IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003935

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	CM[1]
Date of birth:	15 September 1995
Date of death:	25 July 2021
Cause of death:	1a: Neck compression 1b: Hanging
Place of death:	Address Witheld, Diamond Creek, Victoria, 3089
Keywords:	Suicide, family violence, service interactions, Victorian Systemic Review of Family Violence Deaths

[1] This Finding has been de-identified by order of Coroner Simon McGregor which includes an order to replace the names of the deceased and her family with pseudonyms for the purposes of publication.

INTRODUCTION

1. On 25 July 2021, CM was 25 years old when she was found deceased in the garage at her partner's home. At the time of her death, CM was living in Diamond Creek, Victoria, with TZ.

2. CM had an older brother, NJ, and grew up mainly in the Wattle Glen and Diamond Creek area. Her parents separated when she was two years old and CM subsequently lived with her mother and her mother's partner, OM. When she was approximately 15 years old, CM's mother separated from OM, but CM remained living with him. CM completed year 12 when she was 17 years old, then went on to a mechanics apprenticeship.[2] She also had a deep love for animals and being in the garden.[3]

3. CM struggled with depression and anxiety from a young age, and alcohol and drug misuse from her late teenage years and into adulthood.[4] In March 2019, she moved out of the granny flat she had been living in on OM's property, and in with a friend in Diamond Creek. She re-commenced her apprenticeship at Kmart Tyre and Auto while also trying to work as a personal trainer, but her mental health deteriorated in this period and she struggled to take care of herself and her pets, and disclosed suicidal thoughts to her mother.[5]

4. In approximately July 2019, CM began an intimate relationship with TZ. The relationship became more serious in around December 2019 and the couple visited Cambodia together.[6] In May 2020, CM was hospitalised while experiencing a miscarriage. The evidence suggests that CM and TZ had an argument while in hospital and that TZ 'broke up with' CM and left.[7]

5. In July 2020, CM was informed by Kmart Auto and Tyre that she was to be moved to another store in Sydenham after she reported being bullied and threatened by a male coworker. CM was upset by this outcome and took time off work due to anxiety. A short time later, she was informed that her employment would not be continuing beyond the completion of her apprenticeship due to COVID-19.[8]

[2] Statement of PW, Coronial Brief.
[3] Ibid.
[4] Statements of PW, TZ, Dr Alexandra Krupinska, Coronial Brief.
[5] Statement of PW, Coronial Brief.
[6] Statement of TZ, Coronial Brief.
[7] Mercy Health medical records.
[8] Statement of TZ, Coronial Brief.

6. In August 2020, CM moved out of her friend's house and in with a friend of her mother's. Approximately three months later, she moved to her grandmother's house, but found this difficult, and soon after began couch surfing between friends' houses and TZ's house.

7. In the months that followed, CM presented to hospital Emergency Departments multiple times:

    a) in December 2020, after an assault by TZ,[9] attended by Victoria Police;

    b) in January 2021, when she reported being hit by an 'unidentified car' and was brought to the Emergency Department by TZ;[10]

    c) in February 2021, after reporting a fall onto concrete and fracturing her hand;[11] and

    d) in June 2021, reporting suicidal ideation.[12]

8. The evidence gathered during my investigation suggests that in this period, CM experienced considerable family violence. She reported the following incidents to friends and police:

    a) TZ 'drugged' CM so she would have sex with him;[13]

    b) On December 2020, TZ damaged CM's car by kicking it multiple times and was verbally abusive towards CM;[14]

    c) On another occasion in December 2020, TZ was verbally abusive towards CM, grabbed her around the mouth and waist, threw her to the ground, and threatened to harm CM's mother while holding a hunting knife;[15]

    d) in July 2021, CM uploaded a video on social media showing bruises and indicating that TZ repeatedly shut a door on her leg;[16]

    e) TZ would not let CM move out of their shared address until she paid what she 'owed'.[17]

[9] Austin Health Medical Records.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Attachment 6 – Images of text and social media messages from CM, Coronial Brief.
[14] Appendix 3 – Intervention Order brief re incident on 8 December 2020, Coronial Brief.
[15] Ibid; see also statement of TZ, Coronial Brief.
[16] Attachments 2 and 7 – Images of text and social media messages from CM, Coronial Brief.
[17] Attachment 2 – Images of text and social media message from CM, Coronial Brief.

