwealth Governments to increase the quantum of funding provided. I intend to make the following recommendations:

    a) That the Victorian Government review the total quantum of primary prevention funding and prioritise longer-term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria, to assess whether current funding levels meet needs in this space.[43]

    b) That the Federal Government consider the need for long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch[44] in *Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia*.[45] These include:

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[41] Ibid iii.

[42] Ibid 16; Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 109; Family Violence Reform Implementation Monitor (FVRIM), *Monitoring Victoria's family violence reforms Primary prevention system architecture* (Report, 2022) 38-40.

[43] Similar recommendations are made by the FVRIM and Respect Victoria in the following reports - FVRIM, *Monitoring Victoria's family violence reforms Primary prevention system architecture**R*IGH* (Report, 2022) 38-40; Respect Victoria, Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament (Report, September 2022) 11-16.

[44] Our Watch is the national leader in the primary prevention of violence against women and their children in Australia.

[45] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 100-6.

i. Our Watch (to provide independent national leadership on primary prevention)

ii. Australia's National Research Organisation for Women's Safety (**ANROWS**) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)

iii. Australian Bureau of Statistics (to deliver the Personal Safety Survey)

iv. Workplace Gender Equality Agency.[46]

75. These recommendations largely mirror the recommendation made by State Coroner Judge Cain in his finding into the death of Thi Minh Phuong Nguyen.[47]

Primary prevention and migrant and refugee communities

77. Migrant and refugee communities face specific barriers in addressing issues related to family violence.[48] It is therefore essential for effective primary prevention to be accessible to culturally and racially marginalised (**CARM**) communities and must include prevention initiatives led by those communities.[49] The importance of community-specific prevention initiatives is supported by the evidence in this case, which indicates that Mr IPK weaponised perceived community attitudes against Ms HRZ in the course of his abuse, and she found this incredibly distressing.

78. The Victorian Government has previously provided grants to enable local agencies and communities to deliver local initiatives aimed at preventing family violence in CARM communities, however further investment is required.[50] inTouch recently commented on the lack of funding for prevention activities in the federal budget, and called on the government to work carefully with the family violence sector to ensure the announced funding provides appropriate and adequate support for migrant and refugee women experiencing family violence, including through investment in targeted prevention programs.[51]

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[46] Ibid 110.
[47] Finding into death without inquest – Thi Minh Phuong Nguyen (COR 2021 0964).
[48] Segrave, M. Wickes, R, and Keel, C., *Migrant and Refugee Women in Australia: The Safety and Security Survey* (Monash University, 2021) 29; InTouch, Submission to ALRC, *Inquiry into Justice Responses to Sexual Violence* (June 2024) 10-9.
[49] 2 SAS Vic, Submission to VLRC, *Improving the Justice System Response to Sexual Offences* (December 2020) 18.
[50] Respect Victoria, 'Progress on Prevention: Summary of Three Yearly Report on Preventing Family Violence Against Women' (September 2022) 10; inTouch, *Federal Budget Fails to Address Family Violence Crisis* (Statement, 15 May 2024).
[51] inTouch, *Federal Budget Fails to Address Family Violence Crisis* (Statement, 15 May 2024).

79. I therefore echo and endorse inTouch's comment and recommend that the Commonwealth Government work closely with the family violence sector to ensure the family violence funding allocated in the 2024 federal budget and future federal budgets provides appropriate and adequate support for migrant and refugee women experiencing family violence, including through investment in targeted prevention programs. A pertinent recommendation will follow.

Primary prevention of sexual violence

80. Ms HRZ's case is sadly not the only one known to the Court in which a victim of sexual violence has died by suicide. I note my finding into the death of Ms BCJ,[52] dated 5 July 2024, in which Ms BCJ experienced sexual abuse (and other family violence) from her husband and later ended her own life.

