IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002405

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	DCF
Date of birth:	9 February 1963
Date of death:	[redacted]
Cause of death:	1(a) Multiple stab injuries
Place of death:	[redacted]
Keywords:	Family violence; intimate partner homicide; mental illness;

INTRODUCTION

1. On 5 May 2022, DCF was 59 years old when he was found deceased at his home in [redacted] Victoria. DCF and his friend, ZBN, were fatally assaulted by DCF's former partner, Susan Turner.[1]

Background

2. DCF was born overseas on 9 February 1963 and moved to Australia in 1991. DCF's younger brother also moved to Melbourne where he married his wife and had a daughter together who is DCF's only living relative in Australia. One of his support workers described him as "*always cheerful*". He enjoyed the local community and enjoyed attending the local bakery.

3. Susan was reportedly exposed to family violence and substance abuse as a child from her mother and other adults around her. Her relationships prior to DCF were marred with substance abuse and family violence perpetrated against her. Susan had four children prior to her relationship with DCF, all of whom were in her mother's care. Susan and DCF commenced a relationship in 2014. They welcomed a daughter together in 2015; however, she was removed by Child Protection shortly after her birth and remained out of their care.

4. Susan had a complex and lengthy history of mental ill health. She had a diagnosis of schizoaffective disorder and was first admitted to a psychiatric inpatient ward at the age of 25. She was admitted as a psychiatric inpatient on a further 17 occasions in Victoria and New South Wales. She did not consistently comply with her medication regime, either missing or being late to receive her depot injections. Susan's non-compliance often resulted in episodes of acute psychosis and Susan was also noted to be able to mask her symptoms well when she was psychotic. When unwell, Susan often spoke about religious themes, believed that her children were being abused, and demonstrated grandiosity and bizarre beliefs, for example, that she was in a relationship with someone with whom she had not yet had contact with, who was watching and protecting her from afar.

5. Susan also had a history of offending behaviours and incarceration and experienced homelessness and a lack of stable housing, including in the lead up to the fatal incident. At the time of the fatal incident, Susan was experiencing homelessness, after being required to

[1] Pseudonym adopted by the Supreme Court of Victoria in *DPP v Susan (a pseudonym)* [2023] VSC 229.

leave DCF's apartment after living there for about six months, in breach of a Family Violence Intervention Order (**FVIO**) while waiting for transitional housing to become available.

6. From 2014 to May 2022, there were 16 recorded family violence incidents between Susan and DCF. Susan was recorded as the respondent in four of these incidents, while DCF was recorded as the respondent in the remaining 12 incidents. Friends and family of Susan and DCF reported that the entire relationship was characterised by violence. DCF allegedly perpetrated violence towards Susan, which was witnessed by numerous bystanders. Susan reportedly stabbed DCF in 2020 in response to DCF "*starting on her*". Susan feared for her life, however, chose to return to DCF at times. DCF reportedly held very traditional values about the role of a woman, including beliefs that women should do the cooking, cleaning and pay the bills.

7. Susan was referred to Safe Steps in 2020 who completed a risk assessment with her. Susan alleged numerous incidents of serious family violence, including:

    a) DCF hit Susan with the blunt end of a knife and threatened to stab her

    b) DCF threatened to set Susan on fire

    c) DCF whipped Susan with an electrical cord

    d) DCF threatened to put Susan in the refrigerator at the morgue

    e) DCF previously put a dog collar on Susan and made her walk around 'like a dog'

    f) DCF previously assaulted Susan's daughter and friends and made threats to her family.

    g) DCF allowed Susan to leave the home and then locked her out.

8. There were multiple FVIOs issued during Susan and DCF's relationship. From June 2014 to May 2015, a limited FVIO was in place to protect Susan. The order was varied in May 2015 to include Susan's four children. From 17 April 2020 to 16 April 2021, another FVIO was in place to protect Susan. From November 2020 to the time of the fatal incident, a full, no contact FVIO was in place to protect DCF from Susan. DCF allegedly breached the FVIOs against him on five occasions. DCF and Susan were both charged with assault on various occasions.

9. Following the fatal incident in May 2022, Susan was found not guilty by way of mental impairment. She was given a custodial supervision order with a nominal term of 25 years.

