IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006944

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:	GVY
Date of birth:	[redacted]
Date of death:	3 December 2022
Cause of death:	1(a) Head and neck injuries
Place of death:	[redacted]
Keywords:	Family violence; coercive control; recent separation; recent service of intervention order; fixated threat; intimate partner homicide

INTRODUCTION

1. On 3 December 2022, GVY was 43 years old when she was fatally attacked by her husband, MJN. At the time of her death, GVY lived in a suburb of Melbourne, Victoria, with her three children and intermittently, with MJN.

2. GVY was born in [redacted], and was the second eldest of four children. She migrated to Australia with her family in 1990 and completed high school at year 10, then studied hairdressing. She gave birth to her eldest son, DWE, in 1999.

3. MJN was also born in [redacted] and migrated to Australia in 1997 on a student visa to continue his studies in information technology. He attained Australian citizenship in 2008, and his extended family continue to reside in [redacted]. According to MJN's sentencing remarks, as a child, MJN was exposed to verbal arguments between his parents, and his father was strict and drank heavily. MJN lived in [redacted] during a period of significant civil unrest and recalled being afraid of bombings occurring while he was at school. He had a history of depression and was being treated with antidepressants prior to the fatal incident.

4. In November 1999, GVY met her future husband, MJN. GVY fell pregnant to MJN in 2003, however she sadly experienced a miscarriage. GVY started operating a childcare centre from her home in 2003 and in 2004, GVY and MJN purchased their first property together. GVY and MJN welcomed son, QSX, in 2005, and daughter, NHY, in 2006. They married a few months after QSX's birth.

5. In 2014, GVY and MJN purchased a family home in a suburb of Melbourne, Victoria. The couple owned multiple businesses throughout their relationship; however, these were unsuccessful, and this caused significant financial strain for the couple. The property was transferred into GVY's name alone and MJN filed for bankruptcy.

6. In 2020, GVY recommenced a hairdressing course, and was working as a hairdresser at the time of her passing. She was close to her family and was described as a loving, caring person and a great mother. She was noted to love hairdressing and was due to start a new hairdressing job the day after she died.

7. In the years prior to the fatal incident, MJN regularly travelled to [redacted] with plans to build a hotel. GVY discovered that MJN was having an affair with another woman in [redacted] in about September 2021. She confronted MJN, who denied the affair and blamed GVY, before promising to end communication with this woman. On 13 August 2022, GVY confronted

MJN while he was in [redacted] about his ongoing affair and advised him that she wanted to end the relationship. After this conversation, GVY made preparations to leave the relationship. This is discussed in further detail below.

THE CORONIAL INVESTIGATION

8. GVY'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.

9. 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.

10. 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.

11. Victoria Police assigned Detective Senior Constable Benjamin Lavakeiaho to be the Coronial Investigator for the investigation of GVY's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, friends, the forensic pathologist, attending paramedics, and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of GVY including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

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

Identity of the deceased

13. On 4 December 2022, GVY, born [redacted], was visually identified by her son, QSX.

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

Medical cause of death

15. Forensic Pathologist Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 5 December 2022 and provided a written report of her findings dated 20 February 2023.

16. The post-mortem examination revealed multiple injuries, the most significant of which were to the head and neck. These injuries were more than sufficient to cause death.

17. The injuries were classified as "*penetrating injuries*". Many of these had a linear configuration with sharp, well-defined edges but fracturing beneath. Wounds such as these suggest infliction by a heavy but sharp weapon and are not typical for knife injuries. A weapon such as an axe, mattock or similar, may result in injuries with appearances such as this.

    a) At the conclusion of Dr Glengarry's autopsy, she was shown scaled photographs of the axe and knife found at the scene. While the wound outlines on the body were not specific for any one weapon, in her opinion, all of the penetrating wounds could have been inflicted by the axe. The patterns of fractures to the skull, face, neck, left arm, right thumb and left clavicle were all in keeping with axe-related injury.

    b) There were no unequivocal knife injuries, however incised wounds to the skin may have been inflicted in areas with axe injury and be indistinguishable, so the knife is not excluded as having caused at least some of the injuries.

18. Injuries to the head included multiple penetrating injuries to the face, ears and scalp which were associated with multiple fractures of the facial skeleton and skull. There was near-transection of the right ear and a deep defect in the right side of the nose with injury through the nose and septum. There was a penetrating injury to the right side of the mouth with underlying fracturing of the teeth and the maxilla. The right side of the head had extensive, complex fracturing with bone fragments lodged in the underlying brain, and contusions and lacerations of the brain surface beneath, as well as the deeper brain structures. Aspiration of

blood (inhaling blood into the lungs) was evident, which is a complication of mouth or facial injuries.

19. Injuries to the neck included multiple penetrating injuries to the anterior (predominantly right sided) and posterior neck, which were associated with multiple injuries to the muscles of the neck, the right carotid artery and the larynx and hyoid bone. The larynx was opened anteriorly and near-transected. There were fractures to the front of the bones of the neck (cervical spine), but the spinal cord was intact.

20. There were penetrating injuries of the upper chest and abdomen, one of which was associated with a fracture to the underlying left collarbone (clavicle).

