IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005393

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Michelle Margaret Darragh
Date of birth:	30 September 1989
Date of death:	9 October 2021
Cause of death:	1(a) Stab wound to the back extending into the posterior neck
Place of death:	13 Huntingdon Avenue, Bayswater North, Victoria, 3153
Keywords:	Family violence; intimate partner violence; mental health

INTRODUCTION

1. On 9 October 2021, Michelle Margaret Darragh was 32 years old when she died as a result of a stab wound inflicted on her by her former partner, Benjamin Coman. At the time of her passing, Michelle was staying with her parents at their home at The Basin and previously lived with Mr Coman at an address in Bayswater North.

2. Michelle had three siblings and was a qualified social worker who was well respected by colleagues, friends and family. Her sister described her as a "*beautiful girl with a heart of gold who always worried about other people before herself*" and "*a very caring person who had a beautiful soul*".

3. Michelle met Mr Coman through her brother, and they commenced a relationship in 2015. The couple shared two children, Tait and Reid, and Michelle was pregnant with their third child at the time of her passing.

4. Mr Coman was noted to "*not get along with*" his father and experienced conflict with his stepfather from a young age. He accessed psychological support from the age of 10. He demonstrated behavioural problems throughout his school years and smoked cannabis from the age of 16, escalating to methamphetamine from the age of 18, as well as cocaine. Michelle strongly opposed Mr Coman's substance use. At some point, Mr Coman lost his licence for driving whilst intoxicated.

Family violence history and context

5. Most of the evidence provided to the Court indicates Mr Coman's violence towards Michelle was verbal, emotional, and controlling behaviour. There was no known history of physical violence, nor concerns that it would escalate to same. However, Michelle's friend (a trauma counsellor in domestic violence and sexual assault) was concerned about Michelle, particularly in the lead up to the fatal incident. Lorie-Ann McCann, noted the increased risk related to separation, identified red flags and discussed a safety plan with Michelle. Another friend of Michelle's shared these concerns. Others involved with the couple tried to manage Mr Coman's behaviour over time, for example, they deleted text messages to and from Michele to "*keep the peace*".

6. Mr Coman reportedly believed in traditional gender-based roles for families, and did not want Michelle to return to work after their children were born. Mr Coman exhibited controlling behaviours, including how they spent their money, Michelle's weight and appearance. This

extended to verbal abuse when Michelle did things he felt needed his permission, for example, when she rearranged the furniture. Mr Coman isolated Michelle from her family by creating unnecessary conflict, and Michelle hid things from Mr Coman, such as the friends she was socialising with.

7. In 2019, Mr Coman accused Michelle of having an affair with their mutual friend, Leroy. Michelle denied the affair, and the evidence available to the Court suggests there was no basis for this accusation, however Mr Coman persisted and repeatedly returned to this accusation.

8. In 2020, while Michelle was pregnant, Mr Coman allegedly threatened Michelle with a knife in their kitchen. After Reid's birth later that year, Michelle and the children moved away from him and in with her parents for various reasons, including Mr Coman's drug use. Mr Coman refused to sign Reid's birth certificate for six weeks as he believed that Reid was not his child and requested a paternity test. This was despite any evidence to the contrary and was in addition to Mr Coman's admissions to Michelle that he had been unfaithful to her, including transmitting chlamydia to her. Eventually, Mr Coman, Michelle and the children all moved back in together.

9. In early-2021, Mr Coman withdrew over $80,000 of their joint savings (intended for a house deposit) and bought a sports car. He told a friend that Michelle had "*slapped*" him after this. At another (unknown) time, Mr Coman reportedly withdrew $20,000 from an account the couple had established for Tait.

10. During 2021, the pair separated. Mr Coman moved into his factory and visited Michelle and the children who were again staying with her parents. They all eventually agreed to return home to live together once again.