THE CORONIAL INVESTIGATION

10. DCF'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.

11. 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.

12. 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.

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

14. This finding draws on the totality of the coronial investigation into the death of DCF 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]

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

Identity of the deceased

15. On 9 May 2022, Coroner John Olle made a formal determination identifying the deceased as DCF, born [redacted], via fingerprint identification.

[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.

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

Medical cause of death

17. Forensic Pathologist Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 6 May 2022 and provided a written report of her findings dated 7 October 2022.

18. The post-mortem examination revealed a stab wound to the right neck, which severed both a branch of the jugular vein, and the carotid artery. There were also five penetrating wounds into the chest that pierced the aorta, as well as the heart and lungs, and incised multiple ribs on the way through. This group of stab wounds also resulted in a haemopericardium (blood in the membranous sac surrounding the heart), as well as bilateral haemothorax (blood in the chest cavities). The stab injuries to the abdomen damaged the small bowel, mesentery, right kidney, diaphragm and liver.

19. In addition, there were numerous stab wounds to the hands, forearms, upper arms and armpit region, which suggested a defence-type pattern. Defence-type injuries included those to the hands and forearms, which can be sustained in the act of attempting to ward off an attacker or protect the body from injury. There were also stab injuries to the top and back of the scalp and the face and neck. Whilst relatively superficial, these wounds would have resulted in further blood loss.

20. There had been amputation of the penis, and the shaft and glans of the penis was not accounted for. The lack of associated haemorrhage, combined with the regular edges of the wound, was strongly suggestive of post-mortem infliction. There was no evidence to suggest that the deceased was alive at the time this injury was inflicted.

21. There was some natural disease found at autopsy in the form of posterior left ventricular fibrosis (scar tissue in the heart), and moderate steatosis (blockage) of the left anterior descending coronary artery. This was not thought to have contributed to the death due to the overwhelming severity of the stab wounds. There was also cholelithiasis (gallstones) and diverticulosis (outpouchings in the bowel wall) which also did not contribute to the death.

22. The cause of death was multiple stab injuries. The mechanism of death was blood loss from the multiple stab wounds, as well as damage to organs (in particular, the heart and lungs).

23. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine and its metabolite amphetamine, and pregabalin.

24. Dr Archer provided an opinion that the medical cause of death was *1(a) multiple stab injuries.*

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

Circumstances in which the death occurred

26. On the evening of 2 May 2022, Susan was at DCF's home. DCF called 000 at 11.33pm to request her removal, advising she was there in breach of an FVIO. DCF's neighbour also called 000 at 11.45pm after locating Susan crying in the hallway of the apartment complex. The neighbour also reported hearing DCF "*shouting and banging*" inside his apartment. The neighbour handed her phone to Susan while speaking to the 000 call-taker, and Susan alleged that DCF had punched her in the face and dragged her out of the apartment by her hair.

27. The evidence differs regarding the events that followed the two 000 calls.

28. According to the Victoria Police Family Violence Service Delivery Review (**FV-SDR**), there were no police immediately available, so a police member from the local police station initially spoke to Susan via phone, identified a potential risk to DCF's neighbour and asked Susan to attend the local Police Station to make a statement. Susan agreed to attend the police station to make a statement the following morning. Body Worn Camera (**BWC**) footage from when members did arrive indicates that Susan was told to leave the building by the Victoria Police member who telephoned her, due to being in breach of the FVIO. According to LEAP however, Susan "*sought refuge in a neighbouring unit and contacted 000 herself regarding an assault*" and that Susan "*left the address of her own accord and sought accommodation elsewhere*".

29. When Victoria Police attended the apartment complex, they were unable to locate DCF or Susan. They spoke to the neighbour, however, did not appear to have taken any actions in response to DCF's alleged violence and possible mental health condition. Police knocked on DCF's door and tried to call him, however he did not answer. Police spoke to Susan via phone and located her at another address where she disclosed, she had been living with DCF. She reported that DCF allegedly slapped her and dragged her out of the apartment by her hair and she acknowledged that she was living there in breach of the FVIO against her.

