IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 1253

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of FIONA KELLIE BURKE

without holding an inquest:

find that the identity of the deceased was Fiona Kellie Burke

born 2 April 1984

and the death occurred on 17 March 2017

at 20 Rosene Court, Keysborough, Victoria 3173

from:

1 (a) HANGING

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Fiona Kellie Burke was 32 years of age at the time of her death. She resided in Keysborough with her partner, Darren Mather and her two children of prior relationships at the time of her death. Ms Burke met Mr Mather socially in approximately 2001 and they commenced a relationship in approximately 2013.

2. At approximately 6.30pm on 16 March 2017, Mr Mather returned home from work and had an altercation with Ms Burke which started off as a verbal argument and became physical at a later point that evening. Mr Mather left the property at approximately 11.00pm, turned his phone on silent and slept in his car in the Docklands until he awoke at approximately 6.17am the next day on 17 March 2017. The last message sent from Ms Burke's phone was to Mr Mather at approximately 12.36am on 17 March 2017.

3. On 17 March 2017 at approximately 1.20pm, Ms Burke's neighbour, Elizabeth Grasso noticed both of Ms Burke's children sitting on the curb outside their home. When Ms Grasso approached them, Ms Burke's daughter told her that she didn't know where her mother was. Ms Grasso contacted the children's school and Mr Mather. Ms Grasso then entered the Ms Burke's residence using a key from one of the children and searched for Ms Burke.

4. Ms Grasso was unable to find Ms Burke in the house and proceeded to search the garage and found Ms Burke hanging from a cord around her neck. Ms Grasso contacted emergency services. Emergency responders attended and confirmed that Ms Burke was deceased.

INVESTIGATIONS

Identification investigation

5. Upon reviewing the available evidence, State Coroner Judge Sara Hinchey completed a Form 8 *Determination by Coroner of Identity of Deceased*, concluding that the identity of the deceased was Fiona Kellie Burke. Identity is not in dispute and required no further investigation.

Forensic pathology investigation

6. Dr Khamis Almazrooei, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination upon the body of Fiona Kellie Burke, reviewed a post mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death, Form 83.

7. Dr Almazrooei commented that there was an indentation and a ligature in situ about the neck. Dr Almazrooei also commented that there was evidence of minor blunt force

injuries (bruises) to the right lateral chest wall, right upper back and occipital region of the head but these injuries did not cause or contribute to her death. There was no evidence of defensive type injuries which would have caused or contributed to Ms Burke's death.

8. Toxicological analysis of post mortem blood detected the presence of 0.19g/100ml of ethanol (alcohol) but no presence of common drugs or poisons. Dr Almazrooei further commented that blood alcohol levels in excess of 0.15 g/100ml affects cognition and can cause adverse behavioural changes depending on the individual's tolerance to alcohol.

9. Dr Almazrooei ascribed the medical cause of Fiona Kellie Burke's death to hanging.

Police investigation

10. Upon attending the Keysborough premises after Ms Burke's death, Victoria Police seized a mobile phone that contained call records and text messages between Ms Burke and Mr Mather. Police Officers also spoke to Mr Mather, Ms Grasso and Ms Burke's daughter.

11. Senior Constable (**SC**) Jonathan Weisshardt was the nominated Coroner's investigator.[1] At my direction, SC Weisshardt investigated the circumstances surrounding Ms Burke's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mr Mathers and Ms Grasso.

12. In the course of the investigation, my Investigator learned that Ms Burke had a history of family violence in her relationship with Mr Mather. Victoria Police Law Enforcement Assistance Program (**LEAP**) records[2] indicate that Victoria Police were contacted in relation to six family violence incidents between Mr Mather and Ms Burke during their relationship.

13. The first recorded incident of family violence between Ms Burke and Mr Mather occurred on 14 May 2014. On this occasion, Victoria Police attended an incident where

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[1] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

[2] Information about LEAP records provided by Victoria Police. The Law Enforcement Assistance Program (LEAP) online database is fully relational and stores information about all crimes bought to the notice of police as well as family incidents and missing persons. It also includes details on locations and persons involved.

