IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 003368

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Ms BCJ[1]
Date of birth:	[redacted]
Date of death:	25 June 2020
Cause of death:	1(a) Neck compression in the setting of self-suspension
Place of death:	Shepparton, Victoria, 3630
Keywords:	Family violence; suicide; mental health

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased with a pseudonym of a randomly-generated three letter sequence for the purposes of publication.

INTRODUCTION

1. On 25 June 2020, Ms BCJ was 32 years old when she was discovered deceased in the garage of her home. At the time of her death, Ms BCJ lived with her husband, Mr NCN, and two young children in Shepparton, Victoria.

2. Ms BCJ was born and raised in India and married her husband Mr NCN in 2009 in Australia.[2] Ms BCJ arrived in Australia on a student visa in 2009 prior to her marriage to Mr NCN. Ms BCJ worked as a store manager for a local fast-food chain prior to the fatal incident.

3. Between 2009 and 2020 there were three separate reported family violence incidents between Ms BCJ and Mr NCN, with Mr NCN being the respondent on all three occasions. In the course of the associated investigations, Ms BCJ reported to police that due to her Indian heritage and her husband being of Iraqi heritage, she was not accepted within the Indian community nor the Iraqi community. Ms BCJ reported that this left her feeling trapped and isolated without any support outside the marriage.[3]

THE CORONIAL INVESTIGATION

4. Ms BCJ'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.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms BCJ's death. The Coroner's Investigator conducted inquiries on the Court's behalf, including

[2] Coronial brief, 19; Victim Withdrawal Statement, 'Exhibit 13 and 14', 21.
[3] Coronial brief, Statement of Senior Constable Brierley, 76.

taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. Coroner Katherine Lorenz initially held carriage of the investigation into Ms BCJ's death. I assumed carriage on 6 July 2023 for the purposes of conducting discrete additional investigations and making findings.

9. This finding draws on the totality of the coronial investigation into the death of Ms BCJ 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.[4]

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

Circumstances in which the death occurred

10. In the period leading up to the fatal incident, police attended the family home on 12 May 2020 after a call from Ms BCJ. She disclosed ongoing family violence to attending police and that she did not want to live anymore. Attending police members took out a Family Violence Safety Notice (**FVSN**) to protect Ms BCJ from Mr NCN and excluding him from the home. Ms BCJ was subsequently transported for assessment under the *Mental Health Act 2014* (Vic) (as then applied) and disclosed significant family violence to the clinician who assessed her.[5]

11. Both Ms BCJ and Mr NCN attended Shepparton Magistrates Court on 14 May 2020 in relation to the scheduled subsequent intervention order proceedings that resulted from the police FVSN. A final Family Violence Intervention Order (**FVIO**) was determined by consent outside of the hearing,[6] with conditions not to commit family violence, not to damage property, and not to have another person do so, and that the children be added to the order (who were not on the initial application).[7] There were no conditions that excluded Mr NCN from the home.

[4] 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.

[5] Statement provided to CCOV by L Bryant 23.12.2020, Goulburn Valley Health, 1, 2. Upon assessment by a registered psychiatric nurse at the Goulburn Valley Emergency Department, Ms BCJ denied any current suicidal ideation, plan or intent and was discharged with appropriate referrals for support, which she accepted.

[6] Audio recording, Family Violence Intervention Order Hearing 14 May 2020.

[7] Audio recording, Family Violence Intervention Order Hearing 14 May 2020.

12. On 24 June 2020, Ms BCJ went to visit a friend at 7.30pm and returned home after a short period of time.[8] Mr NCN left home at approximately 11.48pm to attend work and returned around 1.15am on 25 June 2020.[9] When he left, Ms BCJ was reported to be in her bedroom with one of their sons watching a cartoon.

13. Upon his return, Mr NCN reported that he was confronted by his son who said, '*come baba, my mother is in the garage'*.[10] Mr NCN discovered Ms BCJ hanging from the roof of the garage and cut her down to attempt resuscitation whilst contacting emergency services.