30. During their conversation with Susan, police queried the following matters:

a) When police asked about "*the fight*", Susan clarified that it was not "*a fight*" but that DCF hit her.

b) When Susan was asked if she sustained any injuries, she answered "*no…just emotional…not hard knocks…I haven't got lumps on my head*".

c) Susan advised that when DCF "*dragged her out of the apartment*" she was "*scared…like something hectic was going on…cause he said earlier you see what I'm doing. You see the grand finale*".

31. During her conversation with police, Susan appeared to present coherently. After receiving this information from Susan, police then focused on the FVIO breach. They explained that Susan would receive a summons in the mail for breaching the FVIO, someone would call her to assist with family violence, she did not need make a statement that evening about the incident and that she could call the police station the following day to get assistance with collecting her belongings. When the members first attended DCF's apartment, they discussed the possibility of applying for another FVIO (to protect Susan), however this does not appear to have been actioned any further.

32. According to the FV-SDR, there was a four-hour LEAP outage from 1.00am to 5.00am on 3 May 2022. Therefore, attending members were unable to review the significant history of family violence between the pair. They were also unaware that Susan was on bail for a previous assault on DCF.

33. DCF was last known to be alive at 10.37am on 3 May 2022, when he spoke to his caseworker via phone. Susan returned to DCF's apartment complex at 12.22pm on 3 May 2022. The CCTV depicted her attempting to enter the building but being unable to gain entry. She waited in the foyer while sending text messages to DCF. After a few minutes, Susan was granted access via the intercom system, although it is not clear whether DCF granted access, or a neighbour granted access. Susan regularly used a neighbour to gain access to the apartment complex.

34. At 2.03pm, Susan's associate, RDX, arrived at the apartment building and called Susan. RDX was granted access to the building (presumably by Susan) and assisted her to remove her personal belongings from DCF's apartment. It is not clear whether DCF was still alive at this time. Susan left the apartment complex at 5.57pm, carrying a handbag and pushing a pram

covered by a cloth. It is not clear what was inside the pram. Susan went grocery shopping, then spent the evening at a friend's home for dinner.

35. Susan returned to DCF's apartment building at 4.23am on 4 May 2022, using DCF's keys to enter the building. Susan left at 8.09am carrying a large backpack, a large shopping bag and her handbag. Susan returned at 12.55pm with her handbag and an empty shopping bag only.

36. Susan was due to attend for her depot injection on 4 May 2022, however she did not attend. When one of her treating clinicians called her, Susan did not answer. Given her suboptimal engagement in the preceding weeks, Susan's treating team planned to advocate for a 52-week CTO to continue to manage her in the community.

37. Susan exited the apartment building at 2.10pm carrying three rubbish bags and a container of Vanish NapiSan washing powder and walked towards the bin collection room. She returned at 6.30pm, carrying three bags, and used DCF's keys to access the building. Susan left the building at 10.17pm carrying a cardboard box which was almost overflowing. She again walked towards the bin collection room and returned to the apartment, empty-handed. At 10.23pm, Susan deposited a white drawer and two bags of unknown items in the foyer, underneath the residents' mailboxes. She rummaged through them, picked them up, and then returned to the elevator.

38. At 12.05am on 5 May 2022, Susan exited the building carrying two tote bags and a Woolworths shopping bag full of unknown items. She returned at 4.57am and used DCF's keys to access the building. At 5.00am, Susan exited the building to allow a man named ZBN, to enter the building with her. ZBN and DCF reportedly did not know one another. Susan escorted ZBN to DCF's apartment. For unknown reasons, Susan armed herself with a kitchen knife and attacked ZBN. Less than three minutes later, Susan exited the apartment's elevator and fled onto the nearby street while nursing her hand and dripping blood.

39. Susan walked towards [redacted], [redacted], then continued north along the road. She was observed on CCTV exiting a vehicle at the corner of [redacted] and [redacted] in [redacted]. A nearby shop owner offered Susan assistance, however she refused help and instead asked to buy flowers. The shop owner called 000 due to concerns for Susan's welfare. Susan left before police arrived and boarded a tram towards the Melbourne CBD.

40. The tram stopped outside [redacted] on [redacted]. The tram driver located Susan crouched in a pool of blood on the tram. Police arrived at 6.15am, arrested Susan and she was conveyed to the RMH where she underwent surgery to her left hand.