11. About two to three months prior to the fatal incident, after a verbal incident, Mr Coman refused to allow Michelle to leave their home, repeatedly "*screaming that she slept with Leroy*". Also, around this time, Michelle fell pregnant again to Mr Coman. Michelle disclosed to her friend that "*my life is completely fucked*" and informed her friend that Mr Coman did not want her to have the baby. Mr Coman gave Michelle an ultimatum, requiring her to choose between him and the baby.

THE CORONIAL INVESTIGATION

12. Michelle'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.

13. 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.

14. 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.

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

16. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to his retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

17. This finding draws on the totality of the coronial investigation into the death of Michelle Margaret Darragh 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.

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

Identity of the deceased

18. On 9 October 2021, Michelle Margaret Darragh, born 30 September 1989, was visually identified by her father, Ashley Darragh.

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

Medical cause of death

20. Forensic Pathology Fellow, Dr Chong Zhou, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 10 October 2021 and provided a written report of her findings dated 6 January 2022.

21. The post-mortem examination revealed subtotal transection of the cervical spinal cord by a penetrating sharp force injury at the level of the C3/C4 cervical vertebrae, leading to disruption of the cardiovascular autonomic pathways, circulatory collapse and cardiac arrest.

22. The most significant injury was a stab wound to the right upper back extending into the back of the right neck. The wound path travelled through muscles of the right upper back and back of the right neck, through the cartilaginous part of the right facet joint between the C3 and C4 cervical vertebra and penetrated into the spinal canal causing subtotal transection of the cervical spinal cord in this region. This is a fatal injury and damage to the cervical spinal cord in this region would be expected to cause immediate incapacitation.

23. The two stab wounds both showed one squared-off and one tapered edge, consistent with being produced by a single-edged knife.

24. There was an incised injury to the palmar aspect of the right hand, which given its location and appearance, could have been consistent with a defence-type injury. Defence wounds re wounds to the extremities that occur when a victim of an assault attempts to use that part of the body to defend against the perpetrator's sharp implement.

25. There were bruises, abrasions, and lacerations about the upper and lower lips and intra-oral mucosa. This may indicate blunt force trauma to the region or may be produced by smothering (mechanical occlusion of the mouth and nose). A subcutaneous bruise was present over the central occipital region, which represents an episode of blunt force trauma to that region,

possibly from terminal collapse. There were no associated fractures of the skull, facial bones, or intracranial haemorrhage.

26. There was significant bleeding within the right neck muscles. This may have been sustained from blunt force trauma or vascular injury. The internal jugular vein and carotid artery were intact, but damage to smaller tributaries was unable to be excluded. Neck compression is also a possibility, however there was no haemorrhage within the left side of the neck or external injuries over the skin.

27. The sharp force injury to the cervical spinal cord would be expected to cause very rapid cardiac arrest, therefore, it was favoured to have occurred after the blunt force injuries were sustained as the degree of haemorrhage associated with the blunt force injuries (particularly of the right neck) would not be in keeping with being sustained after cessation of an active circulation. Additionally, acute inflammatory cells were seen microscopically in a section taken from the left lower lip, which indicates a period of survival following blunt force trauma to this region.

28. The deceased was pregnant at the time of death. The estimated gestational age was about 12 weeks.

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

30. Dr Zhou provided an opinion that the medical cause of death was 1(a) Stab wound to the back extending into the posterior neck.

31. I accept Dr Zhou's opinion as to the medical cause of death.

Circumstances in which the death occurred

32. On 10 September 2021, Michelle attended her parents' home in a state of distress, advising her parents that her relationship with Mr Coman had ended. Three days later, Michelle attended the home she formerly shared with Mr Coman to collect something for her son. She believed Mr Coman would be at work; however, she was surprised to find the front door unlocked, Mr Coman's keys on the bench and empty alcohol bottles and prescription pill packets on the kitchen floor. Michelle initially could not find Mr Coman, however, checked the garage and located him inside his car, with a pipe connected from the car's exhausted into the window, which was taped shut.

