IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003811

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Ingrid Giles, Coroner
Deceased:	Tracey Ellen Knowles
Date of birth:	19 February 1979
Date of death:	Between 17 and 19 July 2021
Cause of death:	1(a) Unascertained
Place of death:	1045 Plenty Road, Bundoora, Victoria, 3083

INTRODUCTION

1. Tracey Ellen Knowles (**Ms Knowles**) was 42 years old when she was found deceased on 19 July 2021. Ms Knowles is survived by her son. She had 12 siblings and half-siblings but had irregular contact with many of them.

2. Ms Knowles faced issues with drug use from a young age. In 2019, Ms Knowles was charged with drug possession. In interactions with police, she stated she was a heroin user but was trying to abstain.

3. Ms Knowles was reported to have been exposed to ongoing violence perpetrated by her ex-partner (who is also the father of her son), and she suffered a significant assault in 2019. Following the assault, a Family Violence Intervention Order (**FVIO**) was put in place. There are no recorded breaches of this order.

4. Ms Knowles moved in with her half-sister at this time. Ms Knowles lived with her sister until about March 2020 and was reported by her sister to not be using any so-called '*hard*' drugs during this period.

5. In November 2020, Ms Knowles moved in with a new partner, Nathan Tilbrook. This relationship was also reportedly marred by family violence, and I will refer to this further below.

THE CORONIAL INVESTIGATION

6. Ms Knowles' 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. Then-Deputy State Coroner Hawkins (**DSC Hawkins**) originally had carriage of this investigation. I took carriage of this matter on 12 October 2023 for the purposes of seeking additional advice from the Coroners Prevention Unit (**CPU**),[1] finalising the investigation and making findings.

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

11. Upon receipt of the family's concerns, a number of other investigative steps were taken in an attempt to better understand the circumstances and cause of Ms Knowles' death. These investigations are discussed in detail below.

12. This finding draws on the totality of the coronial investigation into the death of Ms Knowles 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.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Events of 14 July 2021

13. On 14 July 2021, Victoria Police members attended the home of Ms Knowles and Mr Tilbrook in Kingsbury. Mr Tilbrook contacted '000' on three occasions on this day. The first contact occurred in the early hours of 14 July 2021, wherein Mr Tilbrook contacted '000' and advised that Ms Knowles was behaving erratically. Upon police attendance, Mr Tilbrook told members that they were no longer required and that "*things had calmed down*". Police observed that Ms Knowles presented as "*mildly drug-affected*" and stated that she was distressed due to the death of an ex-partner, and that she suffered from post-traumatic stress

[1] 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.

[2] 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.

disorder (**PTSD**). Police did not note any concerns for either party and police did not take any further action.

14. Two hours after this incident, Mr Tilbrook called '000' again to report that Ms Knowles was walking up and down the hallway of their building yelling and banging on his front door and trying to gain access to the apartment. Mr Tilbrook later called '000' to advise that they were no longer required as "*things had calmed down*". Police attended the scene anyway and spoke to Ms Knowles who explained that she had been using cannabis and was "*having a bad night in relation to PTSD regarding [her] ex-partner*". Victoria Police offered Ms Knowles a referral to support services, and she responded that she would go for a walk to "*cool off*". No further action was taken in response to this incident.

15. At about midday, Mr Tilbrook called '000' for a third time and advised that Ms Knowles was yelling, damaging the apartment and attempting to gain access to the apartment. He called '000' shortly thereafter and advised that he had pushed Ms Knowles out the door as she had damaged his property and was banging on her door. While Ms Knowles was waiting outside the apartment, she was approached by a neighbour named Marcello Rossi (**Mr Rossi**). Mr Rossi, and his partner, Dina, spoke to Ms Knowles briefly. Dina contacted '000' to advise that Ms Knowles had asked them to call police as her boyfriend was "*hurting her*" and "*belting her*".

16. Four members attended in response to this call, two of whom had their Body Worn Cameras (**BWCs**) activated. Ms Knowles had visible injuries to her face and advised police that she "*wanted him [Mr Tilbrook] arrested this time*", that her belongings had been stolen and that every day she is abused, threatened and thrown out. Police spoke to Mr Tilbrook who explained that Ms Knowles "*trashed*" his house, had been yelling and accusing him of stealing her drugs and money, and had taken diazepam and cannabis the night before. Members confirmed there was no property damage evident, although some items in the apartment were in disarray.

17. When asked whether there had been any violence, Mr Tilbrook explained that there had been "*grabbing*" and that he had pushed Ms Knowles out the door, causing her to cut her lip. When asked, Mr Tilbrook told police that he feared Ms Knowles on this occasion, that she threatened him "*all the time*" but that he did not believe she would carry out the threats as she was "*just a little girl*" and it was "*just talk from a small girl*". Mr Tilbrook noted that Ms Knowles had a scalpel in her jumper but that he did not want to make a statement or take out a FVIO.

18. One of the members advised the other members that Ms Knowles said that the cut on her face was caused by another person the night before, however this disclosure was not captured on BWC. Police noted that they would question Ms Knowles regarding her assault allegations when she attended the station. In a discussion between members, one member asked if there were any concerns for Mr Tilbrook's safety. Another member responded and stated that they did not hold fears for Mr Tilbrook's safety, that Mr Tilbrook was "*not in fear*" and that he simply wanted Ms Knowles to leave. One member spoke to a neighbour and reported back that the neighbour had only heard Ms Knowles "*carrying on*" and had not heard Mr Tilbrook.

19. When police advised Ms Knowles that she could gather her belongings and leave the address, it appears that Ms Knowles asked police if they were going to discuss her injuries. Police escorted Ms Knowles into the apartment to gather her items. They followed her to the front of the property where she was advised that they were going to issue a Family Violence Safety Notice (**FVSN**) in protection of Mr Tilbrook. Ms Knowles was also advised that she would need to accompany police to the station as a number of verbal disputes between the pair had been reported that day and that despite earlier police attendance, Ms Knowles had returned to the property. There were no orders in place at the time preventing Ms Knowles from being at the property.

20. When Ms Knowles was informed of the FVSN, she advised police of the injuries to her neck, pulled down her jumper and appeared to show members the injuries to her neck. Police asked when these injuries occurred, and she responded that Mr Tilbrook inflicted them that morning when he prevented her from leaving the apartment. Ms Knowles advised that her previous partner had attempted to kill her and that the experience was not new to her. The members advised Ms Knowles that they would discuss these injuries when they returned to the police station. No further inquiries appear to have been made regarding the injuries or Mr Tilbrook's alleged use of violence.

21. Police then explained to Ms Knowles that they would be searching her. As police were preparing to search her, she asked why she was "*getting treated like a piece of shit*" and asked what she had done wrong. Police told Ms Knowles that she had been told to leave by other members earlier that day and that she had returned. Ms Knowles clarified that she never agreed to leave, and that Mr Tilbrook said that he did not want her to leave. She was visibly distressed and began to raise her voice before stepping towards one of the members and moving her arm through the air while holding a beanie. Three members physically restrained Ms Knowles against a wall and handcuffed her. While restrained, Ms Knowles continued to ask what she

had done wrong, however she was not provided with a response. Ms Knowles spat at one member and the members covered her head with the hood of her jumper. She was placed in the back of a divisional van.

22. Upon arrival at the police station, Ms Knowles reportedly declined police assistance regarding the alleged assault perpetrated by Mr Tilbrook. She reportedly advised police that she would be returning to Mr Tilbrook's home to retrieve her Valium tablets, in contravention of the FVSN. The members explained the ramifications of returning to the address in breach of the FVSN. She declined an offer of police transport and advised that she would stay with her sister.

Events of 16 July 2021

23. Phone tower information obtained by police indicates Ms Knowles was in the vicinity of Mr Tilbrook's home in Kingsbury between 14 and 16 July 2021.