41. Meanwhile, several residents at DCF's building called 000 requesting emergency services. Police arrived at 5.24am and located ZBN lying in the hallway outside DCF's apartment. Fellow residents were providing first aid to ZBN when police arrived. ZBN was noted to be in severe respiratory distress and bleeding profusely from a deep laceration to his back.

42. Paramedics and police attempted to extricate ZBN from the building, in order to transfer him to hospital. However, as he was being removed from the building, ZBN deteriorated into cardiac arrest. Paramedics commenced cardiopulmonary resuscitation (**CPR**) whilst transporting him to the RMH. Unfortunately, ZBN succumbed to his injuries and died at the RMH.

43. Police entered DCF's apartment at 6.15am and located DCF deceased in the far corner of the loungeroom, covered by a blanket. DCF had obvious injuries to his chest, neck and face.

FURTHER INVESTIGATIONS AND CPU REVIEW

Mental health history

44. In November 2020, Susan was incarcerated after stabbing DCF. While incarcerated, she became unwell and was transferred from mainstream prison to Thomas Embling Hospital (**TEH**). Susan's deterioration in mental health occurred in the context of a reduced dosage of her antipsychotic depot injection, which she had insisted upon. She remained at TEH until 22 October 2021. She was initially discharged to the inpatient psychiatric unit at the Royal Melbourne Hospital (**RMH**) on a temporary treatment order (**TTO**). The TEH discharge summary recommended an inpatient admission to allow for titration of her medication, development of a relationship with the community mental health team, graded leave to the community, and referral to an alcohol and other drugs (**AOD**) service, due to her high risk of relapse.

45. Susan was discharged to emergency accommodation at a Hotel and was agreeable to engage with Homeless Outreach Mental Health Support (**HOMHS**). She was provided with two weeks' worth of oral medication (venlafaxine), and her next depot injection was scheduled for 29 October 2021. The plan was for a HOMHS clinicians to attend Susan's home to administer her depot injection as an outpatient. She was also linked with the Court Integrated

Support Program (**CISP**), drug and alcohol counselling, women's housing support, and was due to receive assistance to secure longer-term accommodation.

46. On 29 October 2021, HOMHS clinicians were unable to locate Susan at her home. Despite numerous attempts to locate Susan over the following days, she could not be found so an apprehension order was made. On 5 November 2021, Susan notified her housing support worker and advised that she was staying with a friend.

47. Susan's treating team requested a Mental Health Tribunal (**MHT**) hearing, which was scheduled for 15 November 2021. Susan was located by police on 10 November 2021 and was conveyed to the John Cade Unit at the RMH. Upon admission, Susan was noted to have insight and did not appear acutely unwell or psychotic. She explained that she self-ceased her anti-depressant medication three weeks prior and denied any alcohol or drug use since her release. She eventually agreed to continue with her prescribed depot injection.

48. The MHT hearing scheduled for 15 November 2021 was adjourned to 23 November 2021, as Susan did not have sufficient notice of same. Susan did not attend the MHT hearing, where the Tribunal were satisfied that the treatment criteria were met, and a 26-week community treatment order (**CTO**) was made.

49. During December 2021, Susan presented for her depot injections as required. She was noted to have "*improving insight*". On one occasion, she disclosed a belief that her friend was Jesus, however stated that she was aware that this sounded "*bizarre and crazy*". On 24 December 2021, Susan attended to receive her depot injection and reported a desire to reduce her dosage. Her dose remained unchanged; however, she was provided with a script for benztropine to see if it might alleviate some of the side effects associated with her depot injection.

50. In January 2022, Susan persisted with her requests to have her depot injection reduced, citing sedation and pain in her legs. She stated that she was unable to afford the benztropine and when offered other medications to alleviate the side effects, she refused. On 21 January 2022, Susan was thoroughly reviewed by a consultant psychiatrist. Susan denied any suicidal or homicidal thoughts and the psychiatrist agreed to change her depot injection from zuclopenthixol to aripiprazole. The psychiatrist also agreed to reduce the zuclopenthixol dose from 400mg to 350mg. Susan was referred to her general practitioner (**GP**) to investigate her leg pain.