81. While sexual violence is often perpetrated in the context of family violence, it is also a distinct form of violence requiring specialist prevention and response.[53] Sexual violence is widespread in Victoria.[54] One in five Australian women have experienced sexual violence since the age of 15, compared with one in 16 men,[55] and the vast majority of adults in Australia who have experienced sexual assault were assaulted by a male.[56]

82. Many Victorians still hold harmful attitudes that minimise, excuse or normalise sexual violence.[57] Attitudes about sexual violence may vary amongst different communities,[58] so culturally responsive and targeted primary prevention initiatives are important. In addition to the gendered drivers of violence outlined above, 'Change the Story' also identifies several factors which are specifically linked to men's use of sexual violence. These include:

    a) adherence to forms of masculinity that commonly emphasise control and dominance

    b) performances of strength and toughness through violence outside the home

[52] Finding into death without inquest – BCJ (COR 2020 003368).
[53] SAS Vic, Submission into the Family Violence Reform Rolling Action Plan 2024-2026 (29 February 2024) 2, 5.
[54] VLRC, Improving the Justice System Response to Sexual Offences (Report, September 2021) xxii; Australian Bureau of Statistics, Personal Safety, Australia (Personal Safety Survey results 2021-2022 financial year, 16 March 2023), Sexual Violence.
[55] Australian Bureau of Statistics, Personal Safety, Australia (Personal Safety Survey results 2021-2022 financial year, 16 March 2023), Sexual Violence.
[56] Ibid; ALRC, *Justice Responses to Sexual Violence: Issues Paper* (April 2024) 4.
[57] Coumarelos C. et al 'Attitudes matter: The 2021 National Community Attitudes towards Violence against Women Survey (NCAS), Findings for Australia' (Research Report, February 2023); Respect Victoria, Submission 218 to ALRC, *Inquiry into Justice responses to Sexual Violence* (14 June 2024) 10.
[58] Segrave, M., Wickes, R. and Keel, C. 'Migrant and Refugee Women in Australia: The Safety and Security Survey' (Research Report, 2021) 27.

c) peer pressure and social expectations that men should never say no to sex and should have many sexual partners

d) peer pressure to pursue sex with women in coercive and aggressive ways, and talk about women as sexual objects

e) prior exposure to violence against a parent, or emotional, physical and sexual abuse during childhood

f) current exposure to violent pornography.[59]

83. The primary prevention of sexual violence requires a whole-of-population approach, as well as tailored approaches led by priority communities and experts. Such approaches include affirmative consent education, reducing harmful impacts of violent pornography, and targeting settings where sexual violence is prevalent or where harmful attitudes that drive sexual violence are normalised or entrenched, including workplaces, schools and higher education, and digital spaces. Shifting attitudes which reflect the gendered drivers of sexual violence, including gendered, victim blaming attitudes (which appeared to be present in Ms HRZ's case), has the potential to not only reduce offending and encourage reporting, but to improve responses of services, friends and family to disclosures.[60]

84. The Victorian Law Reform Commission (**VLRC**), Respect Victoria and Sexual Assault Services Victoria (**SAS Vic**)[61] have all made recommendations that the Victorian Government develop a coordinated approach to the primary prevention of sexual violence and provide continued funding and support for relevant organisations to enact this approach.[62]

85. The Victorian Government has previously recognised the need for primary prevention of sexual violence,[63] however SAS Vic recently noted that Specialist Sexual Assault Services (**SSASs**) are not adequately funded to carry out primary prevention work.[64] It is therefore appropriate that the Victorian Government build a community-wide approach to preventing

[59] Our Watch, 'Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia' (2nd ed, 2021) 33.
[60] Respect Victoria, Submission 218 to ALRC, Inquiry into Justice responses to Sexual Violence (14 June 2024) 12.
[61] SAS Vic is the peak body for sexual assault services in the state.
[62] VLRC, Improving the Justice System Response to Sexual Offences (Report, September 2021) 172, 277.
[63] SAS Vic, Submission into the Family Violence Reform Rolling Action Plan 2024-2026 (29 February 2024) 2; State of Victoria, Department of Families, Fairness and Housing, Strong Foundations: Building on Victoria's Work to end Family Violence (November 2023) 10.
[64] SAS Vic, Submission into the Family Violence Reform Rolling Action Plan 2024-2026 (29 February 2024) 3- 4.

sexual violence and commit to doing so in the Sexual Violence Strategy. I intend to make a recommendation to that effect.

