IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000259
COR 2022 000262

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Amended pursuant to Section 76 of the Coroners Act 2008 on 28 August 2025[1]

Findings of:	Judge John Cain, State Coroner
Deceased:	**MJU**
Date of birth:	[redacted]
Date of death:	13 January 2022
Cause of death:	1(a) Stab wounds to the neck and chest
Place of death:	[redacted]
Deceased:	**KJH**
Date of birth:	[redacted]
Date of death:	14 January 2022

[1] This document is an amended finding into the deaths of MJU and KJH dated 22 August 2025 to correct a typographical error in paragraphs 5 and 6.

Cause of death:	1(a) Stab wounds to the back
Place of death:	Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076
Keywords:	Family violence; homicide; filicide; mental illness; substance abuse

INTRODUCTION

1. On 13 January 2022, MJU was 39 years old when she was killed by her husband, CTH. CTH also attacked their six-year-old daughter, KJH, who died in hospital the following day. At the time of their deaths, MJU and KJH lived at their family home in a suburb of Melbourne, Victoria, with CTH and their older daughter, ZRD.

Family background and history

2. MJU and CTH were both born in the same overseas Country. MJU studied dentistry and began working as a dentist at her parents' practice overseas. She was described as a spiritual and lovely person who was very close to her mother and was well liked by everyone she met.

3. MJU met CTH as part of an arranged marriage in 2009, and the couple relocated to Australia shortly thereafter. MJU gave birth to their first child, KJH, in 2011 and had their second child, ZRD, in 2015. ZRD adored her big sister and looked up to her.

4. CTH reportedly experienced violence in his childhood, predominantly from his father who also perpetrated violence against his mother and siblings. As an adolescent, CTH was kidnapped, drugged and taken to a different town before he managed to escape and return home. CTH was using methylamphetamine prior to and at the time of the fatal incident. He experienced periods of psychosis as a result of his drug use. He reported that he first began using substances in response to physical abuse perpetrated by his father and attempted to take his own life twice in his twenties.

Family violence history

5. In their statement to police, a family member noted that CTH exhibited several controlling behaviours towards MJU and that their relationship "*wasn't good*". MJU never disclosed the violence she was experiencing to services or police prior to her passing, however Child Protection records for ZRD indicate that CTH was physically and emotionally abusive towards MJU and the children. The Child Protection records also suggest that MJU had begun the process of leaving CTH prior to the fatal incident, however it is not clear whether CTH was aware of same.

6. Between 2013 and 2016, Victoria Police received eight reports of family violence identifying CTH as the respondent in incidents of violence towards women that he was having extramarital affairs with. These incidents included reports of physical violence, stalking,

threats towards family members, sexual assault, coercive control and psychological abuse. CTH was also convicted of two counts of contravening a Family Violence Intervention Order (**FVIO**) in respect of one of these women and one count of assault.

THE CORONIAL INVESTIGATION

7. The deaths of MJU and KJH were reported to the coroner as they 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.

8. 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.

9. 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.

10. Victoria Police assigned Detective Sergeant Gemma Etherington to be the Coronial Investigator for the investigation of MJU and KJH's deaths. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, attending paramedics, neighbours and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the deaths of MJU and KJH 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]

[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.

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

Identity of the deceased – MJU

12. On 17 January 2022, Coroner John Olle made a formal determination identifying the deceased as MJU, born 7[redacted], using the forensic odontologist's report.

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

Identity of the deceased – KJH

14. On 17 January 2022, Coroner John Olle made a formal determination identify the deceased as KJH, born [redacted], using the forensic odontologist's report.

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

Medical cause of death – MJU

16. Forensic Pathologist Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 14 January 2022 and provided a written report of her findings dated 15 June 2022.

17. The post-mortem examination revealed stab wounds to the neck and chest which would have caused loss of respiratory function and blood loss. No natural disease was identified that may have caused or contributed to the death.

18. Toxicological analysis of post-mortem urine samples identified the presence of methylamphetamine.

19. Dr Baber provided an opinion that the medical cause of death was *1(a) stab wounds to the neck and chest.*

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

Medical cause of death – KJH

21. Forensic Pathologist Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 14 January 2022 and provided a written report of her findings dated 15 June 2022.

22. The post-mortem examination revealed a total of three stab wounds: two to the back and one to the anterior chest. The chest wound was superficial. No defence-type wounds were identified.

23. Toxicological analysis of ante-mortem samples identified the presence of ketamine and lignocaine, which were administered during medical intervention.