33. Michelle dragged Mr Coman out of the car and tried to take him to his mother's home, however he refused. Michelle left Mr Coman at the home, drove to his mother's home and told her what had happened. Mr Coman's mother, Lucy Caulfield, organised Mr Coman's father and emergency services to attend.

34. Police and paramedics attended the Bayswater North home and transported Mr Coman to Maroondah Hospital, where he was admitted to the mental health ward. Mr Coman was medicated with an anti-depressant and an anti-psychotic and was diagnosed with adjustment disorder with depressed mood and polysubstance abuse (cannabis, methylamphetamine, cocaine). Mr Coman was released on 16 September 2021 to return to the Bayswater North address. He was prescribed sertraline, quetiapine and diazepam upon release, and was referred for counselling sessions with the Crisis Assessment and Treatment Team (**CATT**) or a psychologist.

35. Michelle expressed concerns to Ms Caulfield that Mr Coman was "*off his meds*", a concern that Ms Caulfield also shared. Ms Caulfield asked her son if he needed to attend rehabilitation, however he refused. After Mr Coman's suicide attempt, Michelle, her family and Mr Coman's family all decided that Mr Coman was to have supervised visits with the boys and wanted to ensure that he still had contact with them.

36. On 6 October 2021, Michelle spoke to her friend, Hannah, and explained that Mr Coman had collected her, their two sons and Michelle's nephew and told them they were going to the park. However, once they were in the car, Mr Coman stated that they were going to Leroy's house. When Michelle asked Mr Coman why they would go to Leroy's house, he said "*let's just do this and get it over with*". Michelle realised that Mr Coman was persisting in his delusion that she had an affair with Leroy. Mr Coman called Leroy, who was busy, so Michelle returned home with her sons and her nephew. Mr Coman arranged another trip to the park on 9 October 2021. Hannah expressed concerns to Michelle that Mr Coman's behaviour was unsafe and told Michelle that she should not go to the park with Mr Coman.

37. Michelle remained unsure about her pregnancy with Mr Coman. She told her parents on 7 October 2021 that she was considering a termination and the next day, booked an appointment for termination at a clinic in St Kilda East. The appointment was booked for 15 October 2021. However, according to Michelle's sister, she was questioning her decision.

38. In the early hours of 9 October 2021, Michelle submitted an online contact form for a local law firm. She asked for "*advice regarding asset split after separation (de facto) with*

children". Shortly thereafter, Michelle sent a text message to Mr Coman asking him to transfer $10,000 back to her and noted that he owed her $36,000. Mr Coman did not respond to the message.

39. Later that morning, Michelle was at her parents' home at The Basin with her two boys when she exchanged a series of text messages with Mr Coman. They discussed meeting at a local park that morning. Michelle told her parents that she was going to take the boys to meet with Mr Coman at Marie Wallace Reserve in Bayswater. Before leaving the house, she collected some boxes and explained that she was going to pass by the Bayswater North property she shared with Mr Coman and pack some more of her belongings. Michelle and her sons left at about 9.30am.

40. At about 10.30am, Mr Coman sent a text message to Leroy advising him that they were at the park, although it is not clear whether Michelle was aware that Leroy would also be attending the park. Leroy advised Mr Coman that he was running late and arrived at the park at about midday. He stayed at the park for about an hour and said that Mr Coman appeared "*fine*" during that time. Leroy asked Mr Coman if he was abstinent from illicit substances and Mr Coman confirmed he was "*clean*" and that he was also off his "*meds*".

41. After meeting Mr Coman and Leroy, Michelle left with her boys and returned to her parents' home. She initially sent messages to Mr Coman explaining that her parents were not home, so she was not able to go to their Bayswater North property to pack her belongings. At about 2.30pm, her parents arrived home, and she explained that she would attend shortly to pack her belongings. Mr Coman did not respond to any of these messages.