Justice response to sexual violence

86. During Ms HRZ's interactions with police and hospital staff, she was referred to specialist family violence services (once as a victim-survivor and once as a perpetrator). However, the result of these referrals included one phone call from a mainstream family violence service, and one text message with their contact details when Ms HRZ was unable to speak on the phone as she was with police at the time. Without criticising the services involved with Ms HRZ, it would appear that she, and other victims of sexual violence, would benefit from more proactive support.

87. Sexual violence reform is urgent.[65] It has been well established that many victim survivors are traumatised by the legal system.[66] The 2021 VLRC report Improving the Justice System Response to Sexual Offences (**the VLRC Report**) found that the justice system needs to change so that using it is straightforward and not traumatic for people who experience sexual violence, and so that victim survivors have choices and support when seeking justice for sexual violence.[67] The Australian Law Reform Commission (**ALRC**) made similar findings in their January 2025 report, Safe, Informed, Supported: Reforming Justice Responses to Sexual Violence.[68] The ALRC, VLRC and other stakeholders have made a myriad of recommendations in this area, however the following summary focuses on those which may improve victim survivors' experiences of reporting sexual violence, as this is most relevant to Ms HRZ. In every instance, improving the experiences of victim survivors through the justice system requires collaboration with and funding of SSASs.

Crisis support for victim-survivors

88. Although Victoria has the foundations of a strong support system for victim survivors of sexual violence, SASSs are significantly underfunded.[69] Despite only 13% of sexual offences being reported to police,[70] many victim survivors continue to navigate the justice system

[65] SAS Vic, Submission to ALRC, Improving the Justice System Response to Sexual Offences (14 June 2024) 6.
[66] SAS Vic, Submission to VLRC, Improving the Justice System Response to Sexual Offences (December 2020) 30; SAS Vic, Submission to ALRC, Improving the Justice System Response to Sexual Offences (14 June 2024) 5; Victims of Crime Commissioner, *Silenced and Sidelined: Systemic Inquiry into Victim participation in the Justice System (*Report, November 2023).
[67] VLRC, Improving the Justice System Response to Sexual Offences (Report, September 2021) xxii.
[68] ALRC, Safe, Informed, Supported: Reforming Justice Responses to Sexual Violence (January 2025), 62, 142.
[69] SAS Vic, Submission to ALRC, *Improving the Justice System Response to Sexual Offences* (14 June 2024) Ibid 3.
[70] ALRC, *Justice Responses to Sexual Violence: Issues Paper* (April 2024) 4.

without specialist support.[71] In order to make reporting sexual violence less traumatic, victim survivors must have access to specialised counselling and support throughout this process,[72] including prior to being asked to make decisions about proceeding with legal options.[73]

89. inTouch noted that where refugee and migrant women are in fear of community repercussions for reporting sexual violence, '*access to wrap around, specialist services that work in-language and in-culture are critical*' to avoid re-traumatisation and to recognise the cultural nuances and needs of the victim survivor.[74]

90. Centres Against Sexual Assault (**CASA**s) provide crisis support and counselling services to victim survivors of sexual violence. The *Victoria Police Code of Practice for the Investigation of Sexual Crime* guides police to contact CASA to assess the victim survivor's need for crisis care whether they have reported a recent (within 72 hours) or historic (older than 72 hours) offence. However, police referrals to CASA for crisis support, particularly in relation to reports of historic offences, are described by SAS Vicas '*sporadic*'. Further, even when appropriate referrals are made, SSASs in Victoria do not have the resources to provide comprehensive support to victim survivors through the process of making a report to police.[75]