24. Dr Baber provided an opinion that the medical cause of death was *1(a) stab wounds to the back.*

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

Circumstances in which the death occurred

26. In the weeks prior to the fatal incident, CTH was regularly using methylamphetamine and was noted by family, friends, and neighbours to be "*acting differently*". MJU disclosed to her family and friends that CTH was using illicit substances, and that she was stressed due to same. An acquaintance reported that MJU appeared nervous and shaken up in the days prior to the fatal incident and that the arguing between CTH and MJU had escalated. MJU told her mother that CTH was not working and had been taking drugs.

27. On the morning of 13 January 2022, CTH, MJU and their children were all at their home. ZRD later told police that "*ever since we woke up, he [CTH] was really worried something's gunna happen to us*".

28. At 12.11pm, MJU sent a series of text messages to her friend, LHO. She noted that CTH was "*not feeling well*" and that he needed to be admitted to hospital. She reported that CTH was unable to sleep and was having hallucinations that someone was hurting him. MJU pleaded with LHO to come over and help her to convince CTH to get help for his drug use.

29. At 12.15pm, CTH called his friend, OJH, and asked him to come over. OJH thought that CTH sounded stressed, "*sounded low*". CTH reportedly told OJH that "*everything is ruined*" and that his family had been kidnapped. OJH called MJU two minutes later, who confirmed she was at home with CTH and their children, and that CTH had been telling people they had been kidnapped.

30. At about 12.30pm, CTH called MJU's mother, TFC. TFC told CTH that she had sore legs, to which CTH replied "*why do you have pain in your legs, have you been sleeping with another man*". TFC hung up on him and thought that he might have been using drugs as she had never

heard him speak that way in the past. Shortly after receiving the call from CTH, TFC called MJU and told her that she needed to call police and paramedics because CTH's behaviour was unusual.

31. At 12.40pm, MJU called 000 and requested assistance from police in dealing with CTH. She told the call-taker that CTH had previously been admitted to the Northern Hospital, he was having a panic attack and hallucinations, and that he had taken 'ice' again. She confirmed that she and the children had not been harmed, however CTH needed attention.

32. LHO arrived at MJU and CTH's home at 12.51pm. She spoke to CTH, who was pulling his shirt up and down to cool himself off and noted that he was not making a lot of sense. CTH reported visual hallucinations, was unable to calm or sit down and said that someone was trying to harm him and his daughters. LHO observed some small Ziplock bags in a drawer, commonly used for storing drugs.

33. While waiting for police and paramedics to arrive, MJU and LHO spoke about CTH. MJU told her that he had taken some type of drug and that he had been feeling hot and cold all day.

34. Police and paramedics arrived shortly after 1.00pm. Paramedics spoke to MJU first, who explained that CTH had been restless and anxious since the day prior, and that his medication had expired. MJU and LHO then explained to paramedics that CTH had taken 'ice', however they were unsure when he had used it or how much he had used. They asked the paramedics if they could give CTH some Valium (diazepam) to assist with his anxiety.

35. During this conversation, CTH appeared at the door. The attending paramedics recalled that CTH was polite and pleasant and did not appear to be overtly affected by drugs or experiencing visual hallucinations. The attending police members recalled overhearing CTH telling the paramedics that he had used ice earlier that day, and that he had taken some Valium about 15 minutes prior to their arrival. Police opined that CTH appeared "*mildly drug affected*".

36. CTH repeatedly told paramedics that he was fine, that he was a bit anxious and that he just wanted to sleep. MJU told the paramedics that CTH had never been violent or aggressive, and that he would never hurt them.

37. Paramedics and police spoke about CTH and all agreed that he did not meet the threshold for a transfer to hospital under the *Mental Health Act 2014* (Vic). The parties agreed that he was not a threat to himself or to others.

38. Paramedics tried to obtain CTH's vital signs, however he repeatedly refused and stated that he wanted to go to bed. Paramedics spoke to MJU and LHO and explained that they were unable to force CTH to attend hospital and provided them with some options to obtain assistance for CTH. MJU and LHO appeared receptive to this advice.

39. Police and paramedics left the scene at about 1.30pm. LHO stayed at the family home and spoke to MJU about CTH's behaviour. MJU told LHO that CTH had never hurt her or the children and that she only wanted to obtain assistance for him. LHO left the house shortly before 2.30pm.

40. MJU left the family home with her two daughters at about 3.45pm. She intended to take the girls to a local shop to purchase books. CTH left the family home at 4.19pm in his car. From 4.20pm to 4.48pm, CTH called MJU 13 times, however MJU only answered seven of those calls. According to ZRD, CTH stated that he was going to drive to the shopping centre to join the rest of the family.