42. Michelle left her parents' home at about 3.00pm and a few minutes later, called Mr Coman. The phone call lasted for 17 seconds and was the last known call made or received by Michelle.

43. At about 6.00pm that evening, Michelle's parents became concerned as she had not returned home, and she was ordinarily very punctual. Her mother sent Michelle a text message, however she did not respond. Her parents were concerned that something was wrong, so her father, Ashley Darragh, drove to the Bayswater North address. Mr Darragh arrived at the property, saw Michelle's and Mr Coman's vehicles in the driveway so he decided to call them both. Neither answered his calls, so he decided to enter the house.

44. After entering the house, Mr Darragh called out for his daughter and Mr Coman, but did not receive a response. He eventually walked into the third bedroom where he observed feet sticking out from behind a bed. He observed Michelle lying supine on the floor, with Mr Coman lying beside Michelle, leaning towards her. Michelle had blood all over her face and was not moving.

45. Mr Darragh believed Michelle was deceased, so he tried to shake Mr Coman, however he did not respond. He called Triple Zero, explained what had occurred, and his belief that Mr Coman had beaten Michelle to death.

46. Police and paramedics attended the scene. Police entered the house and observed a considerable amount of blood around the house, and what appeared to be the bodies of Michelle and Mr Coman. Mr Coman initially did not move or make any sounds, however, was later heard to make a soft grunting sound. Police dragged Mr Coman out of the bedroom and allowed paramedics to treat Mr Coman. He was noted to have multiple lacerations to his abdomen and had likely lost a lot of blood. Once his condition was stabilised, he was transferred to the Royal Melbourne Hospital for treatment. Paramedics also examined Michelle and confirmed that she was deceased.

47. Mr Coman was subsequently charged with Michelle's murder. He pleaded guilty to the charge of murder and was sentenced to 25 years' imprisonment with a non-parole period of 20 years. Mr Coman sought leave to appeal against the sentence on one ground, however on 2 December 2025, his application for extension of time was refused.[2]

FAMILY CONCERNS

48. Mr Darragh advised the Court that he believed Mr Coman was not assessed properly during his admission to Maroondah Hospital. He believed that this may have been a missed opportunity to prevent Michelle's passing.

FURTHER INVESTIGATIONS AND CPU REVIEW

49. For the purposes of the *Family Violence Protection Act 2008*, the available evidence suggests that Michelle experienced '*family violence*'[3] in the years prior to the fatal incident. In light of this death occurring in connection with circumstances of family violence, it was requested

[2] *Coman v R* [2025] VSCA 302.
[3] *Family Violence Protection Act 2008*, section 5.

that the Coroners Prevention Unit (**CPU**)[4] examine the circumstances of Michelle's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[5]

50. I make observations concerning service engagement with Michelle 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 Michelle's death.

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

Risk and contributory factors

52. The *Family Violence Multi-Agency Risk Assessment and Management Framework* (**MARAM**) details a number of "*evidence-based risk factors associated with greater likelihood and/or severity of family violence*" and factors which "*may indicate an increased risk of the victim being killed or almost killed*". These risk factors are divided into three categories: those which are specific to adult victim-survivors, those which are caused by perpetrators behaviour towards an adult or child victim-survivor and those which are caused by perpetrators which are specific to children. The MARAM also identifies people who can experience "*particular risk, forms of family violence and barriers to accessing support*" which can impact on the options and outcomes available to them. The risk factors identified in this case in the evidence provided to the Court include:

    a) Controlling behaviours

    b) History of family violence

[4] 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.

[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].

c) Mental health issues and threats to suicide or self-harm

d) Previous harm or threat to harm family members

e) Misuse of drugs or alcohol

f) Obsessive jealousy

g) Financial abuse

h) History of violent behaviour to others

i) Recent separation

j) Access to weapons

k) Pending Family Court matters.