91. I agree with SAS Vic, that the presence of a specialist sexual abuse counsellor or advocate during the 'police options talk' (which can include provision of information about justice options such as making a formal statement and applying for an intervention order) with victim-survivors should be regarded as part of the best practice support offered to victim-survivors, and note their recommendation that this should be considered as part of the forthcoming review of the *Victoria Police Code of Practice for the Investigation of Sexual Crime* (2016).[76] In order to provide this support, SSASs require greater support.[77]

92. I note in this connection that Ms HRZ was provided with information regarding support services when she spoke to police, but was not referred to a CASA, who can assess a victim-survivor's need for crisis care. I cannot determine that a referral to a CASA would have

[71] SAS Vic, Submission to ALRC, *Improving the Justice System Response to Sexual Offences* (14 June 2024) 10; ALRC, Safe, Informed, Supported: Reforming Justice Responses to Sexual Violence (January 2025), 135.
[72] Ibid 7; VLRC, Improving the Justice System Response to Sexual Offences (Report, September 2021) 241; SAS Vic, Submission to VLRC, *Improving the Justice System Response to Sexual Offences* (December 2020) 8.
[73] SAS Vic, Submission to VLRC, *Improving the Justice System Response to Sexual Offences* (December 2020) 15.
[74] inTouch, Submission to ALRC, *Improving the Justice System Response to Sexual Offences* (June 2024) 14
[75] Ibid 8; SAS Vic, Submission to ALRC, *Improving the Justice System Response to Sexual Offences* (14 June 2024) 10.
[76] SAS Vic, Submission to VLRC, *Improving the Justice System Response to Sexual Offences* (December 2020) 36; SAS Vic, Submission to ALRC, *Improving the Justice System Response to Sexual Offences* (14 June 2024) 26.
[77] SAS Vic, Submission to VLRC, *Improving the Justice System Response to Sexual Offences* (December 2020) 8

prevented Ms HRZ's rapid deterioration in mental health, however it may have provided a more proactive level of support, following her interactions with police.

Expansion of multi-disciplinary centres

93. A further barrier to victim survivors of sexual offences accessing adequate support occurs where a Multi-Disciplinary Centre (**MDC**) does not exist in the area where the victim survivor makes their report, as was the case for Ms HRZ. There are seven MDCs in Victoria, based in Bendigo, Dandenong, Geelong, Mildura, Morwell, Seaford and Wyndham.[78] MDCs bring together a range of services in one building, including SOCIT, SSASs, Child Protection and community health nurses. MDCs aim to provide a wrap-around trauma informed service, reduce the need for people to re-tell their stories and navigate complex systems. They also aim to improve the ways in which people who respond to violence share information, skills and relationships.[79] The VLRC found that Victorian MDCs are achieving these aims.[80] Further, SAS Vic notes that MDCs promote improved outcomes for victim survivors, including by increasing the ability of SSASs to respond quickly when asked to by police, and police learning from and incorporating CASAs trauma-informed approach.[81]

94. The ALRC found that when people who have experienced sexual violence receive appropriate support, including a safe place to disclose where they can access trauma-informed, multi-disciplinary services, '*their chances of recovery, healing, and ongoing engagement are increased.*'[82] I cannot determine that if an MDC was available in Ms HRZ's area that her mental health would not have declined in the same way. However, she may have received support from a SASS, including to navigate the justice system, which may have had a preventative impact.

95. I note in this connection that the VLRC recommended that the Victorian Government commit to and fund an expansion of MDCs,[83] and noted widespread, powerful support for this recommendation amongst the sector, including from victim survivors who found that MDCs improved availability, communication and continuity between services.[84]

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[78] Victoria Police, *Reporting in Person at Multidisciplinary Centres* (Web Page, 9 July 2024) >Reporting in person at multidisciplinary centres (police.vic.gov.au)>.
[79] VLRC, Improving the Justice System Response to Sexual Offences (Report, September 2021) 93; SAS Vic, Submission to ALRC, *Improving the Justice System Response to Sexual Offences* (14 June 2024) 24.
[80] VLRC, Improving the Justice System Response to Sexual Offences (Report, September 2021) 93.
[81] SAS Vic, Submission to VLRC, *Improving the Justice System Response to Sexual Offences* (December 2020) 36.
[82] ALRC, Safe, Informed, Supported: Reforming Justice Responses to Sexual Violence (January 2025), 136.
[83] VLRC, Improving the Justice System Response to Sexual Offences (Report, September 2021) 98.
[84] Ibid 94.