21. There were injuries to the left and right arms and hands, including multiple penetrating injuries. An injury of the right thumb was associated with transection of a tendon and a fracture (proximal phalanx). An injury of the left arm was associated with transection of a tendon and a fracture (distal ulna). Wounds such as these in the setting of receiving injuries from a weapon may reflect an attempt to "*ward off*" the weapon. Such injuries are sometimes referred to as "*defence-type*" injuries.

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

23. Dr Glengarry provided an opinion that the medical cause of death was *1(a) head and neck injuries.*

24. I accept Dr Glengarry's opinion as to the medical cause of death.

Circumstances in which the death occurred

25. On 24 August 2022, GVY spoke to Victoria Police and reported MJN's violence. She advised police that she was "*really terrified that he might try to do something when [he] comes back to the country…[he] might try break into the house and put [her] in danger*". In their statements to police, GVY's children indicted that their mother was "*scared and shakey everywhere she went*". In the days prior to MJN's return to Australia, he told GVY that he had people watching her and she was fearful of being killed by him.

26. Police applied for a Family Violence Intervention Order (**FVIO**) in protection of GVY. GVY also sought the support of family violence support services who assisted her to change the

locks on her house, develop a safety plan, obtain a personal safety device and move MJN's belongings out of the house and into a storage unit.

27. MJN arrived in Australia on 1 December 2022. While at the airport, he was served with the FVIO against him. The next day, he visited a lawyer who explained the conditions of the FVIO. He asked police to accompany him to the family home to retrieve his car and keys to the storage unit. GVY had ensured the car was filled with petrol and the keys for his car and the storage unit were placed in the letterbox for easy access. MJN attended the storage unit, accompanied by his friend, but was reportedly unable to find his medication. The friend observed that MJN was unhappy with the state of the storage unit and the way his possessions were arranged. He reportedly stated, "*animals get treated that [sic] what he has been treated in this situation*".

28. On 3 December 2022, GVY went Christmas shopping with NHY, QSX and her sister, SWS. After shopping, GVY dropped the children at home and she attended her brother's house, in the company of SWS. When GVY left her brother's house, she was very fearful that MJN would attend and harm her. GVY asked SWS to walk her to her car, which she did.

29. Meanwhile, MJN was becoming increasingly frustrated about his situation. He awoke late on 3 December 2022 and told his friend that he needed to attend his general practitioner to obtain a prescription for his medication. MJN left his friend's house at about midday and arrived at the local shopping centre at about 3.00pm. MJN and his friend spoke over the phone and MJN explained that he was unable to get his prescription medication because the medical centre was closed. He explained that he was at the local shopping centre to clear his head. MJN's friend warned him that he should not stay at that shopping centre too long, given its close proximity to the family home.

30. MJN then attended the nearby Bunnings Warehouse at about 4.20pm where he purchased a jemmy bar and a small fibreglass hatchet weighing 450g. MJN sent a message to his friend to advise that he would be home late. MJN attended the cinemas to watch a movie, then shortly before 10.00pm, MJN attended a petrol station where he purchased a 10-litre plastic jerry can. MJN filled the jerry can with fuel and purchased a cigarette lighter. He drove to a location and parked his car about half a kilometre away from the rear of family home.

31. At 10.12pm, MJN was captured on CCTV walking towards the rear fence of the family home carrying a bag containing the jerry can. MJN used the jemmy bar to remove four fence palings and entered the backyard of the former family home at about 10.30pm. MJN lay in wait in the

backyard until GVY unlocked the rear sliding door and walked onto the rear deck to smoke a cigarette. MJN ambushed GVY and struck her in the head with the hatchet.

32. At the time, NHY was upstairs talking to a friend on the phone and at 11.25pm, GVY's scream was heard on the call. GVY's screams attracted NHY and QSX to run downstairs. NHY and QSX observed their father holding the hatchet at head height while their mother was on the ground, trying to stand up. MJN reportedly told his children that if they tried to run and leave, he would set the house on fire and kill everyone.

33. NHY bravely tried to hug MJN in order to distract him and take him away from GVY. QSX and NHY convinced MJN to let their mother go to the bathroom as she was bleeding heavily and needed an ambulance. MJN forced the children to sit on the couch and talk to him. They tried to diffuse the situation, however MJN became enraged when GVY spoke about MJN's infidelity.

34. MJN struck GVY with the hatchet again. QSX ran towards the rear sliding door and MJN chased him. MJN caught up to QSX and struck him to the head with the hatchet. QSX managed to open the door to try to escape, however MJN struck him again and he fell to the ground on the outside deck. MJN swung the hatchet for a third time at QSX and struck his left knee. Despite her injuries, GVY ran after MJN to protect QSX and dragged MJN away from him. This gave QSX the chance to run away.

35. At some point during the attack, GVY activated her personal safety device. The recorded audio from the device captured GVY yelling "*QSX, run QSX*". After QSX escaped, NHY fled to a small bathroom downstairs where she unsuccessfully tried to call 000. In her evidence, NHY said that she abandoned her phone and left the bathroom because she wanted to help her mother if possible. When NHY entered the kitchen, she observed MJN standing over GVY who was surrounded by a puddle of blood. He had the hatchet in one hand and was trying to open a kitchen drawer with the other hand. NHY closed the drawer on MJN's fingers, but he told her to stop and retrieved a 30cm knife from the drawer. MJN continued to assault GVY with the knife and the hatchet while NHY decided to pick up a knife herself. NHY considered stabbing MJN but was worried that she might get in trouble. The attack continued and NHY fled the house, running to a neighbour's house to seek help.