9. CM appears to have had plans to move out of TZ's home in the week after her passing, into a share house in Arthurs Creek.[18] She expressed to friends that she was looking forward to the move and hoped this would mean no more 'choking, throwing, punching, yelling'.[19]

10. There was no active Family Violence Intervention Order (**FVIO**) in place at the time of CM's death.[20]

11. On 29 June 2021, CM referred herself to the North East Area Mental Health Service (**NEAMHS**) North Easter Triage Service by telephone, reporting acute chronic suicidal ideation and active thoughts of deliberate self-harm with a plan (cutting) but no current intent. She reported an extensive psychiatric history starting when she was 14 years of age and advised that she had been seeing a private psychiatrist, Dr Alexandra Krupinska, for 10 months. CM stated she was taking Alprazolam on an as-needed basis, but had increased her use recently due to her mental state. CM stated she had self-harmed two days earlier by cutting and her deterioration appeared to be exacerbated by an ongoing situational crisis. She gave her address as 4 Progress Road, Eltham North but advised she was currently couch surfing or living in her car. She reported recent conflict with family members and issues with her workplace. CM also identified physical abuse by her ex-partner and disclosed that there were intervention orders in effect. A risk assessment was conducted and the clinician deemed CM to be at moderate risk of suicide.[21]

12. As a result of this contact, CM was referred to the North East Crisis Assessment Team (**NECAT**) for further assessment and ongoing support. Further contact was attempted on 28 and 29 June 2021 and messages were left, but CM did not respond. On 30 June 2021, NECAT attended CM's address, but there was no response. On 1 July 2021, following no response to NECAT's text messages, phone calls and multiple home visits and in the context of CM's homelessness, CM's treating team were contacted, including Dr Krupinska and The Local Doctor medical practice in Diamond Creek, and advised of her discharge from NECAT.[22]

[18] Statement of PW; Attachment 2 – Images of text and social media message from CM, Coronial Brief.
[19] Attachment 7 - Images of text and social media message from CM, Coronial Brief.
[20] Appendix 3 – Intervention Order brief re incident on 8 December 2020, Coronial Brief.
[21] Statement of Dr Therese Lawrence, Coronial Brief.
[22] Ibid.

13. On 12 July 2021, two weeks before her death, CM caused extensive damage to her car while driving and posted a picture of the damage to social media with a caption suggesting that she had attempted suicide, but changed her mind at the last moment.[23]

THE CORONIAL INVESTIGATION

14. CM'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.

15. 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.

16. 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.

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

18. This finding draws on the totality of the coronial investigation into the death of CM 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.[24]

[23] Attachment 7, Images of text and social media message from CM, Coronial Brief.

[24] 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.

19. In considering the issues associated with this finding, I have been mindful of CM's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

20. On 25 July 2021 at around 7:15 am, CM and TZ woke at TZ's house and CM took her dog out to go to the toilet. TZ heard her slam what he believed was a Tupperware container and say, 'Fuck this, what's the point anyway'. CM returned to the bedroom and kissed TZ on the forehead, before again leaving the room. TZ went back to sleep.[25]

21. At 8:05 am TZ woke up and noticed CM's dog in the room, which was unusual, as the dog was otherwise always with CM.[26]

22. TZ searched the house and discovered CM hanging in the garage off a guide rail on the roller door. TZ picked CM up to support her weight and the material she had used as a ligature snapped, releasing her to the floor. TZ called 000 and commenced cardiopulmonary resuscitation (**CPR**).[27]

23. Emergency services personnel arrived a short time later and continued resuscitation efforts, but CM could not be revived and was formally pronounced deceased at 8:40 am.[28]

Identity of the deceased

24. On 25 July 2021, CM, born 15 September 1995, was visually identified by her de facto partner, TZ.

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

Medical cause of death

26. Specialist Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine conducted an external examination on 27 July 2021 and provided a written report of her findings dated 28 July 2021.

[25] Statement of TZ, Coronial Brief.
[26] Ibid.
[27] Statement of TZ, Exhibit 2 - CCTV footage from neighbour's house, Coronial Brief.
[28] Ambulance Victoria Verification of Death Form, 25 July 2021.

27. The post-mortem examination revealed a ligature mark consistent with the hanging circumstances described above and consistent with the submitted ligature. The findings were otherwise unremarkable.