24. At about 10:00pm on 16 July 2021, CCTV footage (which is accompanied by audio recording) depicts Ms Knowles approaching the front door of the Kingsbury apartment building. Phone records indicate she was speaking on the phone to Mr Tilbrook at the time. Ms Knowles tried to open the door of the apartment building, but it was locked.

25. Mr Rossi exited the building at the same time. He spoke with Ms Knowles, and they appeared to recognise each other. Ms Knowles and Mr Rossi had a conversation in which he said something along the lines of "*you get on it?*". Ms Knowles later replied and said "*100%? Ok let's go*". I note however, that the CCTV audio is unclear due to other background noise.

26. Mr Rossi and Ms Knowles were observed on the CCTV footage getting into Mr Rossi's vehicle, a white 1996 Holden Commodore. They drove away from the residence at about 10:10pm.

27. What occurred after Ms Knowles and Mr Rossi got in the car together is unclear. Phone tower information indicates Ms Knowles was in the vicinity of Mill Park between 10:20pm and 11:25pm. She was then within the vicinity of the Kingsbury address again between 11:26pm and 11:30pm, and then phone towers suggest she was in Thornbury shortly after midnight on 17 July 2021. The phone records indicate she was last in the vicinity of the Kingsbury address at about 3:10am on 17 July 2021.

Events of 17 July 2021

28. At about 1:30am on 17 July 2021, Mr Rossi's car is captured on CCTV footage returning to a public car park on Plenty Road, Kingsbury. This car park is within 50 metres of Mr Tilbrook's residence.

29. Mr Rossi spent some time sitting in the vehicle. He was depicted on CCTV getting in and out of the car, walking around the back, and smoking. Mr Rossi walked out of the car park, leaving the car, at about 2:30am. Mr Rossi returned to his apartment complex at 2:46am.

30. CCTV footage does not show anyone approaching, getting into, or out of, Mr Rossi's car until 19 July 2021.

31. Ms Knowles is not seen on the CCTV footage at this time.

Discovery of Ms Knowles' body on 19 July 2021

32. At about 12:50am on 19 July 2021, a witness pulled into the car park on Plenty Road next to Mr Rossi's vehicle. The witness observed Ms Knowles sitting in the passenger seat. He used a torch to check on her and thought she "*didn't look right"*. He contacted emergency services for assistance.

33. Ambulance Victoria and Victoria Police members attended. Ms Knowles was sitting in the passenger seat of the vehicle, with her head tilted back and to the right. She had visible facial injuries including bruising to her cheeks. Attending paramedics confirmed she had been deceased for some time.

34. Two phones were found in Ms Knowles's lap. A syringe was located lodged in her jeans though this did not appear to have pierced the skin. Paperwork belonging to Mr Rossi was found in the vehicle, along with a white paper bag with a small amount of blood on it.

35. Police approached Mr Rossi and his partner Dina regarding the discovery of Ms Knowles in a vehicle which was registered to Dina. Both indicated confusion and denied knowing Ms Knowles. Mr Rossi stated he had used the vehicle to move property to his new place and had not used it since about 10:30pm on 16 July 2021.

36. Ms Knowles' death was initially believed to be the result of a drug overdose, due to the circumstances and presence of a used syringe in the vehicle.

IDENTITY OF THE DECEASED

37. On 20 July 2021, Tracey Ellen Knowles, born 19 February 1979, was identified via fingerprint identification.

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

MEDICAL CAUSE OF DEATH

39. On 21 July 2021, Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy. Dr Beer reviewed the Victorian Police Report of Death Form 83, post-mortem computed tomography (**CT**) scan, contact log, and scene photographs and provided a written report of his findings.

40. Dr Beer noted that Ms Knowles' death was initially considered to be a drug overdose by police and was admitted to VIFM as a routine admission. The initial inspection identified bruising around the mouth, and lacerations on the inner aspect of the mucosa. The scene photograph of the syringe was considered to be in an unusual, atypical position. These features raised the suspicion of potential foul play, and the case was escalated. An autopsy was determined to be required and subsequently approved. Police detectives attended the autopsy as per standard procedure.

41. The cause of death was given as *1(a) unascertained*.

42. Dr Beer noted that this case showed a number of concerning features resulting in the 'unascertained' finding as to cause of death. The autopsy showed blunt force injuries to the mouth region (bruising with buccal mucosal lacerations), and scalp bruising, but with no significant head/intracranial injuries. Dr Beer opined that the injury pattern did not suggest this was an accidental injury (but this could not be completely excluded) and was more indicative of Ms Knowles being assaulted sometime after meeting up with Mr Rossi. It was noted that the CCTV footage from 16 July 2021 showed no evidence of bruising around the mouth. These injuries would not have caused her death. Dr Beer indicated that, however, smothering by a third party as a cause of death could not be eliminated.

43. There was minor bruising to the arms and hands, some of which may represent the same time frame as for the head/mouth injuries, and others were more remote in nature.

44. There were minor cardiac abnormalities and liver centrilobular congestion and early bridging fibrosis identified, which would not have caused the death. There was no other natural disease found at autopsy which may have caused or contributed to the death.

45. Toxicology testing showed that there had been use of heroin (6-Monoacetyl-morphine). This was detected in the urine, but not in the blood. Morphine and codeine were detected in the blood and urine samples.

46. The levels of morphine and methylamphetamine detected in the blood are within reported overlapping non-toxic, low toxic, and low lethal ranges. There were high levels of morphine and methylamphetamine in the urine.

47. The combination of heroin (a respiratory depressant drug) and methylamphetamine (a stimulant drug) carries an increased risk of sudden death. Taking a depressant and a stimulant together causes a "*push-pull*" physiological reaction in the body with the negative effects of both drugs amplified when combined.

48. There were benzodiazepine drugs (diazepam and metabolites) detected in the blood, which were at non-toxic (therapeutic) range levels, but with high amounts in the urine. These drugs may have had a contributory sedation effect.

49. Toxicological testing confirmed that cannabis had also been used, but due to the high volume of distribution issues, no reliable comment can be made regarding the amount or timing of the drug. This was not considered to be contributory to Ms Knowles' death. No blood ethanol (alcohol) was detected.

50. There was an intravenous injection site in the left antecubital fossa suggestive of very recent intravenous drug use. It is unclear where the drugs were injected, noting that Ms Knowles was fully dressed in the vehicle without ready access to the left arm antecubital fossa, and there was no drug paraphernalia in the vehicle other than the needle noted at the scene.

51. The syringe in the left posterior thigh did not appear to penetrate through the jeans at the scene. It was not present in the body bag at autopsy, having been disposed of by the police. There was no mark in the thigh at autopsy.

52. The toxicology results may indicate a mixed drug toxicity mechanism of death, but as noted above, smothering cannot be excluded. Dr Beer indicated that further police investigation

surrounding the circumstances of death may be required and noted that comments and conclusions of the autopsy may be amended should further information become available.

53. Dr Beer provided an opinion that the medical cause of death was *1 (a) Unascertained*.

54. This finding is discussed in further detail below.

HOMICIDE INVESTIGATION

55. Upon receipt of the autopsy results and issues raised by Dr Beer, Victoria Police's Homicide Squad conducted an investigation into the death of Ms Knowles. Attempts were made to speak with Nathan Tilbrook; however, he refused to engage with police.

56. On 5 April 2022, Mr Rossi attended Heidelberg Police Station to provide a further statement, following the police investigations which had established he had been in contact with Ms Knowles prior to her death.

57. Mr Rossi advised police he had recently remembered he did speak with Ms Knowles prior to her death. He described meeting her outside of the apartment building following the dispute with Mr Tilbrook. He said he was going to the doctor, so offered her a lift to a service station. He said this was the last time he saw her and that they did not use or discuss drugs whilst they were together.