36. Police attended the scene and located MJN in the downstairs bathroom. He told police "*I killed my wife, she is dead over there*" and explained that GVY tried to stab him and she bit his finger. He also stated that the house was his and that GVY was "*fucking with other people*".

37. Paramedics also attended the scene and confirmed that GVY had passed away. Paramedics assessed MJN and noted that he did not have any visible or physical injuries. MJN told paramedics that he did not want to live anymore and requested that they "*finish [him] off*". Police arrested MJN and conveyed him to the Police Station and he was later charged with GVY's murder and common assault (regarding the assault on QSX).

38. MJN pleaded not guilty at trial and claimed he was acting in self-defence. He was found guilty of both charges and was sentenced to a total effective sentence of 37 years' imprisonment, with a non-parole period of 30 years.

FURTHER INVESTIGATIONS AND CPU REVIEW

39. As GVY's death occurred in circumstances of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of GVY's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[3].

40. I make observations concerning service engagement with GVY and MJN as they arise from the coronial investigation into her death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and GVY's death.

41. 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*".[4] I make observations about services that had contact with GVY and MJN to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

History of family violence

[2] 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.

[3] 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.

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

42. Records available to the Court suggest that MJN perpetrated family violence against GVY and the three children over the course of their relationship. This included information that MJN:

a) Physically assaulted GVY throughout their relationship, including whilst pregnant.

b) Made repeated threats of suicide in the lead-up to the fatal incident.

c) Repeatedly harassed GVY following her decision to separate from him.

d) Displayed jealousy towards GVY and her contact with other men.

e) Made threats to kill GVY, the children and family pets.

f) Displayed controlling behaviours and became angry when GVY wanted or needed to work.

g) 'Gaslighted' GVY regarding his affair.

h) Was financially abusive and would control the household's finances. Evidence also suggested that MJN allegedly stole money from GVY following the sale of their business.

i) Perpetrated regular and severe physical abuse towards the children. DWE recalled that MJN "…*was violent and angry. He would snap easily at anything. He would hit me, and he would hit my mum. When my brother and sister were born, he would hit them but this didn't happen until they were toddlers*".

j) Regularly verbally abused GVY, including taunting her about her weight.

43. It appears that MJN subscribed to rigid gender roles. He reportedly became upset when GVY had to work, sabotaged her employment and expected her to undertake childcare and household duties whilst working. MJN made direct comments indicating his views on the role of women, stating "*a woman should remember and respect how she was treated*". This is noteworthy, as research demonstrates that rigid notions of gender can create a sense of

entitlement to control or use violence against women and, through his justification, can create resistance in accessing services to address their use of violence.[5]

Service engagement – Victoria Police

44. In 2013, police responded to an incident of family violence perpetrated by MJN towards GVY where he assaulted her, causing injury. MJN was charged with recklessly causing injury and police applied for a FVIO against MJN. The FVIO and the complaint were later withdrawn by GVY and no further contact occurred with police until August 2022.

45. Following GVY's contact with police in August 2022, police gathered evidence, completed a Family Violence Report (**FVR L17**) for GVY, and applied for a FVIO, which was granted in full conditions. Police also coordinated the service of the FVIO upon MJN's return to Australia and accompanied him to the family home to collect his belongings.

46. Following GVY's death, police completed a Family Violence Service Delivery Review (**FV-SDR**), which is a desktop review of police service contact with an offender and victim. The FV-SDR noted that while police largely complied with required policies and procedures, there may have been an opportunity to pursue criminal charges against MJN following GVY's disclosure of recent threats to kill and historical violence when she spoke to police in August 2022.

47. I agree with the findings of the FV-SDR. I also note that given the proximity between MJN's arrival in the country and the fatal incident, arresting and interviewing MJN in that brief period of time is unlikely to have prevented the fatal incident.

48. When the Court provided Victoria Police with an opportunity to respond to the FV-SDR findings, Victoria Police advised that it did not wish to make further comments.

Service contact – Women's specialist family violence services

49. GVY was engaged with both The Orange Door and the Good Shepherd in the period prior to and at the time of the fatal incident. Both services appropriately assessed GVY as being at "*serious risk*", the highest risk category. The services coordinated with police, provided funding to have the locks changed, obtained a personal safety device, assisted in funding a

[5] Boxall, H., Doherty, L., Lawler, S., Franks, C., & Bricknell, S. (2022). *The "Pathways to intimate partner homicide" project: Key stages and events in male-perpetrated intimate partner homicide in Australia* (Research report, 04/2022). ANROWS, 92-95.

storage unit, and undertook extensive safety planning. She was offered with refuge accommodation, given the high-risk period around MJN's return to Australia, but GVY declined, noting that she did not want to move the children from their home and disrupt their schooling.