14. Ambulance paramedics and police members arrived around 1.27am and confirmed that Ms BCJ was deceased.[11]

Identity of the deceased

15. On 25 June 2020, Ms BCJ was visually identified by her husband.

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

Medical cause of death

17. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on Ms BCJ's body and provided a written report of his findings dated 7 December 2020.

18. The post-mortem examination revealed the following:

    a) The external examination of the body showed findings in keeping with the clinical history; and

    b) There were no significant post-mortem CT scan findings.

19. Toxicological analysis of post-mortem samples identified the presence of alcohol at a concentration level of 0.05g/100mL and the following drugs: venlafaxine,[12] desmethylvenlafaxine[13] and deltra-9-tetrahydrocannabinol (cannabis). None of the

[8] *Coronial Brief*, 25 June 2020, 2
[9] *Coronial Brief*, Statement of Mr NCN 25 November 2020, 1-3
[10] *Ibid*.
[11] *Coronial Brief*, Statement of Ambulance Paramedic dated 9 December 2020, 1-2.
[12] Venlafaxine is used in the treatment of depression.
[13] Desmethylvenlafaxine is a metabolite of venlafaxine and is also an anti-depressant drug.

concentrations of drugs detected in post-mortem samples were held to have contributed to the death.

20. Dr Beer provided an opinion that the medical cause of death was '*1(a) Neck compression in the setting of self-suspension*'.

21. I accept Dr Beer's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

22. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Ms BCJ and Mr NCN was one that fell within the definition of '*spouse'*[14] under that Act. Moreover, the available evidence suggests that Ms BCJ experienced '*family violence'*[15] in the lead up to the fatal incident.

23. In light of this death occurring in connection with circumstances of family violence, it was requested that the Coroners Prevention Unit (**CPU**)[16] examine the circumstances of Ms BCJ's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[17]

24. I make observations concerning service engagement with Ms BCJ 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 Ms BCJ's death.

25. 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'*.[18] I make observations about services that had contact with Ms BCJ and her immediate family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

---

14 *Family Violence Protection Act 2008*, section 8(1)().

15 *Family Violence Protection Act 2008*, section 5.

16 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.

17 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.

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

The history of family violence in Ms BCJ and Mr NCN's relationship

26. The available evidence collated from records provided by various services that had contact with Ms BCJ and her immediate family in the lead-up to her passing indicates that there is documented history of the family violence experienced by Ms BCJ throughout her relationship with Mr NCN.

27. The available evidence indicates that Ms BCJ had contacted the NSW Rape Crisis centre around November 2010 and there was Child Protection involvement at this time as a result. Child Protection contacted the family's Maternal Child Health nurse, who reportedly held no concerns about family violence nor the children's development.[19] The relevant Maternal Child Health nurse did note it would be difficult to ask about family violence as Mr NCN attended all Maternal Child Health appointments with Ms BCJ.[20]

28. On 16 August 2012, Ms BCJ reported to Child Protection that she experienced family violence whilst she was pregnant, including reports of Mr NCN pushing her to the floor by strangling her with his knee on her neck, punching/slapping her, and sexually assaulting her.[21]

29. In 2012, the available evidence indicates that several services (including Victoria Police) coordinated to assist Ms BCJ and her child to leave Mr NCN due to the high risk of the family violence occurring, including threats to kill, financial abuse, rape, and physical violence.[22] Ms BCJ advised police that she was rejected by her (Indian) community due to marrying an Iraqi, but rejected by the Iraqi community for being Indian.[23] During this period of engagement with services, an exit plan was coordinated for a day when Ms BCJ had her child without Mr NCN being present. Records indicate Ms BCJ may have been relying on Mr NCN in relation to her immigration status around this time.[24] Ms BCJ initially went to a refuge in Melbourne and eventually returned to Mr NCN after he located her and '*pleaded for her to return'*.[25]

30. In 2013, an '*outside source'* called Victoria Police to the family home and their records indicate that Mr NCN had physically assaulted Ms BCJ after she declined to sleep in the same bed as him.[26]

[19] Department of Families, Fairness and Housing, records relating to Ms BCJ and Mr NCN's children, 304.
[20] *Ibid*.
[21] *Ibid*, 268.
[22] Marian Community, Vincent Care records, 4.
[23] Victoria Police LEAP extract '2022.06.20 – Form 4 response – COR 2020 3368 – Ms BCJ – Victoria Police' 25.
[24] Coronial brief, letter from Nixon St Medical Centre, 35; Marian Community, Vincent Care records, safety plan.
[25] Victoria Police LEAP extract '2022.06.20 – Form 4 response – COR 2020 3368 – Ms BCJ – Victoria Police' 16.
[26] Department of Families Fairness and Housing L17 Portal record dated 18.1.2013, 9.