51. Susan was due to attend for her depot injection on 24 January 2022, however, did not attend, explaining she was out of town at the time. She agreed to attend on 27 January 2022, as she was due to be in Melbourne for a court appearance. On 25 January 2022, the consultant psychiatrist recommended that Susan's depot injection should not be changed to aripiprazole and suggested that her medication change could be managed by her new treating team, once Susan moved to a new catchment area. Susan attended for her depot injection on 27 January 2022 and received her lower dose of 350mg as agreed.

52. Susan did not attend her 10 February 2022 depot injection and did not attend until 14 February. She again reported ongoing side effects from the depot injection and strongly advocated for a further reduction in her dose. At a psychiatric review on 21 February 2022, Susan presented as well-kempt, settled, alert and she reported feeling more positive for the future. She denied persecutory or religious themes and advised that she no longer believed her friend was Jesus. She noted ongoing side effects from the depot injection. The clinician advised that her dose might be able to be reduced to 300mg, if her mental state remained stable.

53. Susan continued to engage well with her depot injections. The dose was reduced to 300mg in mid-March 2022, and she reported feeling more positive and having increased energy since the reduction. On 1 April 2022, Susan again requested a further reduction in her dose, however this was not actioned. The treating team were planning for an upcoming MHT hearing and intended to request further compulsory community-based treatment.

54. Susan was late for her depot injection scheduled on 14 April 2022 (she attended on 19 April 2022). A psychiatrist called Susan on 22 April 2022 and explained that she would like to review Susan and discuss the upcoming MHT hearing (scheduled 6 May 2022) as well as her medication. Susan was agreeable to a review and was offered an appointment on 4 May 2022, the same day that her depot injection was due. Susan did not attend for her depot injection on 4 May 2022, as noted above.

55. The CPU concluded that the mental health care and treatment provided to Susan was of an appropriate standard and was reasonable. There was evidence of very thorough case management provided, and extensive collaboration and communication between clinicians and support workers assisting Susan.

56. In line with the (then) *Mental Health Act 2014* (Vic), Susan's treating team were required to consider the least restrictive treatments options and to involve Susan in decisions about her assessment, treatment, and recovery, wherever possible. In the context of Susan's reported

side-effects, it was reasonable for her treating team to trial a reduced dose (which was still well within the recommended therapeutic dose), with a plan for close clinical monitoring and review. There was evidence of thorough and reasonable attempts on the behalf of the treating team to monitor and stay in close communication with her.

57. The CPU opined that Susan was a complex individual who appeared to adeptly mask her psychotic symptoms and early warning signs of becoming unwell. At the time of the fatal incident, Susan was almost due for her next depot injection and was reportedly engaged in increased use of methamphetamines, which may have accounted for her relapse into acute psychosis.

58. The CPU did not identify any prevention opportunities with respect to Susan's treatment. I accept their advice.

Family violence service contact

59. As DCF's death occurred in context of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[3] examine the circumstances of DCF's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[4].

60. I make observations concerning service engagement with DCF and Susan 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 DCF's death.

61. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[5] I make observations about services that had contact with DCF and Susan to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

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[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.

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

62. With respect to the police response on 2 May 2022, I note that police appropriately investigated the FVIO breach by Susan, however, did not appear to act on any of Susan's reports of violence allegedly perpetrated by DCF, other than to suggest that she could attend the local Police Station to make a statement. The follow-up actions on LEAP only included interviewing Susan for the FVIO breach, and did not seek to thoroughly interrogate the details of who was the predominant aggressor in the relationship.

63. Although she was in breach of the FVIO against her, Susan made significant reports of family violence (being dragged out of the apartment; being assaulted by DCF). Pursuant to the *Code of Conduct for the Investigation of Family Violence*, Victoria Police has a "*Pro-arrest and pro-charge*" policy for investigating and prosecuting reports of family violence.

64. 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-defense 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*[6]

65. Research indicates that when women use violence in heterosexual intimate relationships, the violence tends to be a consequence of their own victimisation and as a violent resistance to a pattern of controlling, coercive and violent behaviour used against them.[7] It is important therefore that the predominant aggressor is selected by police on the basis of a pattern of coercive and controlling behaviour, rather than on the basis of an incident-based approach to investigation which does not take patterns of coercion and control into account.[8]

66. When police attended on 2 May 2022, it appears that they considered Susan to be the predominant aggressor, although it is not clear why or how they reached this conclusion other than the existence of a FVIO against her, given the assaults that she disclosed. I note that LEAP was experiencing an outage at the time and therefore Susan and DCF's family violence

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

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

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

history was not available. Had this information been available to the attending members, it is possible that police may have considered DCF to be the predominant aggressor. Nevertheless, this did not preclude police from investigating Susan's new reports of family violence.