50. It does not appear that this case was referred to the Risk Assessment and Management Panel (**RAMP**), despite the recognised risk faced by GVY upon MJN's return. With the benefit of hindsight, a RAMP referral may have been appropriate and may have prompted further proactive policing methods. However, the brief period of time from MJN's arrival to the time of the fatal incident means that even if a RAMP referral occurred, it may not have prevented the fatal incident. I therefore make no criticism of The Orange Door or the Good Shepherd and their involvement with GVY and I commend practitioners for the work undertaken to promote GVY's safety.

Service contact – Men's specialist family violence services

51. Following GVY's disclosure of family violence to police, The Orange Door received an L17 referral for MJN in August 2022. This referral remained unprocessed for several months. On 1 December 2022, the Good Shepherd contacted The Orange Door 'men's team' to seek an update as to whether contact had been made with MJN. Good Shepherd was advised that The Orange Door had decided not to contact MJN at that time as contacting him so many months after the referral was received "*could cause escalation*". Good Shepherd was advised that service of the FVIO would not trigger a new referral, and that contact would only be made with MJN if a new L17 was submitted. As noted above, the brief period of time between MJN's entry into the country and the fatal incident, it is unlikely that contact between The Orange Door and MJN would have prevented the fatal incident.

52. I note that the failure of family violence services to contact people who use family violence is a regular and consistent theme seen in many cases before the Court. In order to reduce the risk faced by victim-survivors, it is critical that specialist family violence services make contact and offer support to people who use violence in a timely manner. I therefore intend to recommend that Family Safety Victoria (**FSV**) review avenues to rectify these delays and implement any appropriate strategies to improve same.

Personal safety device monitoring

53. The personal safety device GVY received was monitored by S1 Monitoring. On the night of the fatal incident, GVY triggered her alarm which sent an alert and recording to the monitoring company. The monitoring company heard screaming and immediately alerted police. I have not identified any missed opportunities with respect to this service.

NHY and QSX's school

54. While DWE had finished secondary school, NHY and QSX were both at secondary school at the time of the fatal incident. QSX's records demonstrate that his school first became aware of MJN's perpetration of violence in November 2018. The school discussed concerns for QSX's welfare with GVY and during this conversation, GVY disclosed that there had been family violence in the home, but that this had settled in the previous three years.

55. A further conversation occurred between the school and QSX in December 2019. Staff noted that MJN "*seems to be a man who has serious anger management issues in the past and this led to domestic violence with [GVY]*". QSX reported incidents of self-harm due to depression and anxiety related to living with his father. He felt that he had to be careful around his father as he made him tense. After this disclosure, the school spoke to GVY and advised they had spoken with the (then) Department of Health and Human Services (**DHHS**) and requested a referral for counselling, however, on a review of the records, I was unable to locate a record of the outcome of this or evidence that this contact was ever made in Child Protection records.

56. In response, the school submitted that discussions were indeed held with (then) DHHS but that the disclosure was in fact made regarding another student due to comments made by QSX to the counsellor that the other student's father slapped the student (not QSX). The school advised that discussions were held between GVY and the school's counsellor regarding this student and not QSX.

57. It is unclear from the information provided why GVY would be involved in a conversation with the school counsellor about an incident of violence that reportedly occurred to another student. In any event, this occurred three years prior to the fatal incident and therefore it is unlikely to have changed the final outcome.

58. The school further submitted that "*the fact that QSX made disclosure that he has 'depression and anxiety related to living wit his dad who he feels has to be careful of and who makes him tense' was not an indicator of ongoing family violence.*" The school also noted that upon a

review of its records, it believed that QSX received appropriate counselling support at all times while at the school.

59. The school was contacted by The Orange Door on 12 September 2022 to assess NHY's wellbeing however there is no record of what observations were made. NHY spoke to a staff member on 2 November 2022 and advised that her parents had separated and that her father could be violent but had not been violent since primary school. She disclosed that her mother was "*nervous*" around her father and that an FVIO had been taken out against him. Attempts were made to engage NHY in counselling after this conversation, however no further contact occurred prior to the fatal incident.

60. The school submitted that while there are no notes of the school's contact with The Orange Door's, the school's counsellor confirmed that they did contact them to provide an update regarding NYH's attendance, her efforts in school, whether she was in uniform and whether there were any issues to report.

61. The school further submitted that in 2021, it implemented a procedure for *Counselling Service* which was updated in 2024 (and reviewed in June 2025) through the implementation of the school's *Process for managing issues of child wellbeing / safety concerns.* The processes align with the reforms introduced in the areas of child protection inclusive of the family violence toolkit.

62. Given the significant reforms that have occurred in this area, including changes implemented by the school, I am satisfied that no further recommendations are required.

PREVENTION OPPORTUNITIES

63. Police and the family violence support services involved with GVY undertook the steps available to them within the remit of their respective roles. Despite this, GVY continued to be at serious risk from MJN. This highlights the deficiencies in the current systemic response to family violence in Victoria and the restrictions that these services face in responding to and preventing violence from high-risk offenders like MJN. This is not to criticise police or other support services, rather, it is to explore the issue of responding to high-risk offenders in our community.