28. A post-mortem computed tomography (**CT**) scan showed no findings of significance.

29. Toxicological analysis of post-mortem blood samples identified the presence of delta-9-tetrahydrocannabinol[29] (~ 37 ng/mL) and did not identify the presence of alcohol or any other common drugs or poisons.

30. Dr Fronczek provided an opinion that the medical cause of death was 1(a) neck compression secondary to 1(b) hanging.

31. I accept Dr Fronczek's opinion.

CPU REVIEW – FAMILY VIOLENCE

32. CM and TZ were intimate partners. As such their relationship falls within the definition of a family member in the *Family Violence Protection Act 2008* (Vic).

33. CM's death occurred within a context of ongoing reported and unreported family violence perpetrated by TZ, as outlined above. The most recent incident of family violence was on 9 July 2021, as posted by CM on social media. This post showed bruises to CM, who indicated that TZ had shut a door repeatedly on her leg. As such, there was an identifiable history of family violence proximate to the death.

34. In view of this context, I directed the independent practitioners in the Family Violence Team of the Coroners Prevention Unit (**CPU**)[30] to review the various service interactions CM had in recent months as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[31]

[29] THC, the active component in cannabis (marijuana). Concentrations of THC in antemortem blood of 5 ng/mL generally indicate use within a few hours although, there is considerable inter-individual variability. Postmortem concentrations of THC must be interpreted with caution as redistribution can significantly affect interpretation and estimation of time of last use.

[30] 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 comprises health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[31] 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

Family violence risks and contributory factors

35. The *Family Violence Multi-Agency Risk Assessment and Management Framework* (**MARAM**)[32] details a number of 'evidence-based risk factors associated with greater likelihood and/or severity of family violence'[33] and factors which 'may indicate an increased risk of the victim being killed or almost killed.'[34]

36. These risk factors are divided into three categories: those which are specific to adult victim survivors, those which are caused by perpetrators behaviour towards an adult or child victim survivor and those which are caused by perpetrators which are specific to children.[35] The MARAM also identifies a number of people who can experience 'particular risks, forms of family violence and barriers to accessing support' which can impact on the options and outcomes available to them.[36]

37. Family violence risk factors documented in CM's case included threats to kill, property damage, physical assault, controlling behaviours, unemployment, substance misuse, jealous behaviours, threats with a weapon, being forced to participate in sexual acts, and recent or imminent separation.

38. The CPU noted that further risk factors may have been present but could not be substantiated based on the available evidence. Despite the limits of the evidence, the CPU considered CM was likely at 'serious risk' under the MARAM risk assessment framework, as several high-risk factors were present.

Suicide in family violence contexts

39. There is emerging evidence that intimate partner violence is a significant risk factor for suicide, suicidal ideation, and self-injury for women,[37] with the Australian Institute of Health

information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

[32] Family Safety Victoria, Family Violence Multi-Agency Risk Assessment and Management Framework (2018).

[33] Ibid, 26.

[34] Ibid.

[35] Ibid.

[36] Ibid, 33-36.

[37] Agenda Alliance, *Underexamined and Underreported: Suicidality and Intimate Partner Violence: Connecting Two Major Public Health Domains* (Briefing paper, 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', (January 2020) 26(1) *International Review of Victimology* <From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse (sagepub.com)

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.[38]

40. An investigation by Ombudsman Western Australia published in 2022, found that between 1 January 2017 and 31 December 2017, 124 women and children died by suicide and that 68 of them were known to have experienced family violence.[39] 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.[40]

41. In the United Kingdom, coroners are increasingly acknowledging the link between family violence and suicide, with one inquest concluding that a victim of intimate partner violence had been subject to unlawful killing by her partner after she suicided in the context of his abuse.[41]

Review of service contacts

Victoria Police

42. Victoria Police attended one family violence incident between CM and TZ, on 7 December 2020. Whilst charges were not authorised due to 'insufficient evidence',[42] a Family Violence Safety Notice (**FVSN**) was taken out to protect CM,[43] and referrals were made through the L17 portal to support services (see Orange Door section below).