58. Mr Rossi was questioned about the CCTV footage of his vehicle parked on Plenty Road which shows him leaving the vehicle, and no one else entering or exiting the vehicle prior to Ms Knowles' body being discovered on 19 July 2021. Mr Rossi was unable to explain these events nor the inconsistency with his earlier statement.

59. On 4 May 2022, Mr Rossi was arrested in connection to Ms Knowles' death and perjury for providing a false statement. In a recorded interview, Mr Rossi admitted to lying in his earlier statements and indicated that the reason was that he did not want his partner to discover that he was in his car with another woman.

60. Mr Rossi clarified that he first met Ms Knowles on 14 July 2021 and then saw her again on 16 July 2021 when they got in his car together after speaking at the front of the apartment building. He said that Ms Knowles was upset, and he offered to take her for a drive to go and use methylamphetamine. He stated that Ms Knowles said she had been fighting with her boyfriend.

61. He admitted he did not drop Ms Knowles at a service station as previously stated, but rather that he drove to see his doctor in Mill Park, and she came too. He attended his appointment, and she went to the bathroom. Victoria Police confirmed Mr Rossi attended this doctor's appointment. Ms Knowles' phone records indicated she was in the vicinity of Mill Park between 10:20pm and 11:25pm.

62. Mr Rossi stated they left the clinic and "*drove around*". He was "*spaced out*" as he had smoked cannabis. He said they shared an ice pipe but did not use heroin together. Mr Rossi could not explain why they travelled to Thornbury together, other than to say he was spaced out and that Ms Knowles was providing directions. He said they drove aimlessly for some time, but did not meet anyone, stop anywhere, or speak to anyone.

63. Mr Rossi confirmed Ms Knowles was in the car with him when he drove into the carpark on Plenty Road. Regarding his unusual behaviour prior to leaving the car park on foot, Mr Rossi stated that he was contemplating whether he should allow Ms Knowles to stay in the car. He stated that as it was cold, and she had nowhere to go, he agreed to let her stay in the car for shelter. Mr Rossi stated he then went home to bed. He stated that Ms Knowles was alive and, on her phone, when he left her. He advised police he went straight home. This was confirmed on CCTV footage which shows Mr Rossi returning to the apartment building.

64. Mr Rossi indicated that he then did not leave the house for two days as he was tired. He confirmed he did not know Ms Knowles was deceased until police attended his residence. Mr Rossi denied assaulting, touching, smothering, injecting, or having any sexual activity with Ms Knowles. He could not explain how she came to have the injuries to her face, but confirmed they were not there when he left her.

65. Mr Rossi acknowledged he had not been entirely truthful in his two previous statements, but declared he was being truthful in this record of interview.

66. Homicide Squad investigators deemed there were no identifiable offences in connection with Ms Knowles' death. No one else appeared to have had contact with Ms Knowles prior to her death other than Mr Rossi. The Homicide Squad noted that although Mr Rossi was initially untruthful, he eventually provided a version of events consistent with the available evidence. Police accepted that he did not commit an offence in connection with her death. The cause of Ms Knowles' facial bruising remained unexplained.

67. At the conclusion of the Homicide Investigation, police concluded that Mr Rossi's version of events would exclude smothering as a cause of death. It was suggested that death may have been caused by the remaining unexcluded potential cause, being mixed drug toxicity. It was noted that both methylamphetamine and morphine were located during testing in potentially lethal levels, though these were not definitively ascribed to causing to the death.

68. It was acknowledged that there is the possibility that Mr Rossi was not being truthful, however there were no further avenues of enquiry to investigate this.

FAMILY CONCERNS

69. Ms Knowles's sister, Leanne Knowles (**Leah)**, and niece, Rhea Adams (**Rhea**), contacted the Court on 21 June 2022 to express concerns after reviewing the coronial brief. Leanne and Rhea stated they felt the police had not conducted a thorough investigation, and that many questions remained unanswered.

70. Leanne and Rhea noted that the police had not obtained a statement from Ms Knowles's ex-partner. Leanne and Rhea felt this was concerning as Ms Knowles had previously been in a relationship in which he was violent and allegedly strangled her. Ms Knowles' partner at the time of the incident, Mr Tilbrook, also did not provide a statement.

71. It was also suggested that Ms Knowles and Mr Rossi knew each other prior to this incident, as they apparently grew up in the same area. Leanne and Rhea did not think Ms Knowles would get in a car with a stranger.

72. Leanne and Rhea were concerned with Mr Rossi's behaviour when he pulled into the carpark, and is seen walking around the car, and getting in and out of the driver's seat for about an hour before returning to his apartment. Ms Knowles is not able to be seen in this footage.

73. As detailed above, Mr Rossi provided incorrect information to police in his first two statements and initially denied knowing Ms Knowles. Leanne and Rhea felt that Mr Rossi's version of events did not "*add up*", and believe he knew Ms Knowles was deceased in his vehicle.

74. Leanna and Rhea had significant concerns around the injuries to Ms Knowles' face. Dr Beer noted in his autopsy report the possibility of a third-party assault, and stated he could not rule out smothering as a cause of death. These concerns were carefully considered, with then-DSC Hawkins opining that the facial injuries required further investigation.

75. Ms Knowles' family suggested that Mr Rossi and Ms Knowles drove to an unknown location where Ms Knowles was assaulted and then got back in the car. Rhea and Leanne considered Ms Knowles' death to be suspicious and asked the Court to ensure the Homicide Squad had thoroughly investigated the circumstances.

76. Leanne and Rhea raised some additional concerns which were not considered to be within the scope of a coronial investigation.

77. After reviewing the coronial brief and the family concerns, then-DSC Hawkins agreed there were questions left unanswered, particularly surrounding the unknown cause of Ms Knowles' death and the facial injuries. As such, further investigations were directed to be undertaken in an attempt to ascertain what occurred in the hours prior to Ms Knowles' death, and when her body was discovered on 19 July 2021.

FURTHER INVESTIGATIONS

78. Then-DSC Hawkins sought further details from Dr Beer regarding potential causes of Ms Knowles' death, including strangulation. Dr Beer confirmed that the autopsy did not show any evidence of strangulation, due to no strap muscle bruising or hyoid damage. He emphasised that Ms Knowles's facial injuries did not cause her death, but he remained unable to say whether she may have been smothered. Equally, he was not of the view that the cause of death could be ascribed to drug toxicity alone.

79. Dr Beer agreed that it was clear Ms Knowles had experienced some kind of violence. Dr Beer was unable to say whether this was self-inflicted or due to an assault.

80. Having considered this additional information, then-DSC Hawkins (appropriately) considered it necessary to obtain further evidence from the investigating Victoria Police officers, forensic toxicology, forensic odontology, and the forensic pathologist.

81. Upon my review of this matter, I directed further inquiries occur including a referral to the Coroners Prevention Unit, so that the case could be reviewed as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**). These further inquiries are detailed below.

Further investigations by the Homicide Squad

82. The Court contacted the Homicide Squad and requested that a suitably qualified and senior-ranked member of the Squad provide an additional statement addressing the coronial brief and medical examiners report, as well as the family statement and issues raised.

83. Detective Acting Sergeant (**D/A/Sgt**) Telen Stanfield conducted further investigations and provided an additional statement in this matter. D/A/Sgt Stanfield oversaw the Homicide Squad investigation into the death of Ms Knowles.

84. D/A/Sgt Stanfield confirmed that Ms Knowles' death was initially considered to be drug-related due to the circumstances in which her body was found. He noted the autopsy which identified facial injuries which were considered to be the result of a low-level assault, but not contributory to death. Dr Beer later confirmed that he was unable to rule out smothering in the context of a recent assault and sedation.