Mr Mather was reported as the perpetrator of family violence. Police LEAP records indicate that during this incident Mr Mather and Ms Burke had an argument regarding Mr Mather's refusal to take time off work to take Ms Burke to a medical appointment. As a result of this argument Mr Mather decided to end the relationship and took some of his belongings from the residence. The argument then continued in the stairwell outside of Mr Mather and Ms Burke's apartment, resulting in a neighbour contacting the police. When the police attended, Mr Mather had already left. The attending officers noted no signs of violence or struggle and Ms Burke reported that no threats or violence had occurred. The officers made formal referrals to support services for Ms Burke and Mr Mather but took no further action on this occasion.

14. On 1 August 2014 Victoria Police attended a further family violence incident between Ms Burke and Mr Mather where Ms Burke was reported as the perpetrator. Victoria Police LEAP records indicate that on this occasion, Mr Mather had contacted police and alleged that Ms Burke had threatened to kill him. Ms Burke had also contacted police and stated that Mr Mather was being verbally abusive and had a baseball bat in his car. When police attended, Mr Mather was in the process of packing his belongings and stated that he was moving out. Neither Ms Burke nor Mr Mather were cooperative with police following this incident and the police were unable to locate the baseball bat or identify any injuries to either party. The attending officers provided Ms Burke and Mr Mather with the contact details of support services but no further action was taken as the parties were no longer residing together and Ms Burke had advised that she would soon be moving to another location which was a significant distance away.

15. On 30 August 2014 Victoria Police attended another family violence incident between Ms Burke and Mr Mather. LEAP records suggest that on this occasion police attended Ms Burke and Mr Mather's property after Mr Mather called them and alleged that Ms Burke had threatened him with a knife. When police officers arrived, Mr Mather was in the process of packing his belongings and reported that Ms Burke had threatened him with a knife during an argument that day. Ms Burke denied making any threats with a knife and the LEAP records noted that police found no strong evidence of the presence of a knife. Mr Mather later stated that Ms Burke may not have threatened him with a knife and perhaps just moved one. Based on their conversations with Ms Burke and Mr Mather on this occasion, and the past history of abusive behaviour from prior incidents,

the attending members issued a Complaint and Summons for a Family Violence Intervention Order (**FVIO**) to protect Ms Burke.

16. On 25 September 2014 an interim FVIO was issued in the Seymour Magistrates' Court which protected Ms Burke and her children from Mr Mather. This order prevented Mr Mather from committing family violence against them, damaging their property or threatening to do so. However, it did not prohibit him from continuing to reside with them and on 15 January 2015 the application was withdrawn by Victoria Police and the interim FVIO was cancelled.

17. On 6 November 2015 Victoria Police attended a further family violence incident between Ms Burke and Mr Mather. The LEAP records suggest that on this occasion police attended Ms Burke and Mr Mather's property after Mr Mather called them and alleged that Ms Burke was armed with a knife. When police attended Ms Burke made admissions to using a knife to inflict minor self-harm injuries and stated that it was due to her frustration in relation to ongoing relationship issues where Mr Mather was controlling of her and always accusing her of interest in other men. Mr Mather collected his belongings and stated that he was moving out and didn't want to return. Mr Mather was then conveyed to Frankston Police Station and served with a Family Violence Safety Notice (**FVSN**). A local police unit containing a mental health clinician was also called to attend and speak with Ms Burke in relation to her self-harm.

18. On 9 November 2015 an interim FVIO was issued in the Frankston Magistrates' Court which included conditions prohibiting Mr Mather from committing family violence against Ms Burke and her children, and from attending Ms Burke's address without her prior written consent. Mr Mather was present at the hearing and did not agree to the interim order being made. The FVIO proceedings were adjourned to 16 May 2016.

19. Department of Health and Human Services (**DHHS**) records indicate that on 23 November 2015 Ms Burke's daughter disclosed that there had been a family violence incident on the weekend where Mr Mather had punched holes in the walls at their house. Ms Burke's daughter also disclosed that there had been approximately three other times when similar incidents of family violence had occurred and stated that Mr Mather was '*always yelling*' but had never hit or hurt her.