67. Obtaining statements from the attending members nearly three years after the fatal incident is unlikely to be of significant forensic value. Furthermore, even if attending police *did* investigate DCF's alleged offending against Susan, I cannot determine that the fatal incident would have been prevented. However, it again raises the ongoing issue regarding police identification of the predominant aggressor.

68. In response to the concerns identified above, the Court wrote to Victoria Police to provide an opportunity to respond the identified issues. Solicitors on behalf of Victoria Police submitted that the proposed adverse comments are outside my jurisdiction as they are not causally connected to DCF's death and therefore should not be included in the finding.

69. Victoria Police submitted that the identity, cause and circumstances of DCF's death are all well-known. Their solicitors submitted while the events of 2 May 2022 are sufficiently proximate to DCF's death, they are not causally relevant to the death and noted as follows:

    a) *We are not aware of any evidence before the Coroner that DCF's death could have been prevented if Victoria Police investigated Susan's allegations of family violence;*

    b) *We consider the suggestion that there was a missed opportunity to hold DCF to account for his behaviour is speculative; and*

    c) *His Honour has indicated a finding will be made that the events of 2 May 2022 and the police response 'did not materially cause or contribute to DCF's death'.*

70. It is indeed correct that I cannot determine that DCF's death could have been prevented if Susan's allegations were investigated. I also cannot determine that police *would* have prosecuted DCF or held him to account for his alleged perpetration of family violence. Nevertheless, I am not persuaded that the report of family violence on 2 May 2022 is not causally relevant to DCF's death. DCF's death occurred in circumstances of family violence, and in circumstances where there was a significant history of family violence between the pair. Therefore, an incident of alleged family violence shortly before his death is sufficiently proximate in my view.

71. Furthermore, I note the framework under which DCF's death and the 2 May 2022 incident were investigated. As stated above, it was referred to the VSRFVD. The legislative functions of the VSRFVD are documented as:

    a) *to examine deaths suspected to have resulted from family violence;*

    b) *to identify risks and contributory factors associated with deaths resulting from family violence;*

    c) *to identify trends and patterns in deaths resulting from family violence;*

    d) *to identify trends and patterns in responses to family violence*

    e) *to provide coroners with information obtained through the exercise of the VSRFVD's functions described in paragraphs (a), (b), (c) and (d).*[9]

72. The functions of the VSRFVD are broad in nature and explicitly include "*trends and patterns*" in relation to family violence deaths and responses to family violence. As explained above, the research demonstrates that when woman use violence in heterosexual intimate relationships, the violence tends to be a consequence of their own victimisation and as a violent resistance to a pattern of controlling, coercive and violent behaviour used against them. It is critical that police responses to family violence consider these patterns of violence, rather than respond to individual events in isolation. The VSRFVD's review of family violence deaths and responses to family violence should naturally consider the broader pattern of family violence.

73. In those circumstances, I am satisfied that the above concerns can be included in this finding and thus have not removed them. These are not intended to be criticisms of the individual members involved with DCF and Susan; rather, it is to improve the sector's understanding of the issue of misidentification and how it can be prevented.

74. When Victoria Police was offered a further opportunity to respond to the above comments, it did not wish to provide any further response.

Misidentification of the predominant aggressor

[9] Section 102W *Coroners Act 2008* (Vic).

75. Police misidentification of women as predominant aggressors is an ongoing issue in Victoria and other Australian jurisdictions, and has serious repercussions for victims.[10] Work undertaken by Victoria Police to address this issue includes updating the 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 Framework (**MARAM**),[69] and the introduction of the Predominant Aggressor Identification Trial (**the Trial**) in the Northwest Metro Division Five between October and December 2022.