Eastern Health treatment

53. Upon Mr Coman's admission to Maroondah Hospital (operated by Eastern Health) he told clinicians that he had recently separated from Michelle, their relationship had "*not been good*", currently had a machete beside his bed and denied feeling fearful for his safety at home. Michelle reported to clinicians that Mr Coman was feeling unsafe at home and often had a knife beside him. She noted that he was often angry, and his behaviour was similar to a psychotic episode he experienced about 18 months earlier. She explained that she was pregnant, and that Mr Coman was "*demanding*" an abortion. She also noted that Mr Coman had a pornography addiction and would park on the side of the road for two hours before returning home so that he could watch pornographic videos.

54. On the day Mr Coman was admitted, the assessment documentation noted a "*not required*" response to the following questions:

a) Are family violence services involved?

b) Has a family violence risk assessment been completed?

c) Is there a current family violence safety plan in place?

55. The documented observations during Mr Coman's admission included:

a) Ongoing paranoid themes that Michelle had been unfaithful and beliefs that she used him to become pregnant as her new partner was infertile.

b) Mr Coman appeared guarded and minimised recent events and his substance abuse.

c) Clinicians considered a Child Protection notification, however assessed this as not necessary as Michelle had moved out of the house, she had ended the relationship, and Mr Coman would only be permitted to have supervised access to the children.

56. During outreach contact, following Mr Coman's discharge, the following clinical impression notes were recorded:

> *Narcissistic personality traits…likely a fragility with fluctuations to his mood as he continues to try to process the separation from his pregnant partner & mother of his 2 boys.*
>
> *Delusions of infidelity relating to his ex-partner…these quickly escalate in intensity, becoming fixed & client historically has resorted to interrogation &intimidation. To date this has not escalated to violence, though has pushed his mother once.*
>
> *Crisis times clearly around pregnancies per family observations, combined with drug use that then will clearly heighten delusional material.*
>
> *Delusions can easily return with drug use but appear to then dissipate. No physical violence to date of concern.*

57. Ms Caulfield advised Eastern Health that Michelle was a social worker, was aware of family violence risks, had likely chosen to separate because of the risks around access to her children if she chose to remain with Mr Coman, and that Ms Caulfield would speak to Michelle about safety planning for herself and the children. The Eastern Health clinician also suggested to Ms Caulfield that she could approach EDVOS (the local family violence service) for further advice. Engagement between Eastern Health and Michelle was very limited and appeared to only be in relation to Mr Coman's initial admission.

58. I note that Eastern Health was required to be MARAM-aligned from April 2021. If a MARAM risk assessment had been completed, based on the information documented by Eastern Health and provided to the Court, the following risk factors would have been identified:

a) Previous harm or threat to harm victim or family members

b) Showed signs of a mental health condition

59. The MARAM factors indicating the risk of a victim being killed or almost killed contained within the Eastern Health records also include:

a) Threatened or attempted suicide

b) Misused alcohol, drugs or other substances

c) Obsessively jealous

d) Access to weapons

e) Recent separation

60. I note that Eastern Health did repeatedly consider Mr Coman's risk to himself and others, including asking him about homicidal intent, which he denied. This did not include a specific family violence risk assessment.

61. In their statement to the Court, Eastern Health explained that:

> *Ms Darragh was an intelligent and insightful woman who, despite having separated from Mr Coman, remained actively engaged with him and supportive of him, particularly so in ensuring he continued his role as the father of their two children. She did not consider she was at risk of family violence nor did any of his family members.*

62. I note that this is not the only case before the Court where a service potentially relied upon a victim's level of fear too heavily, when it should be a consideration alongside professional judgment. The MARAM framework notes that

> *an adult victim survivor's self-assessment of risk, fear and safety is central to the assessment process…in the context of information known or gained through assessment and/or information sharing, you should be aware and consider if a victim survivor is minimising their self-assessment.*

63. It is concerning that Michelle's professional role as a social worker may have also played a role in the assessment, leaving a potentially missed opportunity to reinforce to her the evidence-based risks she was facing.

