IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002413

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:	ZSQ
Date of birth:	[redacted]
Date of death:	6 May 2023
Cause of death:	1(a) Community acquired pneumonia in a man with acute on chronic renal failure
Place of death:	[redacted]
Keywords:	Family violence; isolation; control; elder rights

INTRODUCTION

1. On 6 May 2023, ZSQ was 81 years old when he passed away at a regional Victorian hospital. ZSQ is survived by his two adult sons, CDF and LKN, and long-term partner, RTG. At the time of his death, ZSQ lived in a regional Victorian town, with RTG.

2. ZSQ's medical history included anaphylaxis (wasps), chronic bronchitis, chronic sinusitis, hypercholesterolaemia and osteopenia. ZSQ presented to the regional hospital in December 2022 with increased shortness of breath. He was diagnosed with heart failure and a chest x-ray demonstrated interstitial oedema with small right and moderate left effusion, consolidation of the left base and probable chronic obstructive pulmonary disease (**COPD**) change.

THE CORONIAL INVESTIGATION

3. ZSQ'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.

4. 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.

5. 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.

6. Victoria Police assigned Sergeant Christopher Taylor to be the Coronial Investigator for the investigation of ZSQ's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of ZSQ 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]

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

Identity of the deceased

8. On 6 May 2023, ZSQ born [redacted], was visually identified by his son, CDF.

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

Medical cause of death

10. Forensic Pathologist Adjunct Associate Professor (**Adj A/Prof**) Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 9 May 2023 and provided a written report of her findings dated 26 May 2023.

11. The post-mortem examination revealed findings consistent with the reported circumstances. Examination of the post-mortem CT scan showed bilateral pleural effusions, bilateral lower lobe pneumonia and patchy calcification in the kidneys.

12. Signs of injury were noted to the body, including:

    a) A healed abrasion on the right knee, 1cm.

    b) A cluster of small healed abrasions on the right upper chest, 2 x 1cm.

    c) A healing abrasion on the lateral aspect of the right eye, 1 x 0.5cm.

    d) An abrasion on the tip of the nose, 0.5cm.

    e) Possible bruising on the centre of the forehead, 4 x 2cm.

    f) A possible yellow bruise in the centre of the abdomen over an area of 10 x 5cm.

13. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

[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.

14. Adj A/Prof Parsons provided an opinion that the medical cause of death was *1(a) community acquired pneumonia in a man with acute on chronic renal failure.*

15. I accept Adj A/Prof Parsons' opinion as to the medical cause of death.

Circumstances in which the death occurred

16. Sometime in late-February 2023, an alleged physical assault occurred between RTG and ZSQ. RTG allegedly punched ZSQ to the left cheek, pushed him to the ground and dragged him by the hair on the ground.

17. On 28 February 2023, ZSQ consulted with his general practitioner (**GP**) and reported the alleged physical assault. He also reported that RTG took his wallet and identification and had kicked him out of their home. The GP suggested that ZSQ should report the assault to police, however he initially refused.

18. That same day, ZSQ was distressed and attended the workplace of his close friends. His friends observed scratches to his face and forearms, and bruises to his back, and ZSQ alleged that RTG had struck him around the head and pushed him into the corner of the laundry. ZSQ's friends suggested that he should report the allegations to police, however ZSQ again refused.

19. ZSQ later decided to attend a local regional Police Station and reported to police that his GP had instructed him to speak to police, as RTG allegedly took his wallet and refused to give it back. The officer noted a prior family violence intervention order (**FVIO**) from 2020 and was concerned that ZSQ was still exposed to abusive behaviour. The member offered referrals to specialist family violence services for both ZSQ and RTG, however ZSQ refused and left the police station.

20. ZSQ's friends decided to report their concerns to police on 1 March 2023 and provided statements about the allegations of abuse. Police spoke to ZSQ's GP, who confirmed he had seen ZSQ on 28 February 2023 for injuries sustained in an alleged assault with his partner. Police applied for a Family Violence Safety Notice (**FVSN**) against RTG in full conditions to protect ZSQ. The FVSN prevented RTG from residing at the family home and from having any contact or communication with ZSQ.

21. The FVSN was heard at the regional Magistrates' Court on 10 March 2023, where both ZSQ and RTG were present. An interim FVIO was granted, with the conditions varied to permit

RTG to remain in the family home until 27 March 2023. A family friend of both ZSQ and RTG agreed to act as a mediator, as he was also assisting the couple with the sale of the family home. The FVIO was due to return to Court on 21 April 2023 at a regional Magistrates' Court.