85. Investigations were undertaken around possible causes for the injuries to Ms Knowles' mouth. Mr Rossi denied assaulting Ms Knowles and stated she did not have any facial injuries when he left the car. D/A/Sgt Stanfield stated that investigators had no other avenues of enquiry to determine the mechanism of injury. He acknowledged this was an important issue and the Homicide Squad wanted it answered, but it was difficult to do so without speculation.

86. D/A/Sgt Stanfield stated that although Dr Beer had been unable to exclude smothering as a cause of death, this did not mean that it *was* the cause of death. He noted that Mr Rossi denied smothering Ms Knowles, and stated she was alive when he left the vehicle. The CCTV footage does not show any other person attending the vehicle. DA/Sgt Stanfield stated, "*we have no affirmative evidence to suggest smothering other than a lack of ability to exclude it"*.

87. The Homicide Squad held concerns around the reliability of Mr Rossi's evidence from the initial investigation and considered he had engaged in obscuring behaviour. However, in its view, there was insufficient evidence to suggest a homicide had occurred and although investigators have not been able to corroborate Mr Rossi's account in its entirety, there is no evidence to suggest his final account is not true.

88. Mr Rossi was arrested and interviewed by Victoria Police, as detailed above. Mr Rossi claimed Ms Knowles was alive when he left her in the car. Regarding the concerns as to his behaviour before leaving the carpark, Mr Rossi had justified the time spent as stating he was smoking, talking, using his phone, and contemplating if he should allow Ms Knowles to sleep in the car. D/A/Sgt Stanfield noted the reliability of this version of events is a matter for the coroner to determine.

89. D/A/Sgt Stanfield confirmed there was no evidence that Mr Rossi and Ms Knowles' ex-partner were associated, and no evidence that her ex-partner had contact with Ms Knowles in

the weeks prior to her death. Further, there is no evidence that Ms Knowles and Mr Rossi were previously known to each other.

90. Mr Tilbrook, Ms Knowles' partner prior to her death, was approached by the Homicide Squad regarding a statement. He refused to speak with or provide any statement to police. D/A/Sgt Stanfield stated that police have no power to force his cooperation or to force him to provide a statement in the absence of being considered a suspect for any offence. Given the known movements of Ms Knowles in the lead-up to her death and the available CCTV footage, D/A/Sgt Stanfield stated Mr Tilbrook is not at this stage considered a suspect for any offence related to the death of Ms Knowles.

91. D/A/Sgt Stanfield confirmed after having reviewed the material that there is no evidence to support a hypothesis that Ms Knowles was the victim of a homicide. He considered the coronial investigation and brief of evidence was conducted and completed in an appropriate manner.

92. It was emphasised that this investigation, as with all homicide investigations, was treated with the utmost respect and thoroughness. D/A/Sgt Stanfield stated he is sure the matter has not been miscategorised. He acknowledged the unusual aspects and unexplained events, but no evidence has been uncovered to suggest a homicide has occurred. He stated, "*unusual and unexplained does not alone make it suspicious*".

93. Mr Rossi was the only person who realistically had an opportunity to commit an offence which may have led to Ms Knowles's death. D/A/Sgt Stanfield considered he had been appropriately questioned, and no evidence exists to support a hypothesis of homicide, other than the pathologist's inability to exclude smothering.

BWC footage of 14 July 2021

94. One of the attending police members provided a statement to the Court dated 11 December 2022 regarding the family violence incident on 14 July 2021. As discussed above, members of Victoria Police attended Ms Knowles and Mr Tilbrook's residence on two occasions on 14 July 2021 in relation to alleged family violence. On the second occasion, Ms Knowles was issued with a FVSN, and it was decided she would be transported to the Northcote Police Station to be served with the same.

95. During discussions with police, Ms Knowles became verbally aggressive. I have been provided body worn camera (**BWC**) footage of this interaction, which shows Ms Knowles attempting to spit at officers before she is restrained against the wall of the building.

96. I initially held concerns that this restraint may have caused some facial bruising to Ms Knowles and may explain the injuries at autopsy. However, there is no bruising visible in the second half of the footage, and in later CCTV footage on 16 July 2021.

Statement of Ms Knowles' ex-partner

97. A statement was obtained from Ms Knowles' ex-partner on 21 December 2022. He confirmed he had not seen Ms Knowles for about eight or nine months prior to her death. He believed he would have been moving into his residence in Glenroy at the time of her death in July 2021. Ms Knowles' ex-partner stated he was unable to recall any other specifics.

98. I do not consider that Ms Knowles' ex-partner was involved in any way in her death and accept his evidence that they had not seen each other for some time.

Homicide Squad Forensic Report

99. D/A/Sgt Stanfield provided me with a copy of the results of the forensic biological testing conducted in the Homicide Investigation.

100. Mr Rossi's DNA was only found on Ms Knowles's left hand. DASgt Stanfield noted there a number of possibilities of how this got there, particularly given they were in a car together.

101. Blood on the paper bag in the car was found to belong to Ms Knowles. This suggests she may have coughed up or spat out blood whilst in the car, as there was no external bleeding identified at autopsy.

Forensic Odontology Investigation

102. Then-DSC Hawkins obtained an additional statement from VIFM's Forensic Odontologist, Dr Richard Bassed, in relation to this matter. Dr Bassed reviewed Dr Beer's report, the autopsy photographs, and post-mortem CT scans and was asked to comment on any potential causes of the facial injuries. It was noted that Dr Bassed did not examine the body of Ms Knowles and was only relying on case documentation.

103. Dr Bassed stated that he was in full agreement with Dr Beer's descriptions and analysis of Ms Knowles' facial injuries. He agreed with Dr Beer's concerns regarding possible causation. Dr Bassed had nothing further to add regarding the injury descriptions.

104. In considering the possibility of self-inflicted injuries, Dr Bassed noted that the internal cheek lacerations referred to in the autopsy report and visible in the autopsy images had at least two potential causative mechanisms. Dr Bassed stated it is possible there were other mechanisms not considered.

    a) Mechanism 1: injuries were sustained by Ms Knowles biting the inside of her cheeks with sufficient force to lacerate the mucosal cheek lining. Such biting may possibly occur in the setting of drug related impairment where pain tolerance and muscle control is altered.

    b) Mechanism 2: injuries may also result from a medical event, such as an epileptic fit, where control of voluntary muscle movements is lost and muscle spasm to the lower jaw may cause injury to the soft tissue inside the mouth from involuntary biting motions.

105. Dr Bassed stated the specific morphology of the lacerations in this case did not resemble fit-related cheek chewing, which would result in a more macerated appearance. Rather, these resembled injuries caused by a single application of force – such as a single hard bite, blow, or pressure at one particular point against a tooth.

106. The above scenarios do not, however, explain the bruising on the face at the same approximate location (but external to) the internal cheek lacerations. Such skin bruising may only be reasonably explained by the application of blunt force directly to the cheeks.

107. In terms of self-infliction causing these external skin bruises, the only reasonable scenario Dr Bassed could postulate was a medical event resulting in a seizure which caused Ms Knowles to uncontrollably throw herself around inside the vehicle she was found in, impacting her face on a hard surface on both sides of her face with sufficient force to cause bruising to the cheeks and internal lacerations via impact of the cheek tissues with the teeth at the point of impact.

108. Dr Bassed noted that in such a fit-related scenario, he would expect to see evidence of blunt force trauma on other areas of the face. It is odd, if this was a seizure, that only the cheeks each side of the mouth were impacted.