64. Victims of family violence may downplay or minimise risk for various reasons which are complex and extensive, however may include fear, guilt, trauma, and/or a coping mechanism to temporarily reduce stress and gain some sense of control.[7] Some research indicates that up to 50% of subsequent victims of intimate partner homicide did not believe their partner was capable of killing them.[8]

65. It is therefore critical that services balance professional judgment with a victim's assessment of risk, when performing a risk assessment, particularly in circumstances where the victim of family violence's assessment of risk appears lower than indicated by evidence-based risk factors.

66. There was also no evidence of engagement with Mr Coman about his use of violence or controlling behaviours, or referrals to address same. The focus appeared to be on the absence of a history of physical violence, and not the noted risk factors including controlling behaviours, obsessive jealously and access to weapons. I cannot determine that such referrals would have prevented the fatal incident, however they may have assisted in keeping Mr Coman 'in view'.

Changes at Eastern Health

67. At my direction, Eastern Health provided a statement detailing their internal review of Michelle's passing and explaining the changes that have occurred since the fatal incident. A summary of their responses is outlined below:

    a) Eastern Health noted that they conducted an in-depth case review (**IDCR**). I note that the IDCR stated that there was no history of physical violence or other risk factors when both were present, however it accurately noted that risk relevant information was not shared directly with Michelle, a secondary consultation with a Specialist Family Violence Clinician was not sought, and there was a potential missed opportunity to refer Michelle to Families where a Parent has a Mental Illness (**FaPMI**).

[7] See for example Stephanie Thurrot, "It's Really Not That Bad"—Why Some Survivors Minimize Abuse" 18 December 2024, <https://www.domesticshelters.org/articles/taking-care-of-you/why-some-survivors-minimize-their-abuse>; Kellie Scott, Why victim-survivors don't report domestic violence, ABC Everyday 8 April 2021, < https://www.abc.net.au/news/2021-04-08/reasons-why-victim-survivors-dont-report-domestic-violence/100035002>.

[8] Jacquelyn C Campbell, Daniel W Webster, and Nancy Glass, 'The Danger Assessment: Validation of a Lethality Risk Assessment Instrument for Intimate Partner Femicide' (2009), 24 (4), *Journal of Interpersonal Violence*.

b) While not a direct finding of the IDCR, the Eastern Health Program's Specialist Family Violence team subsequently developed and implemented training for medical personnel to improve the understanding that obsessive jealousy is a potential high-risk flag for family violence. This training also reviews how suicide attempts/threats can be used as a tactic by a person using violence. Further training resources were developed by the family violence team to support the understanding of coercive control.

c) If Mr Coman's admission occurred today with the same disclosures about family violence risk, Eastern Health conceded that a MARAM-aligned family violence risk assessment would be undertaken, and it would include risk assessment and safety planning with the victim-survivor. This would be undertaken by Eastern Health or via a referral to an external service such as Safe Steps or The Orange Door.

d) Progress at Eastern Health since Mr Coman's admission includes that, as of 2024, Eastern Health is compliant with the implementation of MARAM and the Information Sharing Scheme (**ISS**). All staff have received the mandatory Family Safety Victoria training and ISS training. A specialist family violence team has been established across the Mental Health and Wellbeing Program to further support clinicians to identify and respond to family violence risk via IFS, MARAM and safety planning. Where the patient is the alleged perpetrator, there are more formal processes in place to reach out to victim-survivors and offer support via MARAM assessment, safety planning and onwards referral.

68. I commend Eastern Health's proactive approach to improving their identification and response to family violence risk. There does not appear to be any further opportunities to change or improve the Eastern Health response, however there may be some gaps in the relevant frameworks and tools being relied upon by Eastern Health (and other service providers). These are outlined further below.