22. ZSQ and RTG both attended court on 21 April 2023 for the FVIO hearing. ZSQ informed police that he was no longer supportive of the FVIO as he had spoken to RTG the day prior, and they agreed to reconcile the relationship. Police maintained concerns for ZSQ's welfare, and the court granted a limited (safe contact) order to protect ZSQ. Police noted that they spoke to the Victoria Legal Aid duty lawyer (who provided advice to RTG) and made arrangements for RTG to attend the regional Police Station on 24 April 2023 for an interview in relation to alleged breaches of the FVIO. ZSQ was due to attend the regional Police Station on 25 April 2023 to speak about the alleged breaches.

23. On 23 April 2023, ZSQ was at a Botanical Gardens in regional Victoria when he suffered a fall. He was transported to his GP clinic, where he was checked by a GP. He experienced some dizziness; however, no injuries were observed.

24. On 24 April 2023, ZSQ was still experiencing dizziness and also reported chest pains and shortness of breath. He attended his GP again, who treated him for vertigo, and advised him to return home and rest.

25. That same day, RTG attended the regional Police Station and was interviewed in relation to the FVIO breach charges. At the conclusion of the interview, RTG was charged and bailed on her own undertaking, to appear at the regional Magistrates' Court on 12 May 2023.

26. On the afternoon of 25 April 2023, ZSQ was at home when he reported feeling unwell, dizzy and was having difficulty breathing. RTG called 000 and reported ZSQ was feeling unwell and had shortness of breath. When paramedics attended, they observed ZSQ had a low heart rate (40 bpm), blood pressure of 140/70, and oxygen saturation of 70%.

27. Paramedics treated ZSQ, before transporting him to the regional Victorian hospital. Upon arrival, ZSQ was noted to be experiencing cardiogenic shock, multi-organ failure and community acquired pneumonia. ZSQ was intubated and underwent invasive ventilation and cardiovascular support with adrenaline and noradrenaline infusions. He was also commenced on antibiotics to treat community acquired pneumonia.

28. ZSQ was admitted to the intensive care unit (**ICU**) on 26 April 2023 where he also received renal replacement therapy and feeding. Clinicians observed that he had multiple wounds

including above the right eyebrow, right knee and the right elbow, and he appeared malnourished.

29. ZSQ's condition initially improved, and he was able to be extubated on 28 April 2023. Unfortunately, he experienced ongoing respiratory failure, weakness, renal failure and delirium, requiring re-intubation on 2 May 2023. Following conversations with ZSQ's family, clinicians initiated end of life care and ZSQ passed away on 6 May 2023.

FURTHER INVESTIGATIONS

30. As ZSQ's death occurred in circumstances where there were allegations that he was experiencing family violence in the lead-up to his passing, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of ZSQ's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[3].

31. I make observations concerning service engagement with ZSQ 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 and ZSQ's death.

Alleged family violence history

32. ZSQ separated from his first wife in about 1994 and divorced in 1997. In 1998, ZSQ met RTG while he was working as a landscaper in Melbourne, and she was working as a nanny. ZSQ's sons, family members and friends reported that the relationship between ZSQ and RTG was tumultuous from about 2000. Over time, ZSQ's contact with his family reduced, which his family attributed to RTG's alleged controlling behaviour. ZSQ reportedly hid a mobile phone at his property so that he could call his family members without RTG knowing or called them from a friend's business phone.

33. In 2013, CDF called his father numerous times over a five-day period and was unable to reach him, so he called police and requested a welfare check. When police attended, ZSQ was noted

[2] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

[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.

to be well and was unaware of any of the messages that CDF had sent him over the preceding five days. RTG reportedly deleted these messages to prevent ZSQ being aware of his son's contact. Additionally in 2013, CDF noted that his father started calling him to warn him that he was about to call him again and that CDF could hang up if he wanted to. When ZSQ called his son back, he started reading what appeared to be "*a list of grievances*". If CDF asked his father whether RTG was standing next to him, ZSQ denied it, however CDF suspected ZSQ was forcing him to read these grievances.

34. In 2020, ZSQ was listed as the affected family member (**AFM**) on an FVIO, which was applied for by police against RTG. ZSQ requested the FVIO be revoked at court, which subsequently occurred.

35. In ZSQ's medical records from 28 August 2020, ZSQ alleged that RTG had locked him out of the house, and he slept in his car or was forced to stay with a friend. He also alleged that she confiscated his phone and became enraged by the text messages he received. He missed an appointment with his counsellor and reported that "*in turn she says she will sell the house*". ZSQ's counsellor noted that he "*presents as somewhat fearful of his partner and has played 2 messages to me from her where she is highly agitated and abusive and mildly threatening in her language toward him*".

36. ZSQ's last known contact with his family occurred shortly before Christmas 2022, including his brother and sister-in-law, whom he had not seen for a decade. ZSQ was observed to have marks on his right forearm, although ZSQ denied they were caused by RTG. ZSQ alleged that on several occasions when he was in the car travelling with RTG, she left him on the side of the road and on one occasion he had to walk and hitchhike home from a town 17 kilometres away. His friends reported receiving calls from ZSQ requesting assistance to get home on several occasions from various locations. While at his brother's home, RTG started calling ZSQ obsessively and repeatedly. When she spoke to ZSQ, she allegedly screamed and abused him over the phone because ZSQ was allegedly that he was not permitted to enter his brother's house.