109. In considering the possibility of the injuries being deliberately inflicted by another party with sufficient force to bruise the face, and at the same time cause significant lacerations to the internal mucosal lining of the cheeks, there were at least two potential scenarios:

    a) Mechanism 1: two blows, one to each side of the face, are a possible mechanism for these injuries. A blow to the cheek with a solid object, such as a fist or similar item, can crush the inner surface of the cheek onto the teeth at the point of impact, thus lacerating the mucosal cheek linking, as well as resulting in external facial bruising.

    b) Mechanism 2: significant pressure applied to both cheeks simultaneously by a hand or similar object in a smothering attempt. This could result in the described injuries to the face of Ms Knowles. Such pressure (sufficient to prevent respiration) can press the cheeks against the teeth for a significant time, during which a variable degree of resistance could reasonably be displayed by the victim. In this scenario both bruising to the face, and cheek lacerations are not an uncommon finding.

110. Dr Bassed concluded that absent of any medically related or drug induced seizure-type scenario, he considered it highly unlikely that the injuries to the face were self-inflicted.

Forensic Toxicology Investigation

111. The Court obtained an additional statement from VIFM's Forensic Toxicologist, Associate Professor Dimitri Gerostamoulos (**A/Prof Gerostamoulos**) in relation to this matter. A/Prof Gerostamoulos reviewed Dr Beer's autopsy report, and the initial toxicology report.

112. He notes that, although a cause of death was unable to be definitively determined, routine toxicological investigations revealed the presence of a number of drugs in Ms Knowles' system at the time of her death.

113. These drugs included heroin (as 6-monoacetylmorphine), morphine, codeine, diazepam, methylamphetamine, amphetamine, diazepam, nordiazepam, temazepam, oxazepam, and cannabis. Ethanol (alcohol) was not detected.

114. A/Prof Gerostamoulos opined that the toxicology results were consistent with recent use of heroin as the specific marker of heroin use was detected in urine (6-monoacetylmorphine). There was also morphine and codeine detected in the blood and urine. Other drugs also found in Ms Knowles were methylamphetamine and its metabolite amphetamine, as well as diazepam (and metabolites) and cannabis.

115. The detection of 6-monoacetylmorphine in urine is regarded as evidence of heroin use within the 12 hours preceding death.

116. A/Prof Gerostamoulos stated that in victims of heroin intoxication, the post-mortem concentrations vary depending on the prior opioid history of the user (i.e. tolerance) hence, the qualitative presence of heroin or its metabolites in the absence of an apparent cause of death is sufficient to designate heroin toxicity as a likely cause of death.[3]

117. The blood concentration of morphine (~0.4mgL) is significant and consistent with fatalities with heroin use.[4]

118. A/Prof Gerostamoulos acknowledged Dr Beer's opinion that smothering could not be excluded. Despite this, he did not consider it unreasonable to conclude that Ms Knowles died as a result of a heroin overdose in combination with the other drugs detected.

Forensic Pathologist Conclusion

119. Upon receipt of the additional statements from Dr Bassed and A/Prof Gerostamoulos, then-DSC Hawkins again contacted the Forensic Pathologist, Dr Beer, to determine whether the expert opinions altered his conclusions at the cause of death.

120. Dr Beer confirmed that his opinion as to the cause of death had not changed.

121. Dr Beer stated the toxicology results are sufficient to propose a mixed drug toxicity as a reasonable cause of death. He emphasised that in the absence of the facial injuries, this would have been the cause of death provided.

122. Ms Knowles appeared free from major injuries (as far as can be seen) and does not appear visibly drug affected when she is seen on the CCTV footage outside the apartment building, and prior to getting in the car with Mr Rossi. Dr Beer stated that it appears she took the drugs that appeared in toxicology findings at some point after this, based on her appearance in the CCTV. It is noted that she was wearing a coat and jacket when she was found, and as such it is unlikely this occurred when the car was in the car park (presumably due to the injection site being in the antecubital fossa, which would be covered by such clothing).

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[3] Peterson BL, Schreiber S, Fumo N, Brooke Lerner E. Opioid Deaths in Milwaukee County, Wisconsin 2013-2017: The Primacy of Heroin and Fentanyl. J Forensic Sci. 2019;64(1):144-8.

[4] Darke S, Sunjic S, Zador D, Prolov T. A comparison of blood toxicology of heroin-related deaths and current heroin users in Sydney, Australia. Drug and Alcohol Dependence. 1997;47(1):45-53.

123. Regarding interpreting the facial injuries in terms of a cause of death, Dr Beer stated he considers the blunt force injury assault (by hand or fist) to either side of the face, with any natural disease or self-inflicted mechanism, to be very unlikely.

124. Dr Beer was unable to determine the timing of the assault, based on his examination of the body. Dr Beer stated that in any event, the injuries would not play a direct role in the death which would be a mixed drug toxicity mechanism.

125. Dr Beer stated his main concern is that either alone or in combination with a bilateral facial assault, suffocation could not be excluded or conclusively proven. Given the overall circumstances, Dr Beer considered the cause of death should remain as 1 (a) 'Unascertained'.

Homicide Squad Conclusion

126. The new forensic evidence was provided to the Homicide Squad for additional final comment. Detective Sergeant (**D/Sgt**) Shaun O'Connell reviewed the investigation and relevant material and provided a written statement.

127. During D/Sgt O'Connell's review, he formed an opinion that the following series of events may have taken place immediately prior to Ms Knowles' death:

    a) Mr Rossi and Ms Knowles met for the first time at the apartment building and had a conversation.

    b) Mr Rossi and Ms Knowles were both drug users with a history of drug abuse. They agreed to go for a drive and use heroin together.

    c) At some point after they both used heroin, Ms Knowles either fell asleep or started to overdose.

    d) Mr Rossi attempted to rouse her by grabbing her face (which caused the bruising to her cheeks) however was unsuccessful.

    e) He subsequently left Ms Knowles in his vehicle and returned to his address.

128. D/Sgt O'Connell considered it necessary to speak with Mr Rossi again to determine if he touched Ms Knowles's face at any point.

129. On 17 June 2023, D/Sgt O'Connell and Detective Senior Constable (**DSC**) Alex Lewis, attended Mr Rossi's home address. Mr Rossi was asked if he touched Ms Knowles in any way throughout the night, and specifically if he touched her to try and wake her. Mr Rossi said:

> *If I had have touched her I think it would have been when I got back to the car from the medical centre. I grabbed her face like that I think [motioned by putting his hand across his face and squeezing his cheeks, with the thumb on one cheek and his fingers on the other cheek] and said, 'wake up, wake up', but after that she woke up.*

130. Mr Rossi's version of events remained consistent with his recorded interview on 4 May 2022, other than his admission about touching Ms Knowles' face.

131. Following the interview, D/Sgt O'Connell stated he was of the view that:

a) The level of drugs found in Ms Knowles' blood and urine at the time of her death was consistent with a drug overdose.

b) The blood located inside the vehicle belonged to Ms Knowles and was most likely deposited by her either during her drug use or as a result of her drug overdose.

c) There were no defensive style indicators from the results of her fingernail swabs which may have suggested a struggle or similar prior to her death and there were no signs that a struggle took place within the vehicle.

d) Mr Rossi's conduct, when taking into account all the circumstances, is not consistent with that of someone who had just committed the offence of murder.

e) The injuries to Ms Knowles' cheeks may have been caused by Mr Rossi in his attempts to wake her whilst she was under the influence of heroin.

f) There is no known motive for why Mr Rossi would have murdered Ms Knowles.

132. D/Sgt O'Connell confirmed it was his belief that Ms Knowles died as a result of a drug overdose.

VSRFVD review

133. Following receipt of this very thoroughly-gathered additional evidence, I assumed carriage of the investigation in October 2023. As Ms Knowles' death occurred in circumstances in which she was experiencing family violence in the lead-up to her passing, I requested that the CPU examine the circumstances of Ms Knowles' death as part of the Victorian Systemic Review

of Family Violence Deaths (**VSRFVD**).[5] In particular, I was concerned that police may have misidentified the predominant aggressor in the reported family violence incident on 14 July 2021 between Mr Tilbrook and Ms Knowles, following which Ms Knowles was excluded from the apartment in which they were living, and was rendered homeless.