31. Between the period of 2013 and 2020, there were no reports of family violence to any services.

32. In May 2020, Ms BCJ disclosed to a friend feeling trapped, subject to physical and sexual abuse, and considering suicide, but that her children needed her.[27] The same friend noted that if Ms BCJ came to visit, Mr NCN would continuously call Ms BCJ.[28]

33. In the same month and as noted above, on 12 May 2020, police attended the family home after a call from Ms BCJ. She disclosed ongoing family violence to attending police and that she did not want to live anymore. She was subsequently transported for assessment under the *Mental Health Act 2014* (Vic) (as then applied) and disclosed significant family violence to the clinician who assessed her.[29]

34. After transport under the *Mental Health Act 2014* on 12 May 2020, the Goulburn Valley Health PACER clinician assessed Ms BCJ as not at risk of suicide, provided phone numbers for support services including Mental Health Triage, and Marion Community and Domestic Violence Services.[30] The assessment notes also list a referral to the Ethnic Council of Shepparton.[31]

35. Ms BCJ provided extensive detail to the PACER clinician, including that while police assistance temporarily reduced the physical abuse, that intimidation, sexual assault and psychological abuse would continue.[32] She also disclosed that Mr NCN would bite, hit, and rape her at any time without warning, and she feared the children would witness this conduct.[33]

36. Ms BCJ further disclosed to the PACER clinician that she wanted Mr NCN to leave, knew the family violence was affecting her children, and did not want the children to miss out on seeing their father but she did not want to live with him.[34] The PACER clinician indicated that she supported Ms BCJ to express this to police and attended the home with Ms BCJ while Mr NCN was excluded with the Family Violence Safety Notice (**FVSN**).[35]

37. As noted above, both Ms BCJ and Mr NCN attended Shepparton Magistrates Court on 14 May 2020. Shepparton was established as a Specialist Family Violence Magistrates Court in late

[27] *Coronial Brief*, Statement dated 25 June 2020, 25.
[28] *Ibid*.
[29] Statement provided to the Court by L Bryant 23.12.2020, Goulburn Valley Health, 1,2.
[30] *Ibid*.
[31] Goulburn Valley Health Medical Records, 9.
[32] Goulburn Valley Health Medical Records, 7.
[33] Goulburn Valley Health Medical Records, 7.
[34] Statement provided to the Court by L Bryant 23.12.2020, Goulburn Valley Health, 1,2.
[35] *Ibid*.

2019.[36] The final Family Violence Intervention Order (**FVIO**) was agreed to by consent outside of the hearing,[37] with conditions not to commit family violence, not to damage property, and not to have another person do so, and that the children be added to the order (who were not on the initial application).[38] As outlined above, the FVIO did not contain exclusion orders and neither Ms BCJ nor Mr NCN appear to have been provided with legal advice at or prior to the hearing.

38. In this case, Child Protection received an L17 referral[39] from Victoria Police members attending a family violence incident on 12 May 2020 and closed off their investigation on 20 May 2020 due to information that:

    a) Child First had offered support to Ms BCJ (which was declined);

    b) Ms BCJ had an intervention order prohibiting all contact with Mr NCN (which was inaccurate); and

    c) Ms BCJ had acted protectively and so there was no action for Child Protection.[40]

39. When Child Protection receives an L17 form referral, they will assess the safety risks to any children potentially to be exposed to or witness family violence. In conducting such risk assessments, Child Protection will obtain a copy of the outcome of a FVIO or FVSN application made in the Magistrates Court.[41]