Assessing for risk of intimate partner homicide (IPH)

64. Research into family violence risk assessment tools, including those used by police, have found them to be largely inadequate for predicting IPH specifically.[6] Whilst these tools have demonstrated capacity to predict further perpetration of violence, the use of these tools to assess the likelihood of IPH has not yet been achieved.[7] Given the similarities in 'factors' indicating continued perpetration of family violence and the risk of escalation to IPH, it is unclear whether current risk assessment tools are able to provide distinction between there being a 'high risk' of the continued perpetration of violence and there being a risk of homicide.[8] The inability to distinguish between high risk offenders and offenders who are at risk of perpetrating IPH has implications for the types of interventions available to prevent escalation to lethal violence.

65. The Victorian Government recently completed the first part of the five-year review of the MARAM framework.[9] This review found the MARAM tools to be valuable resources and made 17 recommendations focused on improving risk assessment approaches.[10] The second part of the review, the Data Review, is currently underway and seeks to 'analyse data on the current MARAM evidence-based risk factors and assess their correlation to the presence and level of family violence risk of lethal outcome'.[11]

66. I note the Court has been approached to provide data to assist with the review. Armed with this data, it is my hope that the review will work to improve current tools for assessing risk of lethal family violence. These tools are critically important, as methods of predicting lethality of family violence and can help to inform targeted interventions with people who use family violence.

'Fixated threat' intimate partner homicide offenders

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[6] Cubitt, T., Morgan, A., Dowling, C., Bricknell, S., & Brown, R. (2024). Targeting Fixated Individuals to Prevent Intimate Partner Homicide: Proposing the Domestic Violence Threat Assessment Centre. *Research in practice*; Trood, M. D., Spivak, B. L., Ogloff, J. R., & McEwan, T. E. (2024). The limits of predicting near lethal and lethal family and intimate partner violence. *CrimRxiv.*

[7] van der Put CE, Gubbels J & Assink M 2019. Predicting domestic violence: A meta-analysis on the predictive validity of risk assessment tools. Aggression and Violent Behavior 47: 100–116. https://doi. org/10.1016/j.avb.2019.03.008; Graham, L. M., Sahay, K. M., Rizo, C. F., Messing, J. T., & Macy, R. J. (2021). The validity and reliability of available intimate partner homicide and reassault risk assessment tools: A systematic review. *Trauma, violence, & abuse*, 22(1), 18-40.

[8] Ibid.

[9] Victorian Government, 'Five-year evidence review (MARAM Framework andpractice guides)', < https://www.vic.gov.au/maramisquarterly-newsletter-quarter-4-2023-24/five-year-evidence-review-maram-framework-and-practice-guides>.

[10] Ibid.

[11] Allen and Clarke Consulting, 'Victorian Family Violence Multi-Agency Risk Assessment and Management Framework 5-year Evidence Review – Final Report', (7 December 2023), 28.

67. In 2022, the Australian National Research Organisation for Women's Safety Limited (**ANROWS**) analysed 199 incidents of male perpetrated homicide perpetrated against a female partner that occurred in Australia between 1 July 2007 and 30 June 2018.[12] This analysis sought to better understand the trajectories of IPH offenders and identify opportunities for intervention along these pathways to IPH.

68. Analysis of these homicides found that offenders fell into three distinct pathways to IPH; the 'fixated threat' pathway, the 'persistent and disorderly' pathway, and the 'deterioration/acute stressor' pathway.[13] A review of this research suggests that MJN's use of violence falls in the 'fixated threat' category.

69. Offenders that fell within the fixated threat pathway were commonly found to be 'jealous, controlling and abusive in relationships but relatively functional in other domains of life…this offender type used IPH as a means to re-establish control, either over the victim or in other domains of his life (that he blamed the victim for loss of control over)'.[14]

70. In the period prior to the fatal incident, fixated threat homicides (in general) were characterised by:

    a) The victim initiating separation.

    b) Controlling behaviours increasing and changing significantly in the context of separation, including repeated requests to reconcile or punish the victim by spreading rumours about them.

    c) Deterioration in the offender's personal care and mental health following separation.

    d) Increase in motivation to kill their partners during a period of separation. 34% made threats to kill the victim in the lead-up to the fatal incident and 36% demonstrated that they were planning the homicide by engaging in activities such as purchasing a weapon.[15]

[12] Boxall, H., Doherty, L., Lawler, S., Franks, C., & Bricknell, S. (2022). The *"Pathways to intimate partner homicide" project: Key stages and events in male-perpetrated intimate partner homicide in Australia* (Research report, 04/2022). ANROWS.
[13] Ibid, 8-10.
[14] Australia's National Research Organisation for Women's Safety. (2022). Pathways to intimate partner homicide: The "fixated threat" offender trajectory [Fact sheet]. ANROWS.
[15] Ibid.