76. In Coroner Despot's recent Finding into the Death of EDH (**the EDH Finding**)[11], her Honour discussed the results of the Trial and commented on the importance of identifying and preventing misidentification of the predominant aggressor. I too support initiatives to reduce the likelihood of misidentification and ensuring that there are appropriate pathways for rectification in circumstances where misidentification has occurred.

77. The Family Violence Reform Implementation Monitor (**FVRIM**) December 2021 report *Monitoring Victoria's family violence records: Accurate identification of the predominant aggressor* (**'the FVRIM report'**) made the following recommendation:

> *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.*

78. As noted by Coroner Despot in the EDH Finding, Victoria Police submitted that the Trial referenced above satisfied this recommendation. However, as noted in my Finding into the Death of FCP (**the FCP Finding**)[12], I noted that while specialist family violence agencies were involved in the *design* of the Trial, they were not involved in the actual review of family violence reports. Therefore, I made the following recommendation:

> *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*

[10] Victoria Police, Victoria Police Manual - Family Violence (2022), 10-1; Family Safety Victoria, MARAM Foundation Knowledge Guide (2021), 113.
[11] Finding into death without inquest – EDH (COR 2021 0204).
[12] Finding into death without inquest – FCP (COR 2020 1981).

Reports should occur by police and members of the specialist family violence sector together.[13]

79. In response to my finding into the death of 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*".

80. In my view, these concerns are not insurmountable. Victoria Police previously advised the Court that they had 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*". I also note 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.

81. In my view, Victoria Police's rejection of the recommendation on the basis that it requires stakeholder consultation is disingenuous. I therefore intend to re-state my recommendation in FCP and will recommend that it is implemented with the assistance of Family Safety Victoria.

82. I cannot determine that the fatal incident would have been prevented if the family violence incident on 2 May 2022 was reviewed by police and specialist family violence sector workers. However, it would have offered an additional opportunity to intervene with Susan and DCF and potentially hold DCF to account for the violence he allegedly perpetrated towards Susan.

Opportunities for prevention or intervention

83. The difficulty in determining prevention opportunities in this case is aligned with the difficulty with various systems' abilities to respond to Susan's complex needs over many years. This included a lifetime exposure to violence, substance use, ongoing housing instability, and mental health challenges, each of which are associated with different service systems. While there is no clear proximate and causative opportunity for prevention of the fatal incident, it is concerning that Susan appeared to return to DCF's home due to her ongoing housing instability. This resulted in her living with a person who had perpetrated significant violence

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

against her for many years and was also involved in substance use, both of which were contributing factors to her mental ill health. The combination of these stressors was considered in Susan's Forensicare report:

> *It appears that her mental health deteriorates significantly on the day leading to the alleged offending, which is likely precipitated by the stress of the domestic violence incident following which she becomes homeless, combined with ongoing use of methamphetamines.*

84. Susan's mentor (who worked with her from June 2019) opined that Susan's main issue was stable housing, being placed in substandard housing after her release from TEH, then being moved to insecure housing. I note that services were proactively working to try and access housing for Susan in the lead up to the fatal incident, however resourcing limitations and housing availability have a significant impact on the capacity of these services to assist clients with housing. Susan then moved back in with DCF, where she experienced further family violence.

85. A lack of housing for victims of family violence has been discussed in detail in several recent cases before the Court. In my finding into the death of Bekkie-Rae Curren, I made the following six recommendations:

a) *In line with the recommendations of the Economic Inclusion Advisory Committee 2024 Report, the Commonwealth Government should review rates for Australian income support payments, with a particular focus on the needs of women and children experiencing family violence.*

b) *That the Victorian Government implement the outstanding recommendations outlined by the Legal and Social Issues Committee Inquiry into Homelessness in Victoria and commit to investing in the establishment of adequate crisis accommodation to meet projected demands for victim survivors and perpetrators of family violence who leave or are removed from their home.*

c) *That the Victorian Government implement the recommendations outlined by the Inquiry into the rental and housing affordability crisis in Victoria, with special consideration given to building 60,000 new public housing dwellings by 2034, in line with projected demands.*

d) *That the Victorian Government consider alternative ways of expanding social housing stock in Victoria, such as exploring incentives for landlords to lease their property at affordable rates.*

e) *That the Victorian Government consider reserving a portion of public housing stock for perpetrators of family violence who have been removed from the family home, with the aim of increasing the safety of women and their children.*

f) *That the Victorian Government, in line with recommendations outlined by The rental and housing affordability crisis in Victoria and the Legal and Social Issues Committee Inquiry into Homelessness in Victoria, include the right to housing in the Victorian Charter of Human Rights and Responsibilities Act 2006 (Vic).*