43. TZ's evidence is that CM assaulted him, and that he placed his hands on her to 'calm her down'.[44] The Victoria Police report indicates that TZ 'grabbed CM around the mouth and

[38] 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)>.
[39] Ombudsman Western Australia, *Investigation into Family and Domestic Violence and Suicide: Volume 1, Executive Summary*, 41 < Investigation into family and domestic violence and suicide Volume 1: Executive Summary (ombudsman.wa.gov.au)>.
[40] In Ombudsman Western Australia, *Investigation into Family and Domestic Violence and Suicide: Volume 1, Executive Summary*, 30.
[41] Sophie Naftalin and Vanessa Munro, 'Investigations into Suicides in the Context of Domestic Abuse' (October 2023) *Legal Action* <Legal Action Group | Investigations into suicides in the context of domestic abuse (lag.org.uk)>.
[42] Victoria Police, Intervention Order Brief One, 7.
[43] Appendix 3 - Victoria Police, Intervention Order Brief, Coronial Brief.
[44] Statement of TZ, Coronial Brief.

waist to keep her quiet', threw her to the ground, pinned her to a staircase and threatened to kill her mother in front of her, before further threatening her with a hunting knife.[45]

44. In January 2021, Victoria Police followed up with both CM and TZ. CM did not respond to Victoria Police's attempted contacts, and TZ advised that he had had no further contact or incidents with CM and that he would like to have the FVIO dropped as they had mutual friends.[46]

45. In June 2021, Victoria Police followed up again with both TZ and CM, who advised that they had had no further contact with each other and that there had not been any further family violence incidents.[47]

46. The CPU did not identify any prevention opportunities in connection with the Victoria Police service contact due to very limited engagement. This is further explored in the Orange Door section below.

Mercy Health

47. CM attended Mercy Health in May 2020 when she had a miscarriage. CM disclosed to Mercy Health during her admission that she found TZ 'intimidating and abusive',[48] however denied physical abuse, and talked about anxiety and her childhood to clinicians.[49] Mercy Health clinicians noted that while CM was hospitalised, TZ 'broke up with her and left'.[50]

48. A plan was made for psychiatric follow up through NECAT (administered by Austin Health) to address suicidal thoughts expressed to Mercy Health clinicians.[51]

49. The CPU identified no prevention opportunities associated with this service contact.

Austin Health

50. Records provided to the Coroners Court of Victoria indicated that:

[45] Appendix 3 - Victoria Police, Intervention Order Brief, Coronial Brief.
[46] Ibid.
[47] Ibid.
[48] Mercy Health medical records.
[49] Ibid.
[50] Ibid.
[51] Mercy Health medical records.

a) On 10 December 2020, CM attended Austin Health and reported she had been assaulted a few days prior by a 6'4" 160kg man,[52] later disclosing it was her partner.[53] Records indicate that CM advised her partner 'lifted her into the air, dropped her onto wooden floorboards and kicked her down the stairs'.[54] It was noted in Austin Health files that police had issued a FVIO against her partner.[55] Injuries recorded during this admission include a 'fractured vertebra of uncertain acuity'.[56]

b) On 17 January 2021, CM attended Austin Health after reportedly being hit by a car and was brought into the Emergency Department by her partner.[57] During this episode of care it was noted that CM had a recent fracture from an interaction with a 'heavy male'.[58]

c) On 8 February 2021, CM attended Austin Health, advising that she had tripped and fallen backwards onto concrete, resulting in an injury to her hand.[59] On 15 February 2021 she advised another practitioner that she had fallen downstairs onto her hand.[60]

d) On 28 June 2021, records indicate CM self-referred to Austin Health due to suicidal ideation and disclosed physical abuse by her ex-partner. CM disclosed that her ex-partner had 'broken her back' and that 'they both have IVO on each other'.[61]

e) CM's last records with Austin Health were when she was discharged from NECAT on 1 July 2021 after not responding to multiple attempts to contact her.[62]

51. The Royal Commission into Family Violence (**RCFV**) recognised that:

> *Health professionals are in a unique position to identify and respond to family violence. Some victims of family violence will not contemplate engaging with a specialist family violence service but will interact with health professionals at times of heightened risk for family violence—for example, during pregnancy or following childbirth—or seek treatment for injuries or medical conditions arising from violence they have experienced. Failing to identify signs of family violence or minimising*

[52] Austin Health medical records.
[53] Ibid.
[54] Ibid.
[55] Ibid.
[56] Ibid.
[57] Ibid.
[58] Ibid.
[59] Ibid.
[60] Ibid.
[61] Ibid.
[62] Ibid.

> *disclosures by patients can have a profound impact on victims and deter them from seeking help in the future.*'[63]

52. Of relevance to this matter, the Victorian Government has implemented Recommendations 3 (revised Family Violence Risk Assessment and Risk Management Framework – MARAM) and 95 (whole-of-hospital model for responding to family violence) from the RCFV.

