IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 3932

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**DONNA MAREE GUSMAN**
Findings of:	**JUDGE SARA HINCHEY**
Delivered on:	10 July 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	9 July 2018
Counsel assisting the Coroner:	Rebecca Johnston-Ryan, State Coroner's Legal Officer

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HER HONOUR:

BACKGROUND

1. Donna Maree Gusman (**Ms Gusman**) was a 47-year-old woman who lived with friends at St Albans at the time of her death. She born to parents, Ray and Dawn, and had one brother, named Mark. She was interested in music and cars and enjoyed spending time with her family and friends.

2. Ms Gusman and her husband, Carmelo Gusman (**Mr Gusman**),[1] met as adolescents and were married for 27 years before her death. They had two adult children, Daniel and Ashley. Although not formally qualified, Ms Gusman worked as a cleaner before the birth of her children. She then returned to work while her children were still young and worked night shifts, caring for the children during the day.

3. Ms and Mr Gusman became estranged at some point during 2008. The evidence suggests that, in the months before he took Ms Gusman's life, Mr Gusman was depressed about his physical condition and his separation from Ms Gusman.[2]

4. After training and working as a farrier for several years, Mr Gusman began working at Toyota but was made redundant. Following this, he found employment as a car detailer at Pickles Auctions in Sunshine. Part of his work duties required him to lift wheelie bins above shoulder height. It was performing these duties that caused him to injure his back in approximately May 2014.

5. Mr Gusman's back injury and subsequent physical restrictions caused him great distress. He became financially dependent upon WorkCover payments and his mental health deteriorated as he was unable to come to terms with the loss of his physical capability.

6. Following their separation, Ms Gusman regularly continued to drive Mr Gusman to his WorkCover medical appointments related to his back injury.

7. In the months before her death, Ms Gusman moved in with two friends, Deanne Beever (**Ms Beever**) and Beverly Pywell (**Ms Pywell**), at St Albans. Ms Gusman told them that she needed space from her husband and that he was no longer interested in spending time together

[1] This finding should be read in conjunction with the *Finding without Inquest into the death of Carmelo Gusman COR 2015 3931*
[2] Statement of Faik Mysli, *Coronial Brief*, 54

as a couple. She told Ms Beever that she was not in love with Mr Gusman anymore but was concerned that he would not cope with that news in light of his physical condition.

8. Ms Beever observed that Ms Gusman began spending more time with a man, Nick Nicolaou (**Mr Nicolaou**), whom she met through her cousin. Ms Gusman initially introduced Mr Nicolaou as her friend but several months later told Ms Beever that the two of them were in a relationship. Ms Gusman disclosed her condition to Mr Nicolaou and made plans to move out of the St Albans house with him shortly before her death.

9. Ms Beever stated that in the two months prior to Ms Gusman's death, Mr Gusman attended their house at St Albans, asking to see Ms Gusman. Ms Beever heard the two arguing at the door and knew Ms Gusman did not want Mr Gusman there. Three days later Ms Gusman's sons, Daniel and Ashley were heard banging on the door. Daniel yelled "*let me in, I want to see where he is sleeping*." Ashley looked in in Ms Beever's bedroom window and she heard him say "*I can see Deanne but Nick's not in there*."[3] Ms Gusman told her sons it was Ms Beever seeing Mr Nicolaou, not her.

10. The evidence suggests that Ms Gusman's family and friends spoke to Mr Gusman about his marital problems with Ms Gusman. Ms Gusman believed that her mother had told Mr Gusman she was having an affair with Mr Nicolaou.

11. A month and a half prior to her death, Ms Gusman's brother told her that he heard Mr Gusman threaten to kill Ms Gusman if she was with someone else. In the days after Ms Gusman became aware of the threat, she confronted Mr Gusman about it; he reportedly responded:

    "*He [said] that he wasn't going to jeopardise his gun licence and he wouldn't hurt her because he loved her too much*."[4]

12. In June 2015, following her involvement in a car crash, Mr Gusman picked up Ms Gusman at a bus stop in St Albans so as to help her pay some bills. Ms Gusman had recently been questioning her mother about why she was given a different surname to her brother. Mr Gusman raised this issue with her, Ms Beever states that Ms Gusman did not understand why he would raise the issue given his knowledge of how distressing she found it.[5]