Frequency and nature of previous and subsequent similar deaths

Pregnancy

69. Pregnancy/new birth was previously listed as a risk factor in the Common Risk Assessment Framework (**CRAF**), which was the predecessor to the MARAM. In the MARAM, this risk factor has been redefined as 'physical assault while pregnant/following new birth'.

70. In the *Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010-2018* report, it was identified that nationally, five of the 240 female intimate partner homicide victims during the period were pregnant at the time they were killed (2.1%).

71. The Victorian Homicide Register (**VHR**) is a database maintained by the CPU and contains detailed information on the offender(s) and the deceased person(s) in all Victorian homicides reported to the coroner since 2000. It comprises over 230 data fields which capture information such as socio-demographic characteristics; location information; presence and nature of physical and mental illness; service contact; and in cases where there was a history of family violence, information on the presence and nature of the violence.

72. The CPU sought data from the VHR in relation to this matter, with a search conducted on 20 January 2025. In the period between 2010 and 2024, there were 91 female victims of intimate partner homicide, six of whom were pregnant or had recently given birth.

73. A literature review in 2015 indicated that:

    a) Studies have found that traditional attitudes towards gender roles, such as the belief that men should control and dominate a relationship and household, or that women should perform domestic duties and always be emotionally and physically available to men, are linked to perpetration of domestic and family violence in pregnancy.

    b) There is a strong correlation in the research between unintended pregnancy and domestic and family violence, in particular, unintended pregnancy can be an outcome of an existing abusive relationship.

    c) Women are at an increased risk of experiencing violence from an intimate partner during pregnancy, and that violence often begins during pregnancy or, if the violence already existed, increases in severity during pregnancy and into the first month of motherhood.[9]

74. It is unclear why the risk factor relating to pregnancy changed from the CRAF to the MARAM. In cases such as this one, the current risk factor of 'physical assault while pregnant' would not accurately reflect or indicate the risk Michelle faced. I therefore intend to make a

[9] Monica Campo, Domestic and Family Violence in pregnancy and early parenthood; overview and emerging interventions, <https://aifs.gov.au/resources/policy-and-practice-papers/domestic-and-family-violence-pregnancy-and-early-parenthood> Australian Institute of Family Studies.

recommendation to Family Safety Victoria to review the removal of pregnancy as a specific risk factor.

Pathways to intimate partner homicide

75. In the ANROWS *Pathways to Intimate Partner Homicide* study, three primary cohorts of homicide offender were identified, one of which was named the 'fixated threat'. Of note, and relevant to this case, fixated threat offenders:

    a) Were typically middle-class men who were well respected in their communities, employed or owned their own business, and had low levels of contact with the criminal justice system.[10]

    b) Their abusive behaviour often took the form of jealousy, controlling, stalking and monitoring behaviours which escalated in the context of the victim's perceived withdrawal from the relationship (e.g., separation).[11]

    c) Only 36% of offenders in the fixated threat category had previously used physical violence towards the victim.[12]

    d) Homicide was used to re-establish control over the victim and in over 50% of cases, the weapon used was a knife.[13]

    e) Offenders were likely to try and conceal their actions and pleaded not guilty, and many appealed their conviction.[14]

    f) Offenders were jealous of the victim's friends and family member and would interfere with their relationships.[15]

    g) In many cases, the separation from the victim led to the offender's mental health deteriorating, including paranoid thinking.[16]

[10] Dr Hayley Boxall, Laura Doherty, Dr Siobhan Lawler, frserChristie Franks, and Dr Samantha Bricknell (2022). The "Pathways to intimate partner homicide" project: Key stages and events in male-perpetrated intimate partner homicide in Australia (Research report, 04/2022). ANROWS, 30.
[11] Ibid, 8, 35.
[12] Ibid, 34.
[13] Ibid, 16, 39.
[14] Ibid, 13-16.
[15] Ibid, 15, 33-34.
[16] Ibid, 15.