Sexual violence strategy

96. Stakeholders agree that a Victorian sexual violence strategy[85] is required to develop a coordinated approach to preventing sexual offending, and to coordinate and improve responses to sexual violence.[86] The VLRC report relies on a sexual violence strategy as an avenue for implementation for many of its 91 recommendations for reform.[87]

97. The Victorian Government has previously committed to developing a sexual violence strategy,[88] but it has since been delayed and the 2024-25 Victorian state budget does not include funding for it.[89]

98. I note that a sexual violence strategy in Victoria could include a commitment to the reforms as outlined above, which would have been relevant to Ms HRZ, including investment in the primary prevention of sexual violence, improved access to crisis SSAS support, and expansion of MDCs across the state. I therefore intend to make a recommendation that the Victorian Government reaffirm its commitment to funding the development and implementation of a sexual violence strategy, as outlined in the VLRC report, and provide a timeframe for completion.

FINDINGS AND CONCLUSION

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

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

    b) the death occurred on 25 December 2020 at Melbourne, Victoria, from 1(a) *neck compression* secondary to 1(b) *hanging*; and

    c) the death occurred in the circumstances described above.

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[85] Note that stakeholders also refer to this as a sexual abuse strategy, and a sexual assault strategy. The term sexual violence is used throughout this report for consistency.

[86] State of Victoria, Department of Families, Fairness and Housing, *Strong Foundations: Building on Victoria's Work to end Family Violence* (November 2023) 10; Victorian Government, Family Violence Reform Rolling Action Plan 2020–2023 (Report, December 2020) Sexual Assault and Family Violence – Sexual Assault Strategy; SAS Vic, *Action on Sexual Violence on Hold* (Statement, 7 May 2024); VLRC, Improving the Justice System Response to Sexual Offences (Report, September 2021) xxv; SAS Vic, Submission into the Family Violence Reform Rolling Action Plan 2024-2026 (29 February 2024) 2.

[87] VLRC, Improving the Justice System Response to Sexual Offences (Report, September 2021) 13.

[88] State of Victoria, Department of Families, Fairness and Housing, *Strong Foundations: Building on Victoria's Work to end Family Violence* (November 2023) 10; Victorian Government, Family Violence Reform Rolling Action Plan 2020–2023 (Report, December 2020) Sexual Assault and Family Violence – Sexual Assault Strategy.

[89] SAS Vic, *Action on Sexual Violence on Hold* (Statement, 7 May 2024).

100. Having considered all of the circumstances, I am satisfied that Ms HRZ intentionally took her own life. In having made such a finding, I note the lethality of means chosen, Ms HRZ's rapid deterioration in mental health prior to her death, and suggestions she made to her children prior to her passing about a desire to end her own life.

101. I find that, whilst there was a constellation of factors involved, the significant family violence that Ms HRZ experienced and resisted for many years, including in the lead-up to her death, underpinned and propelled the decision she made to end her own life. She was culturally and socially isolated and was living in fear that she would be publicly shamed in her community.

I convey my sincere condolences to Ms HRZ's family for their immeasurable loss.

COMMENTS

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

102. Cases such as Ms HRZ's underscore the multiple and intersecting ways in which men can perpetrate family violence against women not only through direct physical, sexual and psychological assault on their victims, but also through the very systems that are designed and intended to keep those victims safe.

103. The impact of such systems abuse can be devastating. It emboldens those who use violence, and it further isolates and renders vulnerable those who are victims. When victims of violence also face the fear of isolation within their communities due to the abuse they have suffered, such as Ms HRZ did, they are often left with desperately few avenues of support to turn to.