41. At 4.42pm, MJU received a call from close family friend, BTR. She told BTR that CTH had overdosed on drugs the day before and she called an ambulance that day because she needed help. CTH called MJU while she was at the shops with her daughters, and he thought that she and the girls had been kidnapped. MJU and her daughters returned home at 4.53pm.

42. At 6.13pm, MJU's next-door neighbour called her and advised that CTH should move his car from the nature strip to avoid getting a fine from the council. MJU told her neighbour that CTH was not well, was having panic attacks and may have taken drugs again. She explained that he was resting and that he would move the car in a few days' time.

43. At 6.17pm, CTH exited the family home to move his vehicle and parked it on his own nature strip. MJU was observed leaving the house at the same time; to bring her rubbish bin in. This is the last time she was seen uninjured.

44. At about 7.45pm, ZRD and KJH were both sitting in the front lounge room of the family home when they heard MJU screaming. They both got up to investigate and located their parents in their 'toy room', at the rear of the house. ZRD stated that MJU got up off the ground, screaming and covered in blood. At this point, it is believed that CTH had already stabbed MJU several times.

45. MJU either walked or ran out of the back room, through the kitchen and out of the house via the rear sliding door. MJU and ZRD ran down the driveway, onto the street, where MJU tried to flag a passing driver. She then ran to her neighbour's house, screaming for help.

46. Less than 30 seconds after MJU could first be heard screaming, CTH was observed on CCTV running down the driveway. In this brief period of time, CTH stabbed KJH in the front bedroom. As CTH ran down the driveway, he observed ZRD outside the family home. He started to chase her; however, he tripped on the footpath, which allowed ZRD to run across the road. CTH stood up and continued screaming at ZRD, brandishing the knife in the air.

47. CTH turned and ran up his neighbour's driveway, where MJU was standing on the front porch, visibly bleeding. CTH screamed at her, while MJU begged him to stop and asked the neighbour to open the door. ZRD tried to cross the road, to check on MJU, however she saw that her father was coming back towards her, still holding a knife. Despite wanting to help her mother, ZRD fled for her own safety and ran to a nearby house for help.

48. CTH stumbled on a nature strip and lay down, still holding onto the knife. He yelled ZRD's name and other incomprehensible words. He later stood up and walked back to the front porch of the neighbour's house where MJU was located. CTH was still holding the knife and yelled at MJU, stabbing her at least a further seven times.

49. CTH retreated to his front yard where he sat on the ground and turned on a garden tap. He was restless, waved his hands around erratically and ranted to himself. At 7.55pm, CTH stood up again, walked over to MJU and attacked her for a third time. After stabbing her again, CTH stood over her and yelled at her. He then stumbled back to his front yard and sat down on the front lawn again until police and paramedics arrived.

50. The first police and ambulance units arrived at 7.58pm. Upon their arrival, CTH was lying on his back in the front yard with both hands holding the knife, which was pointed towards his stomach. One of the police officers drew his firearm and yelled at CTH to drop the knife. He did not comply and told police to kill him. CTH stabbed himself twice to the abdomen. One of the police officers deployed capsicum spray, which immediately subdued CTH and allowed the officers to handcuff and arrest him.

51. Shortly after 8.00pm, further police units arrived and located KJH unresponsive in the front bedroom of the family home, with two visible stab wounds. Paramedics carried her out to the ambulance where they treated her. A few minutes later, emergency services located MJU lying

on the neighbour's front porch, covered in blood with visible stab wounds to her chest. She was unresponsive and her condition rapidly deteriorated. At 8.12pm, paramedics commenced resuscitation attempts.

52. At 8.15pm, the ambulance carrying KJH left the scene for the Northern Hospital. Upon her arrival, KJH experienced a cardiac arrest, and she was rushed to surgery shortly thereafter.

53. Despite the valiant efforts of paramedics at the scene, they were unable to revive MJU, and she was declared deceased at 8.45pm. Sadly, KJH also passed away in the early hours of 24 January 2022.

54. After CTH was arrested, he was conveyed to hospital for treatment for his self-inflicted stab wounds. He remained in hospital for two weeks, where he was noted to be psychotic. After discharge from hospital, he continued to receive treatment for psychosis in prison.

55. CTH later passed a fitness assessment and participated in a formal record of interview. He made full admissions to the offending. He was sentenced to 27 years' imprisonment, with a non-parole period of 19 years.