76. In my view, Mr Coman aligns to many of the above factors, however, not enough is known about this cohort of offenders. Increased and improved research into fixated threat offenders may represent a prevention opportunity for cases such as Michelle. The current research outlines that disrupting the fixated threat offending pathways requires investment in continuing to educate and train frontline staff to identify when coercive control is present, and to treat it seriously when it is detected.[17]

77. In my finding into the death of Samantha Fraser, I recommended:

> *That Family Safety Victoria consider the available evidence and consider including re-partnering and pending criminal date for criminal charges brought by the victim as risk factors to be considered in the MARAM.*
>
> *That Family Safety Victoria consider how the pilot program currently underway in Bayside, Peninsula and Barwon areas may respond to fixated threat perpetrators.*

78. In response, the Department of Families, Fairness and Housing (**DFFH**) stated that it was considering the first recommendation, however declined to include re-partnering as a risk factor to be added to the MARAM. In relation to fixated threats, DFFH explained:

> *The Changing Ways pilot providers are required by the Act to align their work to MARAM, including using MARAM practice guidance and tools. The adult perpetrator-focused MARAM Practice Guide content on assessing and managing homicide risk are informed by findings from the 'Pathways to intimate partner homicide' study (Boxall, H., Doherty, L., Lawler, S., Franks, C., & Bricknell, S. (2022). The "Pathways to intimate partner homicide" project: Key stages and events in male-perpetrated intimate partner homicide in Australia, ANROWS), including the fixated threat pathway and other identified pathways.*

79. In late-2024, the adult perpetrator-focused MARAM Practice Guide and associated tools were released that were informed by findings from the 'Pathways to intimate partner homicide' study, including reference to managing homicide and homicide-suicide risk. I therefore see no need to make further recommendations in this space.

The link between suicide attempts and family violence homicide

[17] Ibid, 12, 103.

80. In the *Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010–2018*, 18.3% of male homicide offenders suicided after the homicide.[18] There are several open cases before the Court involving murder-suicides or murder-attempted suicides, including this case.

81. Information from the VHR, searched on 3 February 2025, noted that between 2010 and 2025, there were 119 intimate partner homicide offenders, with 22 of those offenders previously attempting suicide. There are additional open cases before the Court where the offender has previously attempted suicide.

82. The MARAM comprehensive risk assessment recognises that a recent threat or attempt at suicide by a family violence perpetrator may indicate an increased risk of a victim being killed or almost killed.

83. I therefore intend to recommend that the Department of Health works to ensure that in all Victorian public hospitals when someone is assessed for suicidality, after separation or end of a relationship, that a MARAM risk assessment is also completed, including contact with the partner or ex-partner if willing.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Michelle Margaret Darragh, born 30 September 1989;

    b) the death occurred on 9 October 2021 at 13 Huntingdon Avenue, Bayswater North, Victoria, 3153, from *1(a) stab wound to the back extending into the posterior neck*; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

(i) That **Family Safety Victoria** review the removal of pregnancy as a specific risk factor in the MARAM and consider if the evidence base supports its reinstatement.

[18] Australian Domestic and Family Violence Death Review Network, & Australia's National Research Organisation for Women's Safety. (2022). Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010–2018 (2nd ed.; Research report 03/2022). ANROWS, 13, 29.

(ii) That the **Department of Health** works to amend the policy in all Victorian public hospitals such that when someone is assessed for suicidality after separation or end of a relationship, that a MARAM risk assessment is also completed, including contacting the partner or ex-partner, if willing.

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

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

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

Ashley Darragh, Senior Next of Kin

Department of Health

Eastern Health

Family Safety Victoria

Respect Victoria

Our Watch

Safe + Equal

Victoria Police

Detective Senior Constable Rebecca Maydom, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 06 January 2026

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.