40. In this case, the intervention order that Child Protection had on file and was used as a basis for the decision to close the case, was incorrect and listed conditions as, "*not to commit family violence, not to contact or communicate with a protected person by any means and not to have another person to do so, with expiry date 13 May 2021*"[42] whereas the actual conditions made at the court hearing on 12 May 2020 were "*not to commit family violence, not to damage*

[36] Magistrates Court of Victoria, New family violence court division in Shepparton (31 October 2018) <https://www.mcv.vic.gov.au/news-and-resources/news/new-family-violence-court-division-shepparton>.
[37] Audio recording, Family Violence Intervention Order Hearing 14 May 2020.
[38] Audio recording, Family Violence Intervention Order Hearing 14 May 2020.
[39] L17 referral forms refer to the Victoria Police Risk assessment and Management Report that Victoria Police are required to complete after they have attended a family violence incident. The report contains information about family violence risk and referrals made following a family violence incident.
[40] Department of Families, Fairness and Housing records, 10, 185.
[41] Child Protection Manual – Policies and Procedures – Receiving, registering and classifying a report, available online at: https://www.cpmanual.vic.gov.au/policies-and-procedures/phases/intake/receiving-registering-and-classifying-report
[42] Department of Families, Fairness and Housing, records, 10, 192, 187.

property, and not to have another person do so and that the children be added to the order (who were not on the initial application)".[43]

41. Child Protection sought a copy of the intervention order on 14 May 2020 (the day of the hearing) from Shepparton Magistrates Court in its role as a Risk Assessment Entity (**RAE**) under the Family Violence Information Sharing Scheme (**FVISS**).[44] However, it is unclear from the available evidence as to who provided the FVIO to Child Protection and why it erroneously contained conditions that specified that contact with the respondent (Mr NCN) was excluded, rather than the conditions that allowed contact with the respondent which were actually imposed.[45]

42. I note that with the benefit of hindsight, had this error been picked up and Child Protection updated, Child Protection may have remained involved, and the safety of the family might have remained in view. There is an established mechanism by which Child Protection may receive such information and I consider it to be of concern, and a lost opportunity, that the information provided was in fact incorrect.

The availability of specialist family violence supports at various Magistrates' Court locations

43. The available evidence confirms that both Ms BCJ and Mr NCN attended Shepparton Magistrates Court on 14 May 2020. Shepparton was established as a Specialist Family Violence Court (**SFVC**) in late 2019.[46]

44. The Magistrates Court of Victoria advises that Specialist Family Violence Courts (**SFVCs**) are now established in 13 locations across Victoria.[47] SFVCs deliver an integrated family violence response with magistrates supported by registry and practitioners, who are all trained and specialise in family violence. These Courts are designed to support the safety and wellbeing of people affected by family violence and increase the accountability of people who have used violence against family members.

45. The SFVCs include family violence registrars, specially trained family violence applicant and respondent practitioners who provide non-legal advice, and a collaboration of police

[43] Audio recording, Family Violence Intervention Order Hearing 14 May 2020.
[44] Department of Families, Fairness and Housing, records, 185.
[45] Department of Families, Fairness and Housing, records, 172.
[46] Magistrates Court of Victoria, New family violence court division in Shepparton (31 October 2018) <https://www.mcv.vic.gov.au/news-and-resources/news/new-family-violence-court-division-shepparton>.
[47] Ballarat, Bendigo, Broadmeadows, Dandenong, Frankston, Geelong, Heidelberg, Latrobe Valley, Melbourne, Moorabbin, Ringwood, Shepparton, and Sunshine Magistrates Courts.

prosecutors, community-based specialist family violence services and lawyers with family violence training.

46. Some SFVCs contain safety features such as separate entrances and safe waiting areas, remote witness technology and private interview rooms to provide a safer Court experience.

47. Shepparton Magistrates Court had the following specialist services at the time of Ms BCJ and Mr NCN's attendance in May 2020:

    a) Family violence applicant and respondent practitioners who provide non-legal advice and support. Practitioners can provide referrals to community support agencies to ensure people have the support they need outside of court. They also complete risk assessments, develop safety plans, and provide information;

    b) Safe waiting areas for affected family members and separate entrances and exits for applicants and respondents;

    c) Duty lawyer services from Victoria Legal Aid and Goulburn Valley Community Services;

    d) Magistrates and family violence trained registrars; and

    e) Marion Community and Vincent Care, a specialist family violence service located in Shepparton. They provide a wrap-around model of care including crisis accommodation and case management.