134. I make observations concerning service engagement with Ms Knowles 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 Knowles' death.

135. 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*".[6] I make observations about services that had contact with Ms Knowles to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Identification of the predominant aggressor

136. The term 'predominant aggressor' is at times substituted for the term 'primary aggressor', and:

> *...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]

[5] 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.

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

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

137. The Court obtained a statement from Assistance Commissioner (**AC**) Lauren Callaway, to assist with understanding whether Victoria Police complied with its internal policies and procedures with respect to the 14 July 2021 police contact.

138. AC Callaway noted that the members who attended on 14 July 2021 acted in accordance with relevant policies and procedures. She explained that the members confirmed Mr Tilbrook was in fear of Ms Knowles and that Mr Tilbrook alleged Ms Knowles had a scalpel in her jumper "*which indicated her capacity to inflict injury, and that Ms Knowles had made multiple threats to assault and kill him*". AC Callaway noted that Mr Tilbrook presented this scalpel to members, however based on the evidence available to the Court, I was unable to substantiate this claim.

139. Upon a review of the BWC footage, I am of the view that Victoria Police members did not have significant contact with Ms Knowles during their attendance and did not seek any information about her level of fear or her version of events.

140. The Victoria Police *Code of Practice for the Investigation of Family Violence* in place at the time of this incident provided guidance to members on how to identify the predominant aggressor, listing several indicators for police to consider, including:

    a) How fearful each person is

    b) Any historical pattern of coercion, intimidation and/or violence

    c) The nature of any injuries

    d) The capacity to inflict injury

    e) The need for protection

    f) Any information from other agencies

141. While police spoke to Mr Tilbrook and documented his version of events, it does not appear that police considered the injuries to Ms Knowles' neck in their assessment, or Mr Tilbrook's admission of grabbing Ms Knowles, causing an injury to her lip. Police did not ask Ms Knowles about her level of fear and only asked Mr Tilbrook this question, who noted that he was fearful of her but also commented that she would be unable to carry out any threats she made against him.

142. The BWC footage from members indicated that they intended to discuss Ms Knowles' experience of violence when she attended the police station as it was their assessment that she was drug-affected during their attendance. I cannot determine whether Ms Knowles was indeed substance affected at that time; however, she was articulate and clear with her answers to police and advised police that she had not taken any medication or illicit substances since the night prior.

143. It is interesting that police intended to question Ms Knowles about her experience of violence after already identifying her as the predominant aggressor. This would appear to be in contravention of Victoria Police's guidance for members who are trying to determine the predominant aggressor in a family violence incident. By not asking Ms Knowles questions at the scene *before* deciding who to transport back to the police station, it would appear that the members already determined that she was the predominant aggressor. This was despite the fact that Ms Knowles presented with visible injuries and sought to raise these with attending police, and that excluding her from the address would leave her unhoused.

144. Police misidentification of women as primary aggressors is an ongoing issue in Victoria and other Australian jurisdictions and has serious repercussions for victims.[8] It is well understood and 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.[9] Women who are victims of family violence often "*encounter conditional help*"[10] which disadvantages many woman, especially those who fight back, have a criminal history, abuse alcohol or other drugs, or are seen as less than ideal parents.[11]

145. Misidentification of women as primary aggressors is often driven by these racialised, classed, and gendered stereotypes of ideal victims, and women in general, as being submissive to authority, downtrodden, passive, and dependent.[12] Women who do not fit these stereotypes

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[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] 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).

[10] 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.

[11] Ibid.

[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), 3; Heather Nancarrow et al (n 246) 26; No

may be viewed unfavourably by police leading to decision-making in favour of the perpetrator.[13]

146. Upon a review of the material, it appears that the members identified Ms Knowles as the predominant aggressor during their interactions with her on 14 July 2021, and did not appear to take her concerns or allegations seriously. I do not accept AC Callaway's assessment that the attending members complied with internal policies/procedures in relation to the third attendance on 14 July 2021. The members obtained Mr Tilbrook's account and asked him about his level of fear, however, did not ask Ms Knowles for her account or her level of fear, and did not appear to consider her visible injuries. In accordance with Victoria Police's guidelines for determining the predominant aggressor, members did not appear to consider Ms Knowles' visible injuries, nor Mr Tilbrook's admission that he grabbed her. While members asked about Mr Tilbrook's level of fear, the same question was not asked of Ms Knowles. AC Callaway opined that Ms Knowles' possession of a scalpel (which has not been confirmed based on the evidence available to the Court) was evidence of her capacity to inflict injuries on others. It is purely speculative now to determine why she may have had a scalpel in her possession; however, it is possible that she was holding it for self-defence purposes.

147. When the attending members decided to assign Ms Knowles as the predominant aggressor, they were not making this decision with a complete picture of the relationship. It is understandable that she was restrained once she became physical towards the members, however I query whether the physical altercation would have occurred if the members obtained both Mr Tilbrook and Ms Knowles' sides of the story, before making a decision about the predominant aggressor and deciding to transport Ms Knowles to the police station.

148. The Court provided Victoria Police with an opportunity to respond to my concerns about misidentification of the predominant aggressor. Through their legal representatives, Victoria Police stated that they reviewed the BWC from the event and confirmed that it was unable to identify at any point in the footage where Mr Tilbrook produces the scalpel. Victoria Police did not make any further submissions in relation to misidentification of the predominant aggressor.

To Violence, 'Predominant Aggressor Identification and Victim Misidentification' (Discussion Paper, November 2019)12.

[13] 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) 96.

149. I note that in the time since Ms Knowles' passing, Victoria Police have undertaken work to address the issue of police misidentification of the predominant aggressor. It has updated and improved guidance on identifying the predominant aggressor in line with Victoria's family violence risk assessment and management framework, the Multi-Agency Risk Assessment and Management (**MARAM**) framework.

150. Victoria Police also carried out the Predominant Aggressor Identification Trial (**the Trial**) in the Northwest Metro Division Five between October and December 2022. The aim of the Trial was to examine police risk assessment decisions and identify opportunities for interventions or practice changes that support early recognition and rectification where misidentification has occurred. The Trial encouraged consultation and review at different points in the police process when police members identified a female respondent in the context of an opposite sex relationship. It also involved the provision of a MARAM-aligned tool to assist supervisors with reviewing these cases.

151. The findings of the Trial were discussed in Coroner Despot's recent finding into the death of EDH, namely:

    a) Supervisory support prior to submission of the VP Form L17 was uncommon, possibly due to resourcing issues meaning police members rarely received support with identifying the predominant aggressor prior to committing their assessment to LEAP and taking further actions, such as making family violence referrals and applying for FVIOs.

    b) Supervisor case reviews were completed after the completion of VP Form L17s in 38.4% of the cases where a female was identified as the predominant aggressor (56 of the 146 instances) but were wholly ineffective in identifying cases of misidentification.

    c) There were no documented instances of information sharing with relevant agencies to improve accurate identification of the predominant aggressor. Even uncertainty about the predominant aggressor did not prompt information sharing by police, and the Trial concluded that 'information sharing continues to be under-utilised at the frontline and across the broader systems into Victoria Police'.

    d) Following the Trial, a review of the police records relating to the 146 instances where police identified a female predominant aggressor found likely cases of

misidentification which were not identified at any stage of the trial. This is particularly concerning given the additional mechanisms in place for improving accurate identification of the predominant aggressor during the Trial.

e) The Trial found that police continue to take an incident-based approach to assessing predominant aggressors, and to 'equate criminal offending with the predominant aggressor at a family violence incident', and that this has led to instances of misidentification of the predominant aggressor.

f) Which party contacted the police influenced the subsequent direction taken by police - when a male using systems abuse contacted police to make a report about their partner, misidentification was more likely to occur.