104. The precipitants for Ms HRZ's suicide are multifactorial, and the systems abuse that occurred in the lead-up to her death was just one dimension of her broader experience of family violence. However, it is incumbent on the Victorian Government to ensure that the systems designed to keep victims of violence safe are capable of doing so; that they are culturally responsive, adequately funded and better equipped to withstand weaponising by those who use violence. This is a question of not only of policy, but of human rights.[90] Future initiatives ought to explicitly state the ways in which human rights obligations are being addressed.

[90] *See in this regard*, UN Committee on the Elimination of Discrimination Against Women (**CEDAW**), *CEDAW General Recommendation No. 19: Violence against women*, 1992, https://www.refworld.org/legal/resolution/cedaw/1992/en/96542 [accessed 18 January 2025], para. 6. Australia is a signatory to the Convention on the Elimination of all Forms of Discrimination Against Women, which provides that States condemn discrimination against women in all its forms, and agree to take appropriate measures to eliminate

105. Ultimately, it is also a matter for government – both State and Federal – to pursue primary prevention initiatives that ensure that, over time, the current levels of violence against women are disrupted and reduced, and that safety, respect and dignity for all women is genuinely able to be realised.

106. This ought to be regarded as a matter of urgency.

107. I make a series of recommendations in this connection.

RECOMMENDATIONS

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

(i) That the **Victorian Department of Justice and Community Safety** consider the Broadmeadows Community Legal Service's submission to the Royal Commission into Family Violence and conduct sector-wide consultation and research about the feasibility of the same (specifically, to seek feedback from and conduct consultation with the family violence sector regarding the feasibility of the use of Applicant and Respondent Workers' risk assessments by the Magistrates Court of Victoria). Feedback should be obtained from (but not limited to) Applicant and Respondent workers, specialist family violence staff, Magistrates, Victoria Police and Victoria Legal Aid.

(ii) That the **Victorian Government** review the total quantum of primary prevention funding and prioritise longer-term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria, to assess whether current funding levels meet needs in this space.

(iii) That the **Victorian Government** reaffirm its commitment to funding the development and implementation of a Sexual Violence Strategy, as outlined in the Victorian Law Reform Commission (**VLRC**) 2021 report, Improving the Justice System Response to Sexual Offences, and provide a timeframe for its completion. As part of the Sexual Violence Strategy, the Victorian Government should:

discrimination, which includes "*violence that is directed at a woman because she is a woman or that affects women more disproportionately*".

a) Develop a coordinated, community-wide approach to preventing sexual offending which includes investment in the development, delivery and evaluation of initiatives focused on the primary prevention of sexual violence by specialist sexual assault services and other relevant experts (including inTouch); and
b) Consider the circumstances and comments contained within this finding with respect to any future investments in the expansion of: (i) Multi-Disciplinary Centres; (ii) Specialist Sexual Assault Services; and (iii) culturally-responsive support for victim survivors of sexual violence.

(iv) That the **Commonwealth Government** commit to long-term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch in *Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia*. These include:

a. Our Watch (to provide independent national leadership on primary prevention)

b. Australia's National Research Organisation for Women's Safety (**ANROWS**) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)

c. Australian Bureau of Statistics (to deliver the Personal Safety Survey)

d. Workplace Gender Equality Agency.

(v) That the **Commonwealth Government** work closely with the family violence sector to ensure the family violence funding allocated in the 2024 federal budget and future budgets provides appropriate and adequate support for migrant and refugee women experiencing family violence, including through investment in targeted prevention programs.

ORDERS AND DIRECTIONS

Pursuant to section 73(1A) of the Act, I order that a de-identified copy of 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:

Ms YBH, Senior Next of Kin

Ms KRZ

Commonwealth Government

Victorian Government

Secretary, Department of Justice and Community Safety

Magistrates' Court of Victoria

Victoria Police

Victorian Law Reform Commission

Northern Community Legal Centre

Senior Constable Albina Huremovic, Coronial Investigator

Signature:

Ingrid Giles

Coroner

Date: 4 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.