13. Ms Gusman told Ms Beever that, on another occasion, Ms Gusman arrived at Mr Gusman's home to go with him to a WorkCover appointment. They argued because Mr Gusman was

[3] Statement of Deanne Beever, *Coronial Brief*, 48
[4] *Ibid*, 49
[5] *Ibid*, 50

concerned that they would be late. As Mr Gusman drove, Ms Gusman became scared because he was driving fast. She asked Mr Gusman to drive her back to her car and he then turned and raised his fist at her and stated, "*[i]f you don't shut your mouth, I'll shut it for you*."[6] After this point, Ms Gusman noted a change in Mr Gusman and became fearful of him. Before leaving him at his house that day, Mr Gusman asked Ms Gusman to drive him to her own father's grave in Fawkner. The unusual nature of the request, combined with Mr Gusman being aware of her wishes that she be buried with her father, distressed Ms Gusman. Ms Gusman later told Ms Beever that she feared for her life that day and thought Mr Gusman was going to kill her.[7]

THE PURPOSE OF A CORONIAL INVESTIGATION

14. Ms Gusman's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as his death occurred in Victoria, and was both violent, not from natural causes and resulted from an injury.[8]

15. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[9] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

16. It is not the role of the Coroner to lay or apportion blame, but to establish the facts.[10] It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

17. The term *'cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

18. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all of the circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

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[6] *Ibid*, 49
[7] *Ibid*, 49-50
[8] Section 4, definition of 'Reportable death', *Coroners Act 2008*
[9] Section 89(4) *Coroners Act 2008*
[10] *Keown v Kahn* (1999) 1 VR 69

19. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the '*prevention role*'.

20. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

21. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[11] 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 that they caused or contributed to the death.

22. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

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

Identity of the Deceased pursuant to section 67(1)(a) of the Act

23. On 12 August 2015, Jeremy Graham of Identification Services at the Victorian Institute of Forensic Medicine produced a scientific report based on DNA comparison evidence collected from Daniel Gusman which identified the deceased to be Donna Maree Gusman, born 21 January 1968.

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

[11] (1938) 60 CLR 336.

Medical cause of death pursuant to section 67(1)(b) of the Act

25. On 7 August 2015, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Gusman's body and provided a written report, dated 18 September 2015. In that report, Dr Dodd concluded that the cause of death was '*[a]cute external blood loss*' and '*[m]ultiple stab wounds to the neck.*'

26. Dr Dodd commented that:

    (a) the immediate cause of death in this case was acute external blood loss secondary to multiple stab wounds to the neck region;

    (b) the external examination showed a multiplicity of incised defects;

    (c) the internal examination disclosed incised defects to both the right and left carotid arteries; and

    (d) the incised defects to the neck were the immediate cause of death.

27. I accept the cause of death proposed by Dr Dodd.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the Act

28. On 4 August 2015, Mr Gusman had a 3.00pm WorkCover appointment for clearance to resume work. He had arranged with Ms Gusman to drive him to the appointment.

29. At approximately noon that day, Ms Gusman's son Daniel drove past the family home and noticed Ms Gusman's car in the driveway. He decided to return to the house later, to avoid arguing with his mother and making matters worse between his parents. Several hours later, Daniel returned to the address and observed that Ms Gusman's car had been moved to the front lawn. He then spent the night at the family home and Mr Gusman did not return.

30. On 5 August 2015, Daniel located Mr Gusman's mobile phone, Ms Gusman's handbag and mobile phone, and a small amount of blood in the garage and on a door handle. He observed a knife pouch sitting on the sink and noticed a firearm missing from the gun safe in the shed. Both Daniel and Ashley became concerned about their parents' welfare. They reported their parents missing the following morning, 6 August 2015.

31. On 6 August 2015, while at Keilor Downs Police Station filing a Missing Person's report, Daniel and Ashley were informed by police members that their parents' bodies had been

located in a vehicle outside 1388 Taylors Road, Plumpton, by a council worker inspecting the roads.

32. Ms Gusman was wrapped in blankets in the rear of the vehicle, laying across the rear foot well behind the front seats. Ms Gusman had injuries to her neck and chest. Mr Gusman was in the front passenger seat with a loaded double barrel shotgun located between his legs. He had a major head trauma.

33. The evidence supports a finding that, as she sat in the driver's seat, Mr Gusman stabbed Ms Gusman multiple times to the neck and chest before wrapping her in blankets and moving her body to the rear foot well.