152. During the Trial, the only point of review which was effective in identifying instances of misidentification was review by a Family Violence Court Liaison Officer (**FVCLO**). Of the 16 cases subject to a review by a FVCLO six were confirmed as misidentified, and three others were identified as suspected misidentification. These included cases which had previously been reviewed by a supervisor at a police station. The Trial report suggests that one reason for the discrepancy in different types of reviews' efficacy in picking up on misidentification may be the differing priorities between police members working in different contexts whereby '*the station focuses on criminality and immediate safety in contrast to the pre-court space, where there is a civil and justice focus*'.

153. Following the Trial, Victoria Police have continued their work on addressing misidentification of the predominant aggressor through the Predominant Aggressor Program of Work, which started in December 2022 after the Trial ended. This work includes improving training and guidance and considering amendments to record keeping systems which promote correct initial identification of the predominant aggressor.

154. In a recent statement from police in relation to the passing of FCP,[14] Victoria Police advised that they are currently developing a Family Violence Predominant Aggressor Practice Guide which will be aligned to the Family Violence Multi-Agency Risk Assessment and Management Foundation Knowledge Guide and Practice Guides. This guide will also highlight specific factors which may increase risk of misidentification, require police to

[14] Finding into the death without inquest – FCP (COR 2020 1981).

consider bias in their decision making and require members to consider violence in the context of self-defence or violent resistance.

155. I acknowledge the recent and ongoing work by Victoria Police to address the issue of misidentification of the predominant aggressor. However, it would seem prudent to take steps to try to prevent misidentification occurring in the first place, rather than responding to it once it has occurred. There are additional and alternative strategies to improve Victoria's response to family violence, and to reduce the changes of misidentifying the predominant aggressor. These options are discussed further below.

Expansion of Victoria's co-responder program

156. 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.[15]

157. 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%,[16] increased reporting,[17] and transfer of skills and knowledge between police and specialist family violence workers.[18]

158. During the VSRFVD panel on multi-disciplinary responses to family violence both Family Safety Victoria and Victoria Police expressed support for the expansion of co-responder programs in principle but noted barriers to implementation. Most notable were workforce capacity and funding, given that co-responder programs are considered relatively resource

[15] 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.
[16] Dr Lisa Harris, Dr Anastasia Powell and Dr Gemma Hamilton, Alexis – Family Violence Response Model (Evaluation Report, 2017) 28.
[17] 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.
[18] Ibid, 145-152.

intensive, and the family violence sector is struggling to fill vacancies. These challenges do not appear insurmountable, nor that they should prevent a recommendation to expand co-responder programs. Specialist family violence services are currently unable to successfully engage with a large proportion of the affected family members (**AFMs**) referred to them under the current system, whereby police make referrals after attending family violence incidents.[19]

159. In the present case, if a specialist family violence worker responded to this incident in combination with police, they may have been able to elicit further information from Ms Knowles about her experience of violence. This, in turn, may have assisted attending police to make a more informed decision regarding who was the predominant aggressor.

160. I note that the State Coroner, Judge Cain, has recently made comments regarding the potential benefits of a co-responder program in his finding into the death of Carolyn James. In his finding into the passing of Noeline Dalzell, Judge Cain recommended:

> *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.*

161. In response to this recommendation, Victoria Police advised that it consulted with the Department of Families, Fairness and Housing (hereinafter **DFFH**; the department with oversight of The Orange Door) and explained that Victoria Police would work with DFFH to consider the options and 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.

[19] Dr Lisa Harris, Dr Anastasia Powell and Dr Gemma Hamilton, Alexis – Family Violence Response Model (Evaluation Report, 2017) 17.

162. In the State Coroner's recent finding into the death of Jessica Geddes,[20] he recommended that Victoria Police and DFFH provide funding to implement Recommendation 5 (above) in his finding into the passing of Noeline Dalzell. At the time of delivering this finding, Victoria Police and DFFH have not yet formally responded to this recommendation.

163. I therefore endorse Judge Cain's recommendation and will direct a copy of this finding be provided to Victoria Police and DFFH, for their consideration.

Specialist family violence sector reviews of Victoria Police Family Violence Reports

164. The Family Violence Reform Implementation Monitor's (**FVRIM**) recent report Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor (**FVRIM report**) made recommendations in relation to improving accurate police identification of the predominant aggressor, and all were endorsed by State Coroner Judge Cain in the finding into the death of Michael Power. Victoria Police are undertaking a program of work designed to address "*the intent of all [FVRIM] recommendations*", however I note that this does not include recommendation five, that Victoria Police:

> *Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possibly for other targeted cohorts) before it is committed to Victoria Police's LEAP database.*

165. In Judge Cain's finding into the death of FCP,[21] Victoria Police submitted that it had met this recommendation by consulting with family violence and other support services in the design of the Predominant Aggressor Identification Trial. However, whilst the *design* of the trial was conducted with input from the family violence sector, the actual *reviews* of family violence reports were not completed by police in consultation with specialist family violence sector workers. In Judge Cain's finding into the death of FCP, he recommended:

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

[20] Finding into death without inquest – Jessica Geddes (COR 2020 006055).
[21] Finding into death without inquest – FCP (COR 2020 1981).

Reports should occur by police and members of the specialist family violence sector together.[22]

166. In response to FCP, Victoria Police advised that it had concerns about the recommendation due to "*potential safety risks associated with any delays in information being committed to LEAP…noting resourcing constraints across the sector which may impact the timely review of FVRs/L17s*". It further submitted that trials and reforms should be "*developed and implemented in a whole of government setting to determine the best solutions and avoid unintended consequences*".

167. In the State Coroner's recent finding into the death of DCF,[23] his Honour noted his view that these concerns are not insurmountable and that Victoria Police previously advised the Court that they set a long-term goal to determine "*a time threshold for delaying the upload of family violence reports to allow further time to obtain additional information to assist correct identification*". The State Coroner noted that the FVRIM Report involved consultation with stakeholders and recommendation 5 was made based on recurring suggestions during consultations with key government staff, community organisations and victim-survivor groups. His Honour re-stated the FVRIM recommendation 5 and recommended that it should be implemented with the assistance of Family Safety Victoria.

168. In circumstances in which Victoria Police has not yet responded to DCF, I am satisfied that I do not need to make a further recommendation in the same terms, however I endorse and support the State Coroner's recommendation.

DISCUSSION

169. The investigation into Ms Knowles' death has been deeply complex. I consider there are a number of potential circumstances leading up to her death, however there are gaps in the available evidence. It is difficult to come to a definitive conclusion without speculating. I have reviewed all of the material obtained and have attempted to reach a conclusion on the balance of probabilities as to the circumstances and cause of Ms Knowles' death.

170. Ms Knowles was found with potentially fatal levels of heroin in her system. Forensic Toxicologist A/Prof Gerostamoulos considered that heroin toxicity was a likely cause of

[22] Ibid, 19.
[23] Finding into death without inquest – DCF (COR 2022 2405). This finding was issued on 7 August 2025 and responses to recommendations therein are due three months from that date.

death. I note that Mr Rossi's evidence was that he did not see Ms Knowles using heroin and claims they did not purchase heroin while they were together.

171. Given that he gave three different accounts to police in relation to his interactions with Ms Knowles, I do not consider Mr Rossi to be a credible witness and note that it would not be in his interests to disclose his drug use activity (such as any use of heroin in the vehicle prior to Ms Knowles' death).

172. In any case, A/Prof Gerostamoulos' evidence is that Ms Knowles' toxicology results indicate she used heroin within 12 hours of her death. There was a recent injection site on her arm, and a needle found in the car. It is therefore possible she used heroin after Mr Rossi left the car and this then led to her overdose. It is also possible that she used heroin in Mr Rossi's presence, became unconscious and either Mr Rossi did not appreciate her condition, or he did observe her become unconscious, feared police involvement and left the scene.