FURTHER INVESTIGATIONS AND CPU REVIEW

56. As the deaths of MJU and KJH occurred in circumstances of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[3] examine the circumstances of their deaths as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[4].

57. I make observations concerning service engagement with the family as they arise from the coronial investigation into his 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 the deaths of MJU and KJH.

58. 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*

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

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

potentially distorting prism of hindsight".[5] I make observations about services that had contact with the family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

59. The family were engaged with various services in the years prior to the fatal incident. These are explored in further detail below.

Northern Health and Melbourne Health

60. CTH attended the Northern Hospital on several occasions prior to the fatal incident, largely for physical medical conditions, however there was one admission relating to mental ill health.

61. On 19 April 2021, CTH was admitted to the Northern Hospital after MJU contacted the Centralised Triage number, expressing concern for her husband's mental state. CTH was placed on a Temporary Treatment Order (**TTO**), was noted to have used methylamphetamine, and was experiencing a drug-induced psychosis.

62. Northern Hospital staff contacted MJU on 21 April 2021, who provided collateral history. She explained that CTH had become irritable and yelled at her because the chores were not done. She denied any previous episodes of violence towards her or the children but noted concerns about his return home due to his "*bizarre behavioural [sic] prior to admission*" and noted that the events had been "*traumatic*". She also disclosed that other women had taken out intervention orders against CTH due to "*doing something wrong like aggression*" and had attended an anger management course. Following disclosure of this information, a social worker attempted to call MJU later that day, however they were unable to speak to her.

63. CTH's TTO was revoked on 23 April 2021, and he was discharged from hospital. His psychotic symptoms were noted to have resolved, and he was assessed as not posing an acute risk to himself or others. He told staff that he was "*motivated to abstain from substance use*" and was provided with information on drug and alcohol support services. Staff previously encouraged MJU and CTH to call the Mental Health Triage number if they had concerns for CTH's mental health. Staff were unable to speak to MJU and therefore she was not involved in the discharge planning process.

64. CTH's treating clinician requested that he be provided with brief support following discharge to monitor his mental state in the event that he returned to substance use. The treating clinician

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

noted risks to the children in making this request but was informed that ongoing support was not possible "*unless there are requirements on discharge or risk to self or others*".

65. On 25 April 2021, clinicians attempted to contact MJU to "*clarify child at risk concerns*" but were unsuccessful. That same day, a notification to Child Protection was made, noting ongoing concerns for the children's safety in the context of no community mental health follow up.

66. Having reviewed the medical records, in particular, CTH's discharge planning, I noted concerns with respect to the following:

    a) MJU's involvement in discharge planning (noting two unsuccessful attempts to speak to MJU on 23 and 25 April 2021)

    b) The impact of CTH's mental health and substance use on his parenting capacity.

67. A notification to Child Protection was made due to concerns for the children's safety, which demonstrates some understanding of the risks posed to the children. However, it would have been prudent for further attention to be given to CTH's parenting capacity at the time of discharge. This may have been achieved via further engagement with CTH and MJU.

68. I further note the findings of the Royal Commission into Victoria's Mental Health System, which highlighted a disconnection between mental health services and alcohol and other drug agencies, and recommended that:

> *All mental health and wellbeing services, across all age-based systems, including crisis services, community-based services and bed-based services:*
>
> *a. Provide integrated treatment, care and support to people living with mental illness and substance use or addiction; and*
> *b. Do not exclude consumers living with substance use or addiction from accessing treatment, care and support.*

<u>Response by Northern and Melbourne Health</u>

Commentary on previous family violence

69. Melbourne Health explained that on 21 April 2021, a clinician recorded "*a previous forensic history but not specifically in relation to family violence or family violence intervention*

orders". It submitted that this was a nuanced issue that should be taken into consideration by the Court and noted that MJU informed the medical team that there was no history of family violence from CTH towards her or her children.

70. I accept that this is a nuanced issue and ultimately as it did not cause or contribute directly to the death, I do not need to explore this issue further.

Attempts to contact MJU on 25 April 2021

71. Melbourne Health noted that the inpatient and community teams attempted to contact MJU on at least eight occasions, including on 25 April 2021. Several of these attempts were made for the purpose of obtaining a nuanced understanding of the familial dynamics that might clarify a risk assessment. Furthermore, when these attempts to contact MJU were unsuccessful, staff contacted Child Protection. Melbourne Health submitted that their attempts to ensure that safety concerns were addressed (as far as reasonably practicable) were appropriate and reasonable.