71. Regarding the fatal incident (per the research), most fixated threat offenders entered the victim's space with an intent to control them through the use of lethal force. Many fixated threat offenders forced their way into the victim's presence and brought a weapon with them, most often a knife. Fixated threat offenders were also likely to plead not guilty and engage in victim-blaming narratives following the fatal incident.[16]

72. Similarities between this category of offender and MJN's perpetration of violence and homicide are clear. MJN's violence and attempts to control GVY increased after being informed of her wish to separate from him. MJN initially made attempts to reconcile and when this was unsuccessful, became abusive towards GVY. Following his return to Australia, MJN was noted to be distressed and repeatedly stated that GVY had "*disrespected*" him, that his children were not contacting him and that the family home rightfully belonged to him. There appeared to be some level of planning involved in the incident, as MJN purchased weapons and hid in the backyard, although I note that the sentencing Judge did not believe that he planned to murder GVY that night; only to attack or confront her. Following the fatal incident, MJN pleaded not guilty and continued his narrative that GVY was to blame for her own death, making comments such as "*she deserved this*" and "*look what she made me do*". He suggested that if GVY had handled the divorce "*nicely*" and did was she was "*told*", she would not have died.

73. The ANROWS research noted that fixed threat offenders pose significant risk to victims as they are often not visible to law enforcement, with their risk going largely unmonitored.

74. In a large-scale national project that considered the help-seeking journeys of victims of family violence and people who use family violence, 33 per cent of participants who used violence sought assistance from health services, including General Practitioners, making these services the most utilised formal support among this cohort.[17]

75. Whilst research suggests that fixated threat offenders may not come into regular contact with the justice system, they were commonly found to have a mental illness and, in some instances, a long-term health condition, suggesting that this cohort may access health services. This was true of MJN who accessed his general practitioner for treatment of anxiety and depression in the years prior to the fatal incident, including a failed attempt to seek such assistance on the

[16] Ibid.
[17] Hegarty, K., McKenzie, M., McLindon, E., Addison, M., Valpied, J., Hameed, M., Kyei-Onanjiri, M., Baloch, S., Diemer, K., & Tarzia, L. (2022). "I just felt like I was running around in a circle": Listening to the voices of victims and perpetrators to transform responses to intimate partner violence (Research report, 22/2022). ANROWS.

same day that he killed GVY. Exploring the potential role of health services in identifying an intervening early with this cohort appears to be a crucial area for further investigation.[18]

76. In recent years, researchers have also started to note connections between fixated threat IPH offenders and grievance fuelled violent offenders.[19] Grievance fuelled violence is noted to be violence that is motivated by "*idiosyncratic grievances, underpinned by a sense of injustice, loss, inquiry, or victimisation*".[20] In acknowledgement of the similarities between these cohorts of offenders (whilst noting that IPH is gendered in nature) researchers have begun to explore whether grievance fuelled intervention frameworks may offer useful learnings for interventions with populations at risk of perpetrating IPH.[21]

77. I note that research into fixated threat typologies is only in its infancy and as explained above, risk assessment frameworks are currently not able to accurately assess risk of IPH. In those circumstances, I intend to recommend that the Victorian Government invest in researching possible interventions with this cohort, particularly with respect to primary prevention and early intervention.

Systems of accountability

78. Vlais[22] argues that current mainstream forms of accountability operate in isolation of one another and act as "*consequences that in themselves generally do not promote behaviour change*".[23] Justice responses, for example, use carceral tools that aim to punish threatening or violent behaviour, whilst mainstream men's behaviour change programs are sometimes mandated, are vulnerable to the "*performance*" of accountability and may not offer an

[18] Ibid.

[19] Boxall, H., Bragias, A., & Corner, E. (2024). "You Have Caused All of This, It's All Your Fault": An Argument for the Application of Grievance-Fuelled Violence Frameworks to the Prevention of Male-Perpetrated Intimate Partner Homicide. *International Journal for Crime, Justice and Social Democracy*; Cooper, A. J., Pathé, M. T., & McEwan, T. E. (2022). The role of grievance in fatal family violence and implications for the construct of lone actor grievance-fuelled violence. *Frontiers in psychology*, 13, 1057719; Cubitt, T., Morgan, A., Dowling, C., Bricknell, S., & Brown, R. (2024). Targeting Fixated Individuals to Prevent Intimate Partner Homicide: Proposing the Domestic Violence Threat Assessment Centre. *Research in practice.*

[20] Cooper, A. J., Pathé, M. T., & McEwan, T. E. (2022). The role of grievance in fatal family violence and implications for the construct of lone actor grievance-fuelled violence. *Frontiers in psychology*, 13, 2.

[21] Cubitt, T., Morgan, A., Dowling, C., Bricknell, S., & Brown, R. (2024). Targeting Fixated Individuals to Prevent Intimate Partner Homicide: Proposing the Domestic Violence Threat Assessment Centre. *Research in practice.*

[22] Mx Rodney Vlais is a psychologist who specialises in gendered based violence, specifically working with men to change their use of violent behaviour. Mx Vlais was the previous CEO of No to Violence and provides training, capacity building and policy and practice review support to a number of family violence agencies across Australia.

[23] Rodney Vlais, 'What does it mean to support victim-survivor led, community-held and service system scaffolded accountability for adults who perpetrate domestic, family and sexual violence harm?', (March 2025), 4.

appropriate environment to challenge deep seeded belief systems that support the use of violence.[24]

79. Whilst the use of surveillance, monitoring and supervision may serve as useful tools to "*restrain his behaviour and tighten the web of accountability*",[25] these mechanisms do not change harmful behaviours in isolation. These tools must, instead be supported by a "*web of interventions*" in which each actor, service and system works in collaboration with one another to create opportunities for the person who uses violence to work towards responsibility and accountability.[26]

80. A key element to achieving accountability in people who use violence is through the social power of communities. As noted by Vlais, many victims of violence do not report their experiences to law enforcement or services, meaning that the person who uses violence may not be known to services.[27] This remains true for GVY, who did not disclose her experience of violence to services between 2013 and 2022, despite the violence being severe and persistent. GVY did, however, disclose her experience of violence to her family and friends, whose responses, rightfully, focused on supporting GVY. With resources and support, however, community networks have the potential to also respond to the use of harmful behaviours by members of their community and form part of the web of interventions used to promote accountability.