53. In response to a request for information in relation to CM's case, Austin Health identified that challenges remain in relation to implementing a hospital-wide MARAM framework to large volumes of staff with varying levels of clinical responsibility. Austin Health also noted challenges of conducting family violence risk assessments alongside competing clinical priorities (such as within an Emergency Department).[64]

54. Austin Health identified that CM's admissions to Emergency in January and February 2021 preceded the introduction of policies around family violence in April 2021, and so she was not asked about family violence during those admissions.[65]

55. Austin Health further advised that in 2024 they established processes and requirements for various levels of clinicians relating to family violence. However, their response to questions about measures that might enable medical practitioners to quickly identify and respond to persons at risk from family violence, and how information might be shared across different departments across multiple presentations, largely referred to practitioners recognising signs and indicators of family violence and responding to disclosures.[66]

56. While I commend Austin Health on the breadth of their implementation of the MARAM, concerns remain that there is nothing in place to trigger questions about family violence if a previous concern has been noted. In CM's case, there was a history of significant physical assault that would have been helpful for future practitioners to know when she presented with further physical injuries or falls, to prompt further enquiry, risk assessment and safety planning, or offers of support and referral.

57. It is particularly important to be able to respond to family violence as a pattern of behaviour, rather than responding to a single identified incident.

[63] Royal Commission into Family Violence, Summary and Recommendations, 28.
[64] Statement of Rachel Sassi, Family Violence and Child Safe Program Lead, Austin Health (received 10 May 2024).
[65] Further statement of Rachel Sassi, Family Violence and Child Safe Program Lead, Austin Health (dated 19 June 2024).
[66] Ibid.

Dr Alexandra Krupinska - Psychiatrist

58. CM was referred to Dr Krupinska by a GP at the Victoria Medical Centre in May 2020 after her miscarriage, which was noted to have 'exacerbated her depression'.[67]

59. Dr Krupinska had eight phone consultations with CM between 13 July 2020 and 19 February 2021.[68] Dr Krupinska notes that CM disclosed on 9 December 2020 that she had been assaulted by TZ when he 'lost his shit', threw her to the ground and damaged her spine.[69] Dr Krupinska notes that during their last conversation in February 2021, CM had advised that she was living at her nan's property and was not seeing TZ.[70]

60. Several recommendations have previously been made by Coroners relating to the upskilling of psychiatrists and psychologists in family violence,[71] however the CPU did not identify any specific prevention opportunities in this case.

The Local Doctor

61. CM attended The Local Doctor clinic in Diamond Creek on 17 December 2020 and advised that scans of her upper back were to be sent to the clinic from a 'domestic incident'.[72] During this attendance, CM described the circumstances of the assault, noting that she was 'picked up physically and thrown against the steps'.[73] CT scan results indicated a stable endplate fracture of the second thoracic vertebra (T2).[74] The discharge summary sent to The Local Doctor from CM's hospital admission on 10 December 2020 noted that CM had disclosed an assault by a 6'6" 160 kg man, that police were involved and that a FVIO had been issued.[75]

62. Several recommendations have previously been made by Coroners relating to the upskilling of GPs in family violence.[76]

63. In the time since CM's passing, the Royal Australian College of General Practitioners (**RACGP**) has taken steps to improve responses by GPs to family violence, including:

[67] Records and clinical notes from Dr Alexandra Krupinska.
[68] Ibid.
[69] Ibid.
[70] Ibid.
[71] See for example Alicia Little 2017 006543.
[72] The Local Doctor medical records.
[73] Ibid.
[74] Ibid.
[75] Ibid.
[76] See for example Fatima Batool 2018 3266; Mr A COR 2019 001858.

a) the *Professional Development Program on Family Violence*, which aims to improve GPs skill and knowledge in responding to family violence;[77]

b) the Royal Australian College of General Practitioners (RACGP) manual *Abuse and Violence: Working With our Patients in General Practice* (also known as **the White Book**) which was published in 2014.[78] The White Book contains a table of potential presentations of intimate partner abuse which lists 18 indicators of family violence under two categories – psychological and physical.[79] The White Book goes on to provide guidance about what GPs should do if they suspect family violence is occurring;

c) from April 2021, GPs in Victoria have been included in Family Violence Information Sharing and Child Information Sharing Schemes, prompting the RACGP to release an additional chapter within the White Book providing guidance to GPs about making and responding to family violence information requests; and[80]

d) voluntary professional development on family violence open to GPs, Practice Nurses, Nurse Practitioners, Aboriginal Health Workers and Allied Health Professionals across Australia.[81]

64. Due to the now considerable time since CM's death and this commendable progress by the RACGP, the CPU did not identify any further prevention opportunities in connection with GP services in this case.