173. Without the concerning facial and mouth injuries, I could comfortably find Ms Knowles' cause of death to be drug toxicity. The evidence of Forensic Odontologist Dr Bassed was that whilst these injuries may have occurred in the context of a medical episode or drug induced seizure, in the absence of any other evidence of this, he considered it unlikely. Dr Beer and Dr Bassed have been unable to rule out the possibility of an assault occurring prior to Ms Knowles' death. Dr Beer further stated he was unable to rule out suffocation as a cause of death, in the context of the facial injuries. However, it is not believed that the facial injuries caused her death.

174. Based on her facial injuries and the expert evidence I received, I consider that Ms Knowles was the victim of an assault, though there is insufficient evidence as to the identity of any perpetrator. I acknowledge Mr Rossi denies assaulting Ms Knowles or witnessing an assault occurring. His evidence is that Ms Knowles was conscious and, on her phone, when he left her in the car. I note it is unclear what occurred in the hours between Mr Rossi and Ms Knowles leaving the apartment and returning to the car park. Mr Rossi's evidence was vague.

175. Mr Rossi has more recently admitted via the Homicide Squad that he may have grabbed Ms Knowles' face in an attempt to wake her when he got back into the car after the doctors. If this occurred, it may explain the facial injuries found at autopsy. However, the degree of

force required to inflict such injuries is suggestive of something more than the mere grabbing of Ms Knowles' face to wake her up, as was Mr Rossi's evidence.

176. As a matter of procedural fairness, Mr Rossi and Mr Tilbrook were both provided with an opportunity to respond to the facts outlined above. Neither provided a response to the Court's written correspondence. This cannot and should not be interpreted as any form of guilt on their behalf, and I reiterate that it is not my role as a Coroner to apportion blame, or civil or criminal liability. I only note their non-response for completeness.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Tracey Ellen Knowles, born 19 February 1979;

    b) the death occurred between 17 and 19 July 2021 at 1045 Plenty Road, Bundoora, Victoria, 3083, from *1(a) Unascertained*; and

    c) the death occurred in the circumstances described above.

178. I find that Ms Knowles and Mr Rossi encountered each other by chance at the Plenty Road apartment building on 14 July 2021 and may have already been acquainted. I consider it likely that they decided to go for a drive together to purchase and use drugs. Mr Rossi has admitted that they shared an 'ice pipe'.

179. It is not clear whether Ms Knowles then used heroin with Mr Rossi, or whether she did this after he had left her in the car. In any event, I find that Ms Knowles at some stage in the 12 hours prior to her death, used heroin.

180. I consider Mr Rossi's description of grabbing Ms Knowles' face in an attempt to rouse her to be a potential cause of the facial injuries found at autopsy. Indeed, it is the only available evidence I have to explain this injury.

181. However, given the opinion of Dr Beer, and given the degree of force required to inflict such injuries would suggest more than the mere grabbing of Ms Knowles' face to '*wake her up*', I am unable to rule out another cause of the facial injuries, or of Mr Rossi using far more force on Ms Knowles than he represented to police.

182. Given the presence of injuries to the face and mouth, I am unable to rule out smothering as a potential cause of death.

183. Ultimately, however, I do not have sufficient evidence to find that Mr Rossi or any other person caused the death of Ms Knowles.

184. In the event of additional information or evidence coming to light, this case may be re-opened if the conditions of section 77 of the Act are met.

COMMENTS

185. I acknowledge that Victoria Police has undertaken significant work on their responses to family violence since Ms Knowles' passing, in particular, their work on the issue of identifying the predominant aggressor.[24]

186. However – and noting this is often a very difficult task – this case serves as a timely reminder of the importance of police correctly identifying the predominant aggressor when attending incidents of family violence. As noted by Coroner Despot in her recent finding into the death of EDH, misidentification can have significant and lasting impacts on a victim's mental health, wellbeing and their ability/desire to seek help in the future. In this case, Ms Knowles' removal from Mr Tilbrook's home increased her vulnerability by rendering her homeless. It may have also reduced her willingness to seek help in the future, fearing that she might be misidentified as the predominant aggressor again.

187. This gives rise to concerns, in my view, not only in relation to the approach of attending police members **but of the broader system in which misidentification continues to occur**.

188. In this connection, I reiterate my comments in the Finding into the death of Ms HRZ, delivered on 4 June 2025 (which also concerned issues of misidentification), that it is incumbent on the Victorian Government to ensure that the systems designed to keep victims of violence safe are capable of doing so. This is a question of not only of policy, but of human rights.[25]

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[24] Along with the findings of several of my fellow coroners on this issue, I have discussed this at length in recent findings, including the Finding into death without inquest of Ms KSQ, 28 July 2025, COR 2023 002596, and the Finding into death without inquest of Ms HRZ, 4 June 2025, COR 2020 007005.

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

REFERRAL TO DIRECTOR OF PUBLIC PROSECUTIONS

189. I note that an in-depth investigation has occurred in relation to Ms Knowles' death, including by way of the coronial investigator and multiple Homicide Squad members, who have dedicated many hours to obtaining and analysing evidence and to responding to requests for assistance from the Court. Following this investigation, no charges have been laid in relation to Ms Knowles' death.

190. Notwithstanding, if I believe an indictable offence *may* have been committed in connection with the death, the Court's Principal Registrar is obliged pursuant to section 49(1) of the Act to notify the Director of Public Prosecutions. I direct for such notification to occur in respect of the death of Ms Knowles (noting that, in addition to the events in the lead-up to Ms Knowles' death, offences that may have occurred in the course of the investigation of her death, including those related to the administration of justice, may be appropriately considered '*connected with the death*' and may not yet have been the subject of any criminal charges).

ACKNOWLEDGEMENTS

191. I convey my sincere condolences to Ms Knowles' family for their loss. I thank them for the detailed contributions to the coronial investigation and for raising their concerns with the Court, which has assisted me greatly in the course of the investigation.

192. I acknowledge Ms Knowles' family maintains ongoing concerns about the circumstances of Ms Knowles' death. I am conscious that the lack of resolution of key issues may cause additional distress for family. However, after reviewing the evidence before me in totality, I am satisfied that all reasonable lines of enquiry have been exhausted in this jurisdiction and that it is appropriate to finalise the investigation.[26]

193. Finally, I acknowledge the tireless work of my former colleague, then-Deputy State Coroner Hawkins, to progress this investigation prior to me assuming carriage, and to members of the Homicide Squad, for their ongoing and in-depth assistance to the Court.

[26] *Priest v West* (2012) 40 VR enshrines the well-established principle that, in investigating a death, the coroner must pursue all reasonable lines of enquiry, be an active investigator and discover all they can about the circumstances surrounding the death (at [521], [525] and [560]), which I am satisfied has now been fulfilled in this case. I also note for completeness that, pursuant to section 52(2)(a) of the *Coroners Act 2008*, I am required to hold an inquest (public hearing) where I suspect the death was the result of homicide. Given that there is insufficient evidence to suggest that another person caused the death of Ms Knowles, and where I did not otherwise consider that an inquest would advance my investigation, I have seen fit to finalise this investigation with a Chambers finding, that is '*on the papers*', having considered in depth the raft of documentary evidence before me.

ORDERS AND DIRECTIONS

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

Pursuant to section 49(1) of the Act, I direct the Principal Registrar to notify the Director of Public Prosecutions that I believe an indictable offence may have been committed in connection with Ms Knowles' death.

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

Mark Cholodniuk, Senior Next of Kin

Rhea Adams

Victorian Government

Victoria Police (via the Victorian Government Solicitor's Office)

Department of Families, Fairness and Housing

Coronial Investigator

Detective Acting Sergeant Telen Stanfield, Homicide Squad

Signature:

INGRID GILES

CORONER

Date: 25 August 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.