81. In GVY's case, services were aware that she had the support of family and friends, and that MJN was in regular communication with friends who were organising accommodation ahead of his return to Australia. Creative responses that enlist the whole of the community and service system are critical in creating an environment in which the use of violence is denounced and where people who use violence are held to account. With resources and support, services could have been positioned to work with these networks to monitor MJN, assess his risk to GVY and encourage behaviour change.

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[24] Ibid.

[25] Chung, D., Cambell, E., Vlais, R., & Watts, L. (2020). Locating "accountability" within perpetrator intervention systems: Inceptions and limitations in current understanding in Chung, D., Upton-Davis, K., Cordier, R., Campbell, E., Wong, T., Salter, M. … Bissett, T. (2020). *Improved accountability: The role of perpetrator intervention systems* (Research report, 20/2020). Sydney: ANROWS. p. 55

[26] Rodney Vlais, 'What does it mean to support victim-survivor led, community-held and service system scaffolded accountability for adults who perpetrate domestic, family and sexual violence harm?', (March 2025), 5.

[27] Ibid, 10.

82. This case highlights the need for public education and campaigns to build awareness amongst the community about the risks of serious harm or death associated with coercive and controlling behaviour. I intend to make a recommendation to that effect.

83. As noted above, the mechanisms for monitoring people who use violence can serve as useful tools for risk management and to encourage engagement with behaviour change. However, in order to be effective, they must be proactive, consistent and supported by opportunities for the offender to undertake work to change their behaviour.

84. I note that in GVY's case, the burden of ensuring her safety and that of her children lay with her. She had her locks changed, she developed safety plans, monitored MJN's movement and wore a safety device. In contrast, MJN was only required to comply with the conditions of the FVIO. I note the Victorian Government is committed to keep "*perpetrators in view*" and holding them "*to account*", however this does not appear to be the case in this instance. Redirecting that responsibility to the person using the violence and having systems in place to proactively monitor compliance is critical if we want to keep victims safe and promote offenders' accountability.

85. Addressing men's decision to use violence is also critical if we wish to prevent family violence and intimate partner homicide. As evidenced in the sentencing remarks, MJN had a history of trauma, having lived through the [redacted] civil war. Research suggests that many adults who chose to use interpersonal violence have a history of trauma, often rooted in adverse experiences during their formative years. This connection is further supported by ANROWS pathways to homicide research which found that trauma was also prevalent across all cohorts of intimate partner homicide offenders, with findings indicating that 58 per cent had at least one significant traumatic experience over the course of their lives.

86. While trauma is not a direct cause of family violence, nor does it excuse the decision to engage in violent behaviour, it is important to recognise that traumatic experiences can influence the likelihood that an individual will choose to use violence. Trauma can influence the formation of core beliefs that normalise, justify or enable a person's decision to use violence.[28] To effectively prevent family violence and family violence related homicide it is therefore important that systems are resourced to reach people who use violence and to work with them

[28] Vlais, R. (April 2025). *Working with adult users of domestic and family violence who have a trauma background*.

to understand, address and dismantle the relationship between their experience of trauma and their decision to use violence.

87. As I noted in my finding into the passing of Noeline Dalzell, the Victorian Government has launched the Changing Ways program. This program promises to provide intensive, coordinated responses to high-risk adults using family violence and the victim-survivor(s) impacted by their violence. The program documentation speaks to "*better coordinating across the service system so that serious-risk adults using family violence become and remain in view of services, tailoring an intensive response for victim-survivors, tailoring interventions that directly or indirectly engage the adult using family violence who poses a serious risk, and using multiple approaches to support them to take responsibility for stopping their family violence*".

88. It is not clear how quickly this pilot will be able to respond to high-risk offenders, and to what extent friends and families will be incorporated into the accountability mechanisms. Including an offender's social network when responding to high-risk offenders is critically important for both risk management and accountability purposes, as is responding to the connection between any trauma they may have and their decision to use violence. GVY's murder is a tragic but important example of the need to appropriately manage high-risk offenders and offer interventions to these individuals that address the core beliefs that enable their decision to use violent behaviours. As such, I intend to provide a copy of this finding to the RAMP Statewide Coordinator and the Changing Ways Program Lead in the hopes that learnings from GVY's experience of violence and her murder can be incorporated into their work.

Children bereaved by family violence homicide

89. DWE, NHY and QSX were victims of an extreme family violence perpetrated by MJN, including but not limited to, that which resulted in the murder of their mother. Studies have found that children exposed to fatal family violence can experience substantial mental health and development difficulties, with concerns that these children may also be at greater risk of perpetrating family violence in the future.[29] Ensuring that these victims have access to funded and wholistic therapeutic support can foster healing from this trauma, which can be a form of prevention.