72. I agree that the staff did indeed attempt to contact MJU during CTH's admission several times, however I note that several attempts were made using the incorrect contact details. MJU's disclosure about CTH's history of violence and the disclosure that he "*yelled*" at her were not made until 21 April 2021. Attempts to clarify the risk he posed to the children were not made until CTH's discharge was already underway.

Consideration of CTH's mental health and substance use on his parenting capacity

73. Melbourne Health noted that there were multiple, documented attempts to engage CTH, MJU and the extended family (clinicians spoke to a cousin while CTH was an inpatient) however they were largely unsuccessful in engaging CTH or MJU in the manner and extent hoped for and sought.

74. I agree, as above, however I again note that many of these attempts did not occur until CTH's discharge was already underway.

75. Melbourne Health further submitted that "*[n]otably, CTH indicated that he never used substances in the presence of his children*". While that might indicate a slightly lower risk profile, it does not mean that CTH's ability to effectively parent his children was not affected by intoxication. It also submitted that the assessment of parenting capacity is generally the purview of specialised units dedicated to this purpose.

RMH-MHS alignment with MARAM

76. As of April 2021, North Western Mental Health (**NWMH**) supported a Specialist Family Violence Advisor (**SFVA**) capacity building program which included to full-time SFVAs and senior supervision support across NWMH's clinical streams.

77. Supervision and support for the SFVAs included a Social Worker Advisor, Chief Social Workers at each service/program, and a Safety and Inclusion lead. There was also a network of Family Violence Advocates embedded in teams, supported by SFVA and Social Work leads through six to eight-weekly education and reflective practice sessions.

78. After CTH's attendance at Northern Health, at the RMH, MARAM training modules were uploaded to the RMH's Leaning Management System (**LMS**) in July 2022. This improved accessibility for NWMH staff to these educational resources and included four courses designed to support staff to meet their responsibilities as part of the Family Violence MARAM framework.

79. Melbourne Health noted a broad range of checklists, tools, guidelines, procedures and training available to staff in relation to the identification and response to family violence, at-risk children and risk assessments.

Connection between mental health services and alcohol and other drug services

80. Noting the findings of the RCVMHS (above), NWMH noted that it adopted a multi-layered approach to supporting alcohol and other drugs (**AoD**) treatment and management which includes a dedicated team of specialists — the Substance Use and Mental Illness Treatment Team (**SUMITT**) — as well as additional training and education aimed at building workforce capacity across all disciplines. These educational efforts were delivered through the Mental Health Training and Development Unit (**MHTDU**) and the Centre for Mental Health Learning (**CMHL**).

81. Originally established as an initiative of the Department of Health and Human Services, SUMITT aimed to deliver high-quality services to individuals experiencing co-occurring mental health and substance use disorders. The team also worked to build the capacity of both mental health and AoD services to deliver evidence-based, accessible, and integrated care for consumers and their carers.

82. Given the significant changes made to the provision of mental health services by Melbourne and Northern Health, I am satisfied that I do not need to make any further recommendations on this issue.

Child Protection

83. As noted above, Child Protection received a notification on 25 April 2021. This was the only contact the family had with Child Protection prior to the fatal incident. The notification explained that CTH had been admitted to the Northern Hospital for drug-induced psychosis and advised:

    a) CTH had been using methylamphetamine and had presented as disorganised and nonsensical.

    b) CTH had been subject to a voluntary order and had since been discharged.

    c) KJH and ZRD had been exposed to their father's ill health and in the days prior to his admission, CTH had been yelling at MJU about the housework and told the family that a drug dealer was going to take revenge on him and kill him.

    d) MJU described CTH's decline as "*traumatic*".

    e) CTH was previously subject to FVIOs against him in protection of other women.

    f) MJU disclosed concerns for the safety of the family.

    g) CTH disclosed to clinicians that his family were afraid of him.

    h) The hospital had not spoken to MJU since CTH's discharge, little was known about the children's safety and no safety planning had occurred.

84. In response to this notification, Child Protection sought information from KJH and ZRD's school, who noted no concerns for their presentation or behaviour. Child Protection unsuccessfully attempted to contact police regarding CTH's presentation. Child Protection then closed the referral, given "*insufficient information to indicate that the children are at significant risk of harm*". Child Protection made a referral to Child First for additional support.

85. Based on the evidence available to the Court, it does not appear that Child Protection gave adequate consideration to CTH's deteriorating mental health, regular methylamphetamine

use, history of intimate partner violence and information that the family were afraid of him. Child Protection similarly did not:

a) Seek information from services involved with the family

b) Consider the parents' cultural background and whether this impacted on their understanding or attitudes towards family violence

c) Contact police to obtain information about CTH's history of mental health and violence

d) Speak with CTH's general practitioner regarding his drug use, mental health and parenting capacity.