Orange Door

65. Referrals were made to the Orange Door for both CM and TZ as a result of the December 2020 incident of family violence.[82] Whilst the matter was triaged as high risk,[83] CM's file was ultimately closed as she did not engage with attempts by the Orange Door to contact her.[84] TZ

[77] Royal Australian College of General Practitioners, *The RACGP Professional Development Program on Family Violence*, <https://www.racgp.org.au/familyviolence/>.
[78] RACGP, *Abuse and Violence: Working With our Patients in General Practice* (2014), 4th Edition.
[79] Ibid, 11.
[80] Ibid, 408.
[81] RACGP, *Dine and Discuss Series*, <https://www.racgp.org.au/the-racgp/faculties/vic/racgp-family-violence-gp-education-program/dine-and-discuss>.
[82] DFFH L17 Response template, 8.
[83] The Orange Door records.
[84] Ibid.

was referred to the Victorian Aboriginal Health Service (VAHS), who also closed the file after being unable to contact TZ.[85]

66. As the Orange Door is a voluntary service, no concerns were identified with this service interaction.

67. The CPU noted, however, the ongoing challenges faced by the Orange Door in engaging with clients, including in 2022/2023 when the Orange Door closed 57% of referrals due to clients declining services or being unable to be contacted.[86] Only 28% of referrals either had their needs met by the Orange Door or engaged with the service system.[87]

68. The Court has previously suggested an expansion of co-responder programs in Victoria to increase engagement with both victims and perpetrators of family violence.[88] Co-responder programs involve the presence of a family violence specialist worker during police attendance at family violence incidents to provide a collaborative response. Research has identified key benefits to co-responder programs, including higher satisfaction of victims with police, increased willingness of victims to contact police in future, more information sharing and coordination of services for victims, greater understanding of family violence by police, and a perceived increase in the accountability taken by police in responding to family violence.[89] This may have assisted CM during her engagement with police or specialist family violence services, which was otherwise limited, despite being recognised as at high risk.

FINDINGS AND CONCLUSION

69. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[90] The effect of the authorities is that adverse comments or findings should not be made unless the evidence provides a comfortable level of satisfaction that an individual (or institution) caused or contributed to the

[85] Ibid.
[86] Victorian Government, 'Case closure results: The Orange Door Annual Service Delivery Report 2022-2023, <https://www.vic.gov.au/orange-door-annual-service-delivery-report-2022-23/case-closure-results>.
[87] Ibid.
[88] In his finding into the death of Carolyn James 2023 1604, State Coroner Judge Cain commented on the benefits of co-responder programs, and the positive impact they may have had in that case.
[89] See VSRFVD Review Panel Discussion Paper 'Multidisciplinary Responses to Family Violence' 2023.
[90] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

death, and in the case of individuals acting in a professional capacity, that they departed materially from the standards of their profession.

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

a) the identity of the deceased was CM, born 15 September 1995;

b) the death occurred on 25 July 2021 at Diamond Creek, Victoria, 3089, from 1(a) neck compression secondary to 1(b) hanging.

c) the death occurred in the circumstances described above.

71. Having considered all of the circumstances, I am satisfied that CM intentionally took her own life.

RECOMMENDATIONS

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

(i) That the Victorian Government fund further research into the link between family violence and suicide.

(ii) That Austin Health further consider the integration of risk 'flags' or other notifications into and across their patient record system where serious risk of family violence has been identified.

(iii) That the Victorian Government resource an expansion of co-responder programs across Victoria.

I convey my sincere condolences to CM'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:

TZ, Senior Next of Kin

PW, Mother

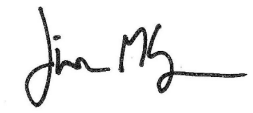
Robyn Shea, Austin Health

Family Safety Victoria

Victorian Government, C/- Secretary to the Department of Premier and Cabinet

Leading Senior Constable Leigh Harris, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 09 January 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.