34. I acknowledge that some of Ms and Mr Gusman's family members have raised concerns in relation to the facts of the case, specifically whether Mr Gusman was physically capable of moving Ms Gusman to the back seats of the car after stabbing her, in light of his back condition.

35. Prior to Ms and Mr Gusman's deaths, Mr Gusman consulted musculoskeletal pain specialist, Dr Steven Jensen, regarding management of his back condition. Mr Gusman first consulted Dr Jensen on 17 March 2015 and attended periodic follow-ups up until 27 July 2015.

36. During my investigation, I sought Dr Jensen's opinion about Mr Gusman's physical capacity in light of his back condition at the time of Ms Gusman's death; specifically, whether Mr Gusman's back condition would have left him unable to move Ms Gusman's body into its final resting position in the rear foot well of the car, without the intervention or assistance of a third party.

37. On this issue Dr Jensen stated the following:

> "*My opinion regarding this man's back pain was that he probably did suffer a lumbosacral "sprain" during the course of his normal work duties on approximately 22 May 2014. However, I was of the further opinion that there were profound psychosocial factors involved in his pain presentation that complicated the issue markedly.*
>
> *I note my entry of 24 March 2015 specifically states: "...degree disability far outweighs organic signs/MRI findings."*
>
> *I am, therefore, of the opinion that, from a strictly physical perspective, and on the balance of probabilities, Mr Gusman's physical capabilities were much greater than he was portraying, and he was purporting to be capable of.*"[12]

[12] Statement of Dr Steven Jensen, dated 13 November 2017

38. On the basis of the physical evidence as well as Dr Jensen's opinion, I am satisfied to the coronial standard that Mr Gusman was capable of the actions necessary to move Ms Gusman to the rear of the car without the assistance or intervention of a third party.

39. The evidence further supports a finding that after killing Ms Gusman, Mr Gusman placed a loaded shotgun in his mouth and discharged it, thereby ending his own life.

COMMENTS PURSUANT TO SECTION 67(3) OF THE *CORONERS ACT 2008*

40. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by family members against each other are particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

41. For the purposes of the *Family Violence Protection Act 2008*, Ms and Mr Gusman's relationship fell within the definition of "*family member*."[13] Moreover, Mr Gusman's actions in fatally stabbing Ms Gusman constitutes *"family violence*."[14]

42. The background and circumstances of both Ms and Mr Gusman's deaths highlights the existence of several risk factors[15] associated with an increased risk of both the occurrence and severity of family violence. In Mr Gusman's case, his risk of perpetrating family violence against Ms Gusman was increased by his access to weapons, previous threats to variously harm and kill her, his unemployment, his depression and mental health and his history of violent behaviour towards Ms Gusman. Further, the literature confirms the risk of family violence also increases upon a couple's separation.

43. Risk factors were also present which increased Ms Gusman's vulnerability to family violence by her husband. The available evidence suggests that Ms Gusman's fear of Mr Gusman's behaviour and threats (both implied and express) as well as her empathy towards his physical and mental condition, made her more vulnerable to continued family violence.

44. Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

Family Violence

[13] *Family Violence Protection Act 2008*, section 8(1)(a) identifying as a spouse or domestic partner
[14] *Family Violence Protection Act 2008*, section 5(1)(a)(i)
[15] The Department of Health and Human Services, *The Family Violence Risk Assessment and Risk Management Framework and Practice Guidelines 1-3* (April 2012) The Department of Health and Human Services website, https://providers.dhhs.vic.gov.au/family-violence-risk-assessment-and-risk-management-framework

(a) the evidence suggest that Mr Gusman died sometime between 4 and 6 August 2015, by suicide[16] and was therefore not charged with an offence in relation to Ms Gusman's death. Section 52(2) of the Act mandates that I must hold an inquest into Ms Gusman's death, because I suspect that Ms Gusman's death was the result of a homicide;

(b) homicide is the killing of one person by another person. Section 69(1) of the Act prohibits me from making a finding that a person is, or may be guilty of a criminal offence. In forming the suspicion that Ms Gusman's death was the result of a homicide, I make no finding as to Mr Gusman's criminality, but I note simply that I am satisfied that Mr Gusman's actions directly caused Ms Gusman's injuries, resulting in her death;