37. On 21 December 2022, ZSQ reported to his general practitioner that "*things are not good at home with the mrs*". He reported that he was staying with a friend, but did not disclose what had occurred. ZSQ alleged similar issues in January 2023 to his general practitioner, namely "*sometimes she is good and then change*" and "*screaming*".

38. ZSQ's friends observed a significant decline in ZSQ's wellbeing in the 12 months prior to his passing. They noted that he was regularly "*kicked out*" of his home by RTG and was forced to sleep in his car. His friends also alleged that RTG took items from ZSQ including his wallet or phone and told ZSQ that he had misplaced them. This reportedly caused ZSQ to become distressed as he started to second-guess himself and his memory.

39. Police offered RTG the opportunity to make a statement, however she declined. RTG also reported to other people that ZSQ allegedly assaulted her in the past, however there was no evidence available to the Court to support those allegations.

Contact with police and other services

40. I note that ZSQ was largely reticent to report allegations of family violence to police and only reported concerns in the two months prior to his passing.

41. ZSQ's friends and his GP were both helpful and urged him to report the allegations to police. His GP appropriately identified concerns for ZSQ's welfare and correctly referred him to police to make a report. When ZSQ made his report to police, they applied for an FVIO to protect him and advocated for the full (no contact) conditions to remain in place, to ensure his protection.

42. Police appropriately interviewed RTG for the alleged FVIO breaches and plans were in place to take a statement from ZSQ. Police believed that RTG allegedly breached the FVIO prior to the 21 April 2023 hearing by contacting ZSQ and threatening suicide, which persuaded him to change his mind about supporting the FVIO. ZSQ initially declined to provide a statement regarding the alleged breaches and later was unable to provide a statement due to being hospitalised. The charges against RTG were not pursued, following ZSQ's passing.

43. I have not identified any deficiencies in the contact ZSQ had with police or his GP and have therefore not identified any prevention opportunities.

Response to allegations of family violence

44. As a matter of procedural fairness, RTG was provided with an opportunity to respond to the alleged reports of family violence. RTG provided numerous photos of cards and letters written by ZSQ to RTG over the course of their relationship. ZSQ expressed his love and appreciation of RTG in this correspondence and pledged his commitment to her and their relationship. She denied that any family violence occurred during their relationship and alleged that she had

been assaulted by one of ZSQ's sons. RTG did not specifically respond to the alleged assault in February 2023 or the resulting FVIO.

45. RTG opined that ZSQ's sons and family were the cause of his isolation from them. She also provided a lengthy history of their relationship and some of the major events in their life. She claimed "*Any 'concerns' with our relationship were CAUSED by [ZSQ's son] and the fact that other members of his family didn't want to know about what LKN was saying, doing or about him assaulting me*". RTG stated that she knew "*at least 6 peiple [sic] that ZSQ spoke to about how his family behaved and treated us, including our solar man, the man at the dog kennels and several olive people*".

46. RTG pleaded with the Court to "*be fair and have compassion and empathy*". She noted that "*if the executors feel that anything in the report suggests I 'caused' ZSQs [sic] death, I won't receive the rest of his estate*". RTG further explained that ZSQ's death was caused by the alleged incompetence of his GP, and that the GP should have picked up his renal failure during routine blood tests.

47. A friend of the family, who was not contacted by the Court, sent an email to the Court explaining that he was one of ZSQ's two executors who prepared his will. He noted that ZSQ decided to leave his entire estate to RTG and noted that ZSQ's death was due to natural causes. He submitted that ZSQ's death was therefore not due to any "*family actions that influenced his demise*".

48. I accept that ZSQ and RTG loved one another and shared many happy memories together. I also note that ZSQ did not die due to an assault or complications from an assault. However, the circumstances *prior* to his passing, namely the alleged family violence, are also relevant as explained above, and it is within that context that these allegations are discussed. These allegations were raised by a variety of people, and not only ZSQ's family members. This discussion is not to apportion blame or determine civil or criminal liability and therefore I make no comment as to the validity of the claims of family violence.

FINDINGS AND CONCLUSION

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

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

b) the death occurred on 6 May 2023 at [redacted], from *1(a) community acquired pneumonia in a man with acute on chronic renal failure*; and

c) the death occurred in the circumstances described above.

I convey my sincere condolences to ZSG'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:

RTG, Senior Next of Kin

Sergeant Christopher Taylor, Coronial Investigator

Signature:

Judge John Cain
State Coroner
Date: 1 April 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.