86. I note that the Department of Families, Fairness and Housing (**DFFH**) are currently developing child and young-person focused MARAM practice guidelines, which were originally due for implementation in 2023. I also note that Child Protection introduced the SAFER framework in November 2021 to replace the Best Interests Case Practice Model. The SAFER framework is a statutory risk assessment framework developed specifically for Child Protection and integrates elements of the MARAM framework.

87. In my finding into the deaths of four children known to Child Protection, Child Protection noted that the SAFER framework would enhance practitioners' information gathering and risk assessment capabilities. Recommendation 3 was as follows:

a) *That DFFH engage a suitable qualified consultant or an internal person to conduct a review of the operation and effectiveness of the SAFER Framework with particular reference to its identification and assessment of risk associated with a parent entering a relationship with a new partner or any other person who is regularly in the house.*

b) *That DFFH publicly report on the implementation and evaluation of the SAFER framework.*[6]

88. In response, DFFH explained that the SAFER risk assessment framework is currently undergoing formal evaluation by the Evidence and Information Branch within the Department of Health. This is the first formal evaluation of the framework, and its application as intended, in assessing and managing risk to children since its implementation in November 2021. This

[6] Filicide Cluster Inquest, Recommendation 3, 162.

follows an updated literature review completed in 2024 which reviewed all the evidence-based factors and essential information categories drawn on within the SAFER framework. Changes are currently underway to align SAFER to contemporary evidence and findings of the review.

89. DFFH noted that the intend of Recommendation 3(a) above is captured in the Child Protection manual in policies and advice about identification and assessment of new relationships and assessments of all adults in the home of a child known to Child Protection is an existing application of practice.

90. With respect to Recommendation 3(b), DFFH submitted that as the review was procured for internal use only, it could not be publicly published.

91. While the SAFER framework evaluation is still underway, I will endorse my earlier recommendation and will direct a copy of this finding be provided to the Evidence and Information Branch within the Department of Health, to inform their review accordingly.

Response from DFFH

92. In response to the concerns identified above, DFFH responded to advise that with the benefit of hindsight, it acknowledged that various aspects of Child Protection practice could have been improved prior to closing the first report of 25 April 2021. In particular, Child Protection could have gathered information from a broader range of sources and considered CTH's history of perpetrating family violence, substance use and mental ill health. DFFH did not seek to make any further formal submissions in response to the concerns noted above.

93. DFFH noted there have been various changes to policy, guidelines and practice at Child Protection since the deaths of MJU and KJH.

SAFER framework and the development of a young-person focused MARAM

94. DFFH noted the introduction of the SAFER framework in November 2021 and the ongoing development of a child and young-person focused MARAM framework. By November 2021, all Child Protection practitioners completed SAFER framework training and further professional development is scheduled in 2025 for the Child Protection practitioners on MARAM Intermediate Adult Using Family Violence guidance.

95. The development of the young-person focused MARAM is currently being led by Family Safety Victoria, with input from DFFH. This new MARAM will focus on direct engagement with children and young people to ensure each child or young person has an individual risk

assessment to support effective risk management, safety planning and referral to appropriate support services. The practice guidance will support professionals to consider a child or young person's intersecting identities and experiences in the assessment and management of risk and wellbeing.

Intake Phase Practice Workshop Series

96. DFFH submitted that the Child Protection service is continuously working to improve its practice and noted various additional practice improvements. The Statewide Children and Families Operations and the Office of Professional Practice jointly developed the *Intake Phase Practice Workshop Series* specifically designed for Intake and After-Hours Service practitioners, managers and practice leaders. There have been 26 practice workshops delivered to date, including SAFER at intake phase, identification of family violence risk factors, parental mental illness, and referral pathways from intake phase, amongst others.

97. I note that significant changes have occurred within the Department and at Child Protection and therefore am satisfied I do not need to make any further recommendations.

The Orange Door

98. Child Protection referred the family to The Orange Door on 5 May 2021, as part of their closure plan. The Orange Door spoke with MJU on 30 June 2021, and she advised that things were well, although when CTH used substances, he became paranoid and that she "*feels like she is the enemy*". MJU was unsure whether CTH was still using substances and that he did not want to attend rehabilitation. She stated that she would contact emergency services if she felt unsafe and did not identify any further support needs.