(c) my investigation into Ms Gusman's death was directed to public health and safety matters and focused on the issue of preventing family violence deaths. The findings of the 2016 Royal Commission into Family Violence (**the Royal Commission**) confirm what many members of the community and legislators have recognised for some time: that family violence should be understood as a broad concept, not merely as constituted by physical violence. Threats, coercion, attempts to control or manipulate, as well as emotional and psychological abuse, all constitute forms of family violence;

(d) the available evidence in this case suggests that Ms Gusman experienced each of those forms of abuse at different times during her relationship with Mr Gusman: threats to kill her, emotional abuse in his questioning of her parentage, psychological abuse in taking her to father's burial site and threats of physical violence by raising his fist at her and threatening to assault her. The evidence also suggest that Mr Gusman used his physical condition to manipulate and control Ms Gusman;

Third party reporting of family violence

(e) this case highlights the difficult and often dangerous predicament that family violence presents to family, friends and others who become aware of it, or suspect that it is occurring. Coupled with this are recurring indications within the relevant research that female victims of family violence are more likely to disclose the violence to family or friends, rather than authorities or specialist services. Many times, third parties feel ill-equipped to assist or are concerned that any intervention may increase the danger for the victim or themselves. This reaction is understandable;

[16] See *Finding into Death without Inquest of Carmelo Gusman* COR 2015 3931

(f) in an effort to address the barriers that third parties face in obtaining access to information about family violence and providing information and assistance to victims and perpetrators of family violence, the Royal Commission reviewed the available resources for third parties and endorsed a model set out in the combined operation of recommendations 10 and 37 of its report;

(g) recommendation 10 focussed on facilitating access to the appropriate information to identify and assist those experiencing family violence, both during crisis periods as well as longer term recovery.[17] The Victorian Government selected '*The Lookout*'[18] website (**the Lookout website**) as the most suitable existing site with the capacity to deliver accessible information for those experiencing, witnessing and being affected by family violence.

(h) in line with Recommendation 10, the Lookout website was scheduled to finalise by March of 2018.[19] It is now active, however the Victorian Government website lists the recommendation as being '*in progress*.' Although the information contained within the Lookout website has changed somewhat,[20] the Government is still continuing to fund improvements, "*to ensure its ongoing role in the prevention of and response to family violence in Victoria, whilst undertaking a review of existing websites to identify information gaps*;"[21]

(i) through the introduction of Support and Safety Hubs (**SSHs**)[22] at 17 locations across Victoria, a central point for the family violence response network will:

(i) receive police referrals, referrals from non-family violence services, including family and friends, as well as self-referrals;

(ii) provide a single, area-based entry point into local specialist family violence services, perpetrator programs and integrated family services and link people to other support services;

(iii) perform risk and needs assessments and safety planning using information provided by the recommended state-wide central information point;

[17] Victorian Royal Commission into Family Violence, Recommendation 10
[18] http://www.thelookout.org.au
[19] http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=12
[20] in particular, there is more information for workers responding to family violence within the website
[21] Above n 20
[22] Victorian Royal Commission into Family Violence, Recommendation 37

(iv) provide prompt access to the local Risk Assessment and Management Panel;

(v) provide direct assistance until the victim, perpetrator and any children are linked with services for longer term support;

(vi) book victims into emergency accommodation and facilitate their placement in crisis accommodation;

(vii) provide secondary consultation services to universal or non-family violence services; and

(viii) offer a basis for co-location of other services likely to be required by victims and any children;[23] and

(j) the Department of Premier and Cabinet, with Family Safety Victoria, is currently collaborating with partner agencies to design and implement SSHs state-wide. The completion date for this adopted recommendation is forecast to be 31 March 2021, with a staged roll out of the SSHs from the end of 2017 onwards;

(k) in light of the comprehensive nature of the Royal Commission's work in this regard, I support the recommendations put forward, specifically in this case as they relate to the issue of assisting third parties to educate and assist both perpetrators and victims of family violence;

(l) I also endorse Recommendation 142 made by the Royal Commission, where the Victorian Government was encouraged to ensure that family violence community awareness and prevention programmes use language, imagery and messaging that reflect the diversity of the Victorian Community and that prevention work should be developed with relevant communities;