48. Records indicate that Ms BCJ spoke to a family violence applicant practitioner on 14 May 2020, and to a Victoria Police liaison officer. Mr NCN also spoke to the family violence respondent practitioner. As noted above, this was for the purposes of receiving non-legal advice and support.

49. However, there is no evidence that either Ms BCJ and Mr NCN received legal advice from Victoria Legal Aid or Goulburn Valley Community Legal Centre, both of which provide a free duty lawyer advice service at Court. Both services report that they were working remotely at the time due to COVID-19 pandemic restrictions.[48] Shepparton Magistrates Court confirmed that the COVID-19 pandemic disrupted many of the services the Court provided.

[48] Legal Aid, Annual Report 2019/2020, 27 and Goulburn Valley Community Legal Centre Annual Report 2019/2020, 4.

50. Both Victoria Legal Aid and the Goulburn Valley Community Legal Centre assist affected family members and respondents by providing free legal advice and assistance through a duty lawyer program. This program provides parties with access to independent legal advice upon request at the Court and referrals to specialist family violence support services like domestic violence advocacy, respondent workers and homelessness services. Both Victoria Legal Aid and the Goulburn Valley Community Legal Centre have training to identify family violence risks and respond to such risks being identified.

51. The available evidence suggests that two days prior to the 14 May 2020 hearing, Ms BCJ disclosed to Victoria Police members significant and ongoing family violence, and '*mental torture'*.[49] In the absence of receipt of independent legal advice on the date of the hearing, it is possible that Ms BCJ may have felt pressure at Court to agree to a FVIO with conditions to allow Mr NCN back into the home, despite founded concerns for her safety and/or wellbeing, given:

    a) his history of pursuing her when she left him previously due to violence;

    b) his persistent requests to police even when served with the FVSN to speak with Ms BCJ;[50] and

    c) her disclosed isolation and rejection by Indian and Iraqi communities.[51]

52. I note with the benefit of hindsight and in the circumstances of this case, Ms BCJ and Mr NCN could have benefitted from additional advice and supports in the lead-up to and at the date of the FVIO hearing. In particular in 2021, the Centre for Innovative Justice (**CIJ**) published research on FVIOs reached by consent and noted:

    a) rather than a court return date very close to the initial incident where a FVSN is issued by police, more time is needed for increased access to legal advice, risk assessment and safety planning;[52]

[49] Victoria Police Body Worn Camera Footage 12 May 2020.
[50] Victoria Police Body Worn Camera Footage 12 May 2020.
[51] Victoria Police LEAP extract '2022.06.20 – Form 4 response – COR 2020 3368 – Ms BCJ Kaur – Victoria Police' 17, 25.
[52] Centre for Innovative Justice, *More than just a piece of paper; Getting protection orders made in a safe and supported way: Responding to Recommendation 77 of the Royal Commission into Family Violence. Summary Report* (2021) 23.

b) access to independent legal advice is a key protective factor often missing in FVIO cases, including in cases in which police have brought the application;[53]and

c) casework support at court scaffolds affected family members' (**AFMs'**) capacity to understand and participate safely in the Consent Order process and assists safe attendance at court and AFM understanding of legal issues, as well as implications of proposed Consent Orders.[54]

COMMENTS

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

Research on family violence and links to suicide

1. There is emerging evidence that intimate partner violence is a significant risk factor for suicide, suicidal ideation, and self-injury for women,[55] with the Australian Institute of Health and Welfare estimating that intimate partner violence is the second leading factor contributing to suicide and/or self-harm behaviours in women over 15 years of age.[56]

2. A recent investigation by Ombudsman Western Australia *Investigation into Family and Domestic Violence and Suicide* found that between 1 January 2017 and 31 December 2017, 124 women and children died by suicide and that of them, 68 were known to have experienced family violence.[57] The report contained a systemic review of available research which found a strong link between intimate partner violence and suicidality, and noted intimate partner abuse as a significant risk factor for suicidal thoughts and behaviours. The report acknowledged however that the link between family violence and suicide is under-researched in Australia.[58]

3. I support further research being funded by the Victorian Government to explore the link between increased suicide rates amongst women who have experienced family violence in the lead up to a fatal incident.