99. The Orange Door encouraged MJU to reconnect with their service in the future if needed and provided a list of support services. The Orange Door closed their involvement with the family on 2 July 2021, noting that MJU advised that things had stabilised and that she had been provided with information to contact support services.

100. It would appear that The Orange Door did not take an active role in their engagement with the family. There appears to have been an overreliance on MJU's self-assessment and her level of fear, rather than balancing this with professional judgment. While it is important to consider a victim-survivor's level of fear, it is also critical that services do not become overly reliant on the victim-survivor to keep themselves safe.

101. In response, DFFH which includes the division of Family Safety Victoria (who operates The Orange Door) wrote to the Court and noted that it did not intend to make any formal submissions in relation to the matter.

102. I note that in 2022, The Orange Door announced that it intended to engage the Centre for Excellence in Child and Family Welfare to upskill its practitioners to "*identify what is in the child's best interests, to work directly with children and young people in ways that promote their participation in the decision-making processes that affect them, as well as making sure they are safe and able to thrive*". The Child Safe Standards came into effect in 2023, which require services such as The Orange Door to more comprehensively consider the risks posed to and the needs of children. I acknowledge that The Orange Door has undertaken significant positive changes since their interaction with the Sharma family, and therefore that no further recommendations are required.

General practitioner

103. CTH was engaged with several general practitioners in the years prior to the fatal incident. He disclosed mental health concerns and methylamphetamine use to his general practitioner on several occasions. His treating clinicians appropriately undertook assessments, provided education and referred him for further support. No issues have been identified with CTH's engagement with his general practitioners.

Children bereaved by family violence homicide

104. While the majority of this finding considers the impact of CTH's violence on MJU and KJH, the impact upon ZRD cannot be understated. She demonstrated remarkable courage on the evening of 13 January 2022 when attempting to save her mother's life whilst simultaneously trying to keep herself safe from CTH. It is within this context that I consider the impact of CTH's family violence upon ZRD.

105. Whilst it is important to emphasise that not all children bereaved by homicide will have the same experience, the impact of a family violence homicide can have long-term effects on a child's development and wellbeing. Studies have found that children exposed to fatal family violence can experience substantial mental health and developmental difficulties, with concerns that some children may also be at greater risk of perpetrating family violence in the future. In an Australian study which interviewed 70 children from Australia, the United Kingdom and Ireland who have been bereaved by intimate partner homicide, researchers

found that surviving children often carried a pervasive sense of being 'different' from their peers, impacting on their social life and capacity to relate to their peers.[7] Surviving children spoke of those around them failing to acknowledge the family violence as causing the death, viewing them as 'damaged' and in some cases, blaming of their deceased parent.[8]

106. Upon a review of the available services, study participants noted that supports were hard to find or non-existent and that when support *was* available, it was not specialised to appropriately respond to the types of traumas experienced by these children.[9]

107. Several support services for children affected by homicide exist internationally and in other Australian jurisdictions. In the United States, the Arizona Child and Adolescent Survivors Initiative providers wraparound services to children bereaved by homicide including personal advocacy, mental health care, peer support, referrals to legal assistance, ongoing case management and mentoring.[10] In Australia, the Homicide Victims Support Group, in collaboration with the New South Wales Government, established Grace's Place in 2022. Grace's Place is the "*world's first residential trauma recovery centre providing tailored support for children impacted by violent crime*".[11]

108. Victoria does not have a similar program targeted at children bereaved by homicide. Children can access:

    a) Victims of Crime - a generic service aimed at providing advice on victim entitlements and the criminal justice program.

    b) Victims Assistance Program – a generalist victim support service provided by community services

    c) Generalist family violence or trauma-informed counselling through services such as Take Two.

109. While these services offer critical assistance in the absence of specialist support, these agencies experience resource limitations which challenge their ability to work with all

[7] Alisic, E, Barrett, A., Conroy, R., Devaney, J., Eastwood, O., Frederick, J., Houghton, C., Humphreys, C., Joy, K., Kurdi, Z., Marinkovic Chávez, K., Morrice, H., Sakthiakumaran, A., & Vasileva, M. (2023) 'Children and young people bereaved by domestic homicide: A focus on Australia', University of Melbourne and University of Edinburgh.
[8] Ibid, 6-7.
[9] Ibid, 13-14.
[10] Ibid, 15.
[11] New South Wales Government, '$5 million towards safe have for children', (media release 30 September 2023), <https://www.nsw.gov.au/media-releases/safe-haven-for-children>.