(m) current family violence information available to victims and third parties does not include information about risk factors that can indicate an increased risk for victims, as set out in the CRAF. A recent review of the CRAF has acknowledged this information gap and online tools are being developed which identify these risks. The SSHs will also provide parties with this information. In my view, it is fundamental that the revised Lookout website contains information for family violence victims and their families and friends about the risk factors and risk assessments for victims;

[23] Victorian Royal Commission into Family Violence, *Summary and Recommendations* (2016), 55

(n) the Lookout website provides links to useful information for family and friends about how to recognise family violence and provide assistance to someone who is in a violent relationship.[24] However, it does not contain any information on how to identify or assess risk factors. There appears to be a gap in the publicly-available information on how to identify family violence risk factors and the escalation of such;

(o) the Lookout website's section for family violence workers contains family violence risk assessment information, but it is not directed to the general public. A '*Red flags*' fact sheet deals with the risk factors for fatal violence,[25] but users need to follow several links in the worker section to find it. It is not easily accessible for members of the public;

(p) I am informed that the Melbourne University has developed a pilot website named '*iDecide*,'[26] which provides a framework for members of the public to conduct a self-assessment of risk. The results of the self-assessment provide users with a clear picture of the level of risk they are facing. It is not specifically developed for third parties, but family and friends may use it to work through the checklist with a victim. Melbourne University intends to evaluate this website, to determine whether it has achieved its aims;

(q) in Ms Gusman's case, education and information via a website, such as the Lookout website or iDecide may have provided an initial avenue for the family members and friends to provide specialist service referrals to support her in seeking assistance, at least during the period of separation with Mr Gusman;

(r) I am informed that Family Safety Victoria is currently in the process of redeveloping the family violence risk assessment and risk management framework. The redeveloped framework will result in a number of risk assessment tools for professionals to use in their assessment, in addition to the development of an online self-assessment, available to the general public. The self-assessment tool is currently in development and communication will be provided closer to the anticipated launch date of December 2018. The self-assessment tool will enable members of the public to assess their own level of risk, and will then provide information about services and support they can access. Although the tool is not specifically targeted at friends and family members, they could still potentially use the online self-assessment tool as a method of engaging with victim survivors, by assisting them to complete this self-assessment in a safe environment.

[24] see http://www.dvrcv.org.au/help-advice/guide-for-families-friends-and-neighbours
[25] http://www.thelookout.org.au/sites/default/files/DVRCV-Red-Flags-Infographic-2017_1.pdf
[26] www.idecide.org.au

(s) in addition to the self-assessment tool, it is important to acknowledge the variety of other tools being developed as part of the new redeveloped framework. These tools will include screening and identification, brief assessment and preliminary assessment. It is anticipated that these tools will be used by a wide variety of workforces, in addition to specialists being provided with a comprehensive risk assessment. Mainstream services that previously did not consistently identify or respond to family violence indicators will now be trained and supported to implement tools that allow for earlier identification and possible intervention. This will improve service response for victim survivors, who may undertake a family violence assessment and receive support, due to their involvement with a mainstream service;

(t) ultimately, the SSHs provide an opportunity to report concerns and create more tangible opportunities for intervention and prevention. The circumstances of this case suggest that the SSH model may have provided an immediate source of support and information for Ms Gusman and those close to her in the event she was disinclined to report instances of abuse herself; and

(u) I am satisfied that the opportunities to prevent Ms Gusman's death were limited, in light of the lack of contact she had with specialist family violence services and given the couple's ongoing, post-separation contact. Notwithstanding this, I note that certain instances of abuse were disclosed at different stages to family and friends and, in this regard, I refer to my comments above in relation to third parties.

FINDINGS AND CONCLUSION

45. Having investigated the death of Donna Gusman and having held an inquest in relation to her death on 9 July 2018, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

(a) that the identity of the deceased was Donna Maree Gusman, born 21 January 1968; and

(b) that Ms Gusman died on or about 4 August 2015, outside 1388 Taylors Road, Plumpton, Victoria from acute external blood loss and multiple stab wounds to the neck, in the circumstances described above.

46. I convey my sincerest sympathy to Ms Gusman's family and friends.

47. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

48. I direct that a copy of this finding be provided to the following:

(a) Daniel Gusman, Senior Next of Kin;

(b) Detective Senior Constable Elise Jinks, Coroner's Investigator, Victoria Police; and

(c) Detective Inspector Tim Day, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER

Date: 10 July 2018