---

[53] *Ibid*, 39
[54] *Ibid*, 37.
[55] Agenda Alliance, Underexamined and Underreported: Suicidality and intimate partner violence: Connecting two major public health domains (February 2023) < Underexamined and Underreported Briefing (agendaalliance.org)>; Vanessa E Munro, From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse, Volume 26 issue 1 January 2020 , International Review of Victimology. <From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse (sagepub.com)>
[56] Australian Institute of Health and Welfare, Suicide and self-harm monitoring data (Web Page, 2023) , Suicide & self-harm monitoring data - Australian Institute of Health and Welfare (aihw.gov.au)>
[57] Investigation into family and domestic violence and suicide, Ombudsman Western Australia, 41.
[58] *Ibid*, 30.

4. In particular, I understand that the implementation plan for the first two years of the Suicide Prevention and Response Strategy, which will extend from 2024-2026, and which is in the process of being finalised by the Victorian government, may include specific initiatives directed at understanding and addressing the link between family violence and suicidality, including initiatives to strengthen suicide prevention capability within the family violence system. I strongly support this work and look forward to the first implementation plan being finalised and made publicly available.

RECOMMENDATIONS

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

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that **Family Safety Victoria** review and update the *g*uidelines for entities sharing information under the Family Violence Information Sharing Scheme to require that any risk information significantly altered within three days of being shared is proactively shared with the requesting entity.

2. With the aim of promoting public health and safety and the administration of justice, I recommend that the **Victorian Government** ensure that all Specialist Family Violence Courts in Victoria have adequately-funded and resourced specialist legal and non-legal specialist family violence services on site to engage with both affected family members and respondents in an intervention order hearing to provide both legal and non-legal advice and support, including where Victoria Police is the applicant for an intervention order.

FINDINGS AND CONCLUSION

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

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

   b) the death occurred on 25 June 2020 at Shepparton, Victoria, 3630; and

   c) the death occurred in the circumstances described above.

2. I accept and adopt the cause of death as ascribed by Forensic Pathologist, Dr Brian Beer and I find that Ms BCJ died from neck compression in the setting of self-suspension and in circumstances where I find that she intended to take her own life. In having made such finding, I note the absence of identified suspicious circumstances, the lethality of the means chosen, and

the evidence pointing to Ms BCJ's previously-expressed desire to take her own life in the context of extreme stressors, including ongoing family violence, mental distress, and increasing isolation.

3. I find that, while there was a constellation of factors involved, the significant family violence that Ms BCJ resisted for many years, including in the lead-up to her death, underpinned and propelled the decision she made to take her own life. Ms BCJ was culturally, socially and geographically isolated, and lived in ongoing fear for her safety and that of her children.

4. She and her husband were known to services, and she was, at various points, reporting the extent of the violence she was enduring and actively seeking help. This brings into sharp relief the need to ensure that those who experience family violence have adequate access to comprehensive trauma-informed support and advice, particularly at key points of contact with the justice and other systems, that perpetrators of family violence are proactively held accountable, and that system responses are facilitated by accurate information-sharing informing proactive risk management between the agencies involved.

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

DIRECTIONS AND ORDERS

Pursuant to section 73(1A) of the Act, I order that a deidentified version of 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:

Senior Next of Kin

Eleri Butler, Family Safety Victoria

Cameron Roberts, Thomson Geer, on behalf of the Chief Commissioner of Police

Assistant Commissioner Lauren Callaway, Family Violence Command, Victoria Police

Department of Families, Fairness and Housing

Victorian Department of Health

Goulburn Valley Community Legal Centre

Abbey McKenzie, Minter Ellison on behalf of Victoria Legal Aid

Magistrates Court of Victoria, Family Violence Division

Detective Sergeant Matthew Clowes, Coroner's Investigator

Signature:

Ingrid Giles

Coroner

Date: 5 July 2024

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.