children needing their support. Research undertaken by the University of Melbourne in collaboration with the University of Edinburgh highlighted the need to introduce specific services that are equipped to offer comprehensive support in response to the uniqueness and complexity of this form of trauma and grief.[12] Researchers have repeated calls for specialist support for children and families bereaved by homicide, noting the urgency in developing this infrastructure in Victoria, with families bereaved by homicide currently accessing specialist services interstate as they have no other option.[13]

110. Recognition for the need for specialist support for families bereaved by homicide was also highlighted by the Centre for Innovative Justice's (**CIJ**) *Strengthening Victoria's Victim Support System: Victim Services Review*. In their final report, the CIJ recommended the introduction of a "*Specialist Service for Bereaved Families*" to provide long-term, highly specialised support and case management for those bereaved by family violence.[14]

111. In the Commission for Children and Young People's 2022-2023 annual report, it noted that DFFH advised that they would "*examine current service responses and identify any gaps and opportunities for service improvement*" and "*progress*" best practice guidelines for Child Protection practitioners working with children bereaved by homicide. As of February 2025, there do not appear to be any relevant practice guides within the Child Protection manual.

112. The introduction of protocols for responding to children bereaved by homicide would indeed help to guide practitioners, however, without dedicated funding and targeted specialist programs, the capacity of workers to meet the needs of this population may be compromised within an already stretched workforce.

113. In my recent finding into the death of Monique Leszak, I recommended:

> *That the Minster for Prevention of Family Violence provide funding for a service designed to provide support to children and young people (and their carers) bereaved by homicide.*

[12] Alisic, E, Barrett, A., Conroy, R., Devaney, J., Eastwood, O., Frederick, J., Houghton, C., Humphreys, C., Joy, K., Kurdi, Z., Marinkovic Chávez, K., Morrice, H., Sakthiakumaran, A., & Vasileva, M. (2023) 'Children and young people bereaved by domestic homicide: A focus on Australia', University of Melbourne and University of Edinburgh.

[13] Outcomes Practice Evidence Network, 'You Should Ask That: Continuing the conversation with the children of women killed by men' (video, 10 December 2024), <https://youtu.be/qAoYo3LaqgM?si=Jp5ac_TyHX3jEhpo>.

[14] Centre for Innovative Justice, 'Strengthening Victoria's Victim Support System: Victim Services Review – Final Report', (2020).

114. I reiterated this recommendation in my recent finding into the death of GVY. As the Government has not yet responded to this recommendation, I will direct that a copy of this finding be provided to the Minister for Prevention of Family Violence, for their consideration in response to the above recommendation.

FINDINGS AND CONCLUSION

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

a) the identities of the deceased were MJU, born [redacted] and KJH born [redacted]

b) the death of MJU occurred on 13 January 2022 at [redacted], from *1(a) stab wounds to the neck and chest;*

c) the death of KJH occurred on 14 January 2022 at the Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076, from *1(a) stab wounds to the back*; and

d) the deaths occurred in the circumstances described above.

I convey my sincere condolences to MJU and KJH's family for their loss. I also wish to acknowledge ZRD's extraordinary bravery in attempting to keep herself safe and protect her mother. I commend the exhaustive efforts of the emergency services personnel and medical professionals who were confronted with an extremely distressing situation and valiantly tried to save MJU and KJH's lives.

COMMENTS

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

1. I endorse and echo the Recommendation 3 in my finding into the deaths of four children known to Child Protection:

a) That DFFH engage a suitable qualified consultant or an internal person to conduct a review of the operation and effectiveness of the SAFER Framework with particular reference to its identification and assessment of risk associated with a parent entering a relationship with a new partner or any other person who is regularly in the house.

b) *That DFFH publicly report on the implementation and evaluation of the SAFER framework.*[15]

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:

TFC & AQZ, Senior Next of Kin

Commission for Children and Young People

Department of Education

Department of Families, Fairness and Housing

Detective Sergeant Gemma Etherington, Coronial Investigator

Evidence and Information Branch, Department of Health

Family Safety Victoria

Melbourne Health

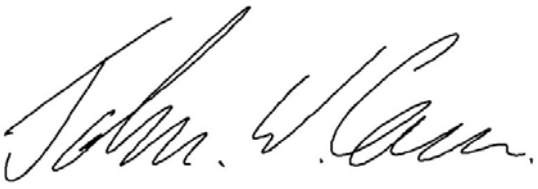
Northern Health

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

Victoria Police

Victorian Government

Signature:



Judge John Cain

[15] Filicide Cluster Inquest, Recommendation 3, 162.

State Coroner
Date: 28 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.