[29] 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.

90. The impact of a family violence homicide can have long term effects on a child's development and wellbeing. In an Australian study, which interviewed 70 children from Australia, the United Kingdom and Ireland who had 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.[30] Surviving children spoke of those around them failing to acknowledge the family violence as causing the death, viewing them as "*damaged*" and, in some instances, blaming of their deceased parent.[31]

91. In a review of available services, 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 that these children had been through.[32]

92. 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 provides wraparound services to children bereaved by homicide including personal advocacy, mental health care, peer support, referrals to legal assistance, ongoing case management and mentoring.[33] 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*".[34]

93. Victoria does not have a similar program targeted at children bereaved by homicide. In Victoria, children can access Victims of Crime, a generic service aimed at providing advice on victim entitlements and the criminal justice system; Victims Assistance Program, a generalist victim support service provided by community services; and generalist family violence or trauma informed counselling through services such as Take Two. Whilst these services offer critical assistance in the absence of specialised support, these agencies experience resource limitations which challenge their ability to work with all children needing their support.

[30] Ibid.
[31] Ibid, 6-7.
[32] Ibid, 13-14.
[33] Ibid, 15.
[34] 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>.

94. 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.[35] 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.[36]

95. Recognition of 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.[37]

96. In their 2022-2023 annual report, the Commission for Children and Young People (**CCYP**) noted that the Department of Families, Fairness and Housing had advised they would "*examine current service responses and identify any gaps and opportunities for service improvement*"[38] and progress[39] best practice guides for Child Protection practitioners working with children bereaved by homicide. As of February 2025, there do not appear to be any relevant practice guides on the Child Protection manual.

97. While the introduction of protocols for responding to children bereaved by homicide would help to guide practitioners, without dedicated funding and targeted specialised programs, the capacity of workers to meet the needs of this population may be compromised within an already stretched workforce. I made a recent recommendation in my finding into the death of Monique Lezsak that the Minister 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. As the Minister has not yet responded to this recommendation, I will direct a copy of this finding be provided to the Minister for their consideration.

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[35] 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.

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

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

[38] Commission for Children and Young People. Annual Report 2022-23, 48.

[39] Ibid.

FINDINGS AND CONCLUSION

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

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

    b) the death occurred on 3 December 2022 at [redacted], from *1(a) head and neck injuries*; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to GVY's family and friends for their loss. I note the remarkable bravery and courage displayed by QSX and NHY during the fatal incident and commend their valiant efforts to save their mother's life, even when they faced significant risk of harm to themselves.

COMMENTS

99. Pursuant to section 67(3) of the Act, I make the following comments:

    a) I support and endorse Recommendation 1 in my finding into the death of Monique Lezsak:

        > *That the **Department of Families, Fairness and Housing** and **Family Safety Victoria** work with and resource bodies such as Respect Victoria and Safe and Equal to deliver a public campaign to resource the broader community, beyond service providers, to better understand the risks that perpetrators of family violence pose, including in the absence of physical violence. This campaign should consider how to reach the broadest possible audience including through education, health, local community, sports and faith groups. The campaign should enhance awareness of fatality risks posed by those who use coercive and controlling behaviour, factors that may increase risk (such as in the context of separation) - and should include clear information to victims, friends, family and bystanders as to services available to help keep them safe.*

        As the Department and Family Safety Victoria have not yet responded to this recommendation, I direct that they receive a copy of this finding for their consideration.

b) I support and endorse Recommendation 2 in my finding into the death of Monique Lezsak:

> *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.*

As the Minister has not yet responded to that recommendation, I direct that they receive a copy of this finding for their consideration.

RECOMMENDATIONS

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

(i) That **Respect Victoria** invest in researching possible interventions with the 'fixated threat' cohort of intimate partner homicide offenders, with a focus on identifying opportunities for primary prevention and early intervention. This research should consider the role of trauma on the decision to use family violence and explore opportunities to strengthen system capacity to engage, where appropriate, with 'fixated threat' individuals in addressing and dismantling the choice to use violence. Research into early intervention with this cohort should explore the health settings as a point of intervention with these individuals and how to mobilise health settings to identify and respond to these individuals.

(ii) That **Family Safety Victoria** review avenues to rectify delays in specialist family violence services contacting people who use violence and implement any appropriate strategies to improve same.

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:

DWE, Senior Next of Kin

Changing Ways, Program Lead

Department of Families, Fairness and Housing

Family Safety Victoria

Good Shepherd

Respect Victoria

Risk Assessment and Management Panel (RAMP), Statewide Coordinator

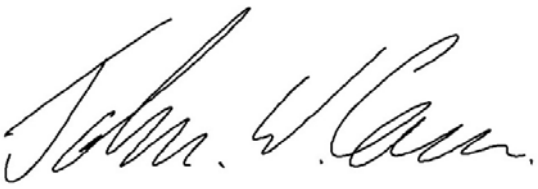
Safe + Equal

[redacted] **(C/- Gilchrist Connell)**

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

Detective Senior Constable Benjamin Lavakeiaho, Coronial Investigator

Signature:



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Judge John Cain
State Coroner
Date: 28 July 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.