86. In response to recommendations b, c, d, and e, The Department of Families, Fairness and Housing (**DFFH**) advised that it supports the outstanding recommendations of the Legal and Social Issues Committee Inquiry into Homelessness (**'the Homelessness Inquiry'**), recommendations 9, 10 and 35. DFFH noted there is no timeframe for full implementation, but indicated a number of programs of work were underway. It noted that 23 specialist family violence agencies are currently funded to provide Flexible Support Packages through a mix of fixed-term and ongoing funding across Victoria.

87. DFFH explained that it has funded two trials of supported accommodation for perpetrators of family violence, both of which have been evaluated and embedded as ongoing services. This includes the Men's Accommodation and Counselling Service (**MACS**) (short term crisis accommodation for people who have been excluded from the family home due to family violence and who agree to participate in counselling). The second service is called Place for Change and involves medium-term accommodation available in five areas across the State for people who have used family violence and who remain engaged with the specialist family violence system.

88. The State Government has committed over $250 million since the Family Violence Royal Commission made its recommendations in 2016 to improve and expand refuge and crisis accommodation responses in Victoria.

89. In response to recommendation c) above, DFFH stated that an alternative is being implemented:

a) *"The Victorian Government supports in-principle recommendation 30 of the Legislative Council Legal and Social Issues Committee Inquiry into the rental and housing affordability crisis in Victoria, that 'the Victorian Government commit to building 60,000 new social housing dwellings by 2034, with 40,000 completed by 2028'.*

b) The Victorian Government is committed to delivering on our current investment programs including the $6.3 billion Big Housing Build and Regional Housing Fund. Up to 1,000 homes will support victim survivors of family violence.

c) Victoria's Housing Statement includes a continued focus and investment in building more social and affordable homes across Victoria.

d) The Victorian Government will continue to explore investment options and delivery models for increasing supply, in alignment with government policy objectives and budget processes that achieve value for money outcomes."

90. DFFH noted that recommendation d) is being implemented and proposed an alternative to recommendation e), namely:

a) "Several initiatives exist that contribute towards the intent of recommendation e, providing support to perpetrators with the aim of reducing repeat offending thereby increasing the safety of women and children.

b) In addition to MACS and Medium-term accommodation (detailed above), case management is available for persons using family violence service across the State. Providers delivering case management are also funded for crisis brokerage, which can be used to support and assist men as they secure private accommodation. Providers delivering case management and crisis brokerage include Aboriginal Community Controlled Organisations.

c) Applicants who meet the eligibility criteria for social housing are placed on the Victorian Housing Register according to their housing need. Perpetrators may be eligible for priority access into social housing if they meet the eligibility criteria."

91. While I am pleased to see progress towards addressing the critical issue of housing in Victoria, I remained concerned that progress is not keeping up with demand, and there is a significant risk that we will see more family violence related deaths in the context of homelessness.

FINDINGS AND CONCLUSION

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

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

    b) the death occurred [redacted] at [redacted], [redacted], from *1(a) multiple stab injuries*; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

1. 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 Reports should occur by police and members of the specialist family violence sector together. Victoria Police should work with **Family Safety Victoria** to implement this recommendation.

I convey my sincere condolences to DCF'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.

[redacted], Senior Next of Kin

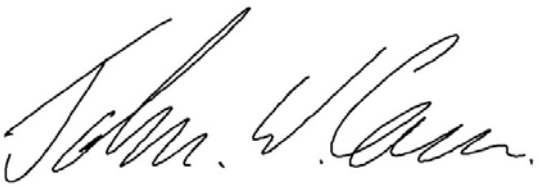
[redacted], Senior Next of Kin

Family Safety Victoria

Victoria Police

Detective Senior Constable Caitlyn Prathipaty, Coronial Investigator

Signature:



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Judge John Cain
State Coroner
Date: 7 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.