20. On 25 December 2015 police attended a further family violence incident between Ms Burke and Mr Mather at Ms Burke's home. On this occasion, Ms Burke advised police that an argument had commenced between them because Mr Mather believed Ms Burke was having an affair. Mr Mather left the home for a period to calm down but later returned, at which point the argument recommenced and Mr Mather punched Ms Burke to the face. Mr Mather admitted to punching Ms Burke to the face but claimed that Ms Burke had kicked him to the back of the head first, and that he had punched her in the face as a reaction. An ambulance attended, and it was noted that Ms Burke had bruising to her left eye, however Ms Burke declined to go to the hospital as she reported being fine. Mr Mather was taken to Frankston Hospital to treat a suspected broken hand and his complaint of a severe headache. Mr Mather's actions on this occasion were considered by police to be in breach of the FVIO issued on 7 November 2015 and he was subsequently charged with contravening a FVIO and unlawful assault.

21. Ms Burke later refused to make a statement regarding the assault as she reported that everything was '*now fine.*' However, Victoria Police decided to proceed with the criminal charges against Mr Mather as police members had witnessed Ms Burke's injuries, and Mr Mather had made admissions to the assault. At a hearing at the Frankston Magistrates' Court on 19 August 2016, Mr Mather was convicted of contravening a FVIO and fined $600.

22. On 16 May 2016 a two-year FVIO was issued in the Frankston Magistrates' Court protecting Ms Burke and her children from Mr Mather. The order was made with Mr Mather's consent and prevented Mr Mather from committing family violence against them, damaging their property or threatening to do so, or getting someone else to do so. The Magistrate also directed Mr Mather to attend an eligibility assessment regarding participation in court directed counselling. The FVIO did not prohibit Mr Mather from residing with Ms Burke and her children and had a listed expiry date of 16 May 2018. This order was still in place at the time of Ms Burke's death.

23. On 18 July 2016 police were called to Ms Burke's home by a neighbour who had overheard Ms Burke and Mr Mather arguing in their backyard. Victoria Police LEAP records indicate that Ms Burke and Mr Mather appeared to be alcohol affected when police arrived. On this occasion, Ms Burke and Mr Mather reported that Ms Burke had accused Mr Mather of being unfaithful and had called his ex-girlfriend to confirm her

suspicions. The attending officers noted the FVIO that was in place against Mr Mather at the time, however, they regarded Ms Burke as the perpetrator in this instance and so took no further action in relation to the FVIO, concluding that the matter was '*verbal only*' and '*exacerbated by both parties being alcohol affected.*'

Family violence investigation

24. In light of Ms Burke's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[3] examine the circumstances of Ms Burke's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[4]

25. This case was included in the VSRFVD as the death of Ms Burke occurred in the context of a history of family violence which was proximate to her death. As de facto partners, the relationship between Ms Burke and Mr Mather met the definition of 'family member' under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**). The reported behaviour of Mr Mather towards Ms Burke meets the definition of 'family violence' in the FVPA, specifically in the form of physical abuse, emotional and psychological abuse, threatening behaviour, and controlling behaviour. Mr Mather's account of Ms Burke's behaviour during altercations also meets the definition of family violence.

26. An in-depth family violence investigation was conducted in this case and I requested materials from a number of key service providers that had contact with Ms Burke, Mr Mather and Ms Burke's children.

27. Material provided to the Court by the Department of Health and Human Services – Child Protection (**DHHS**) suggests that family violence had occurred in Ms Burke's relationships prior to her relationship with Mr Mather. As a result of that prior family violence, Ms Burke was referred to a range of services including DHHS, Victoria Police, mental health services and family support services.

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[3] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[4] 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.

28. Family violence also appears to have been a recurrent and ongoing issue in the relationship between Ms Burke and Mr Mather. Whilst both parties have engaged in family violence against one another materials provided by Victoria Police and DHHS suggest that Mr Mather was more often identified as the perpetrator of family violence in their relationship. The CPU also noted that in appointments with mental health practitioners, Ms Burke described Mr Mather as being 'abusive and controlling' towards her and described being emotionally and financially dependent upon him.

29. In the course of their investigation, the CPU identified the presence of a number of risk factors known to increase the risk of fatal family violence between intimate partners.[5] The CPU identified the presence of risk factors utilising the *Family Violence Risk Assessment and Risk Management Framework* also known as the *Common Risk Assessment Framework* (CRAF). Practitioners like child protection workers, Victoria Police members, mental health clinicians and medical professionals are recommended to consider the content in the CRAF as a best practice model for identifying risks and responding consistently in services provided to family violence victims or perpetrators.

30. The CRAF contains a number of evidence based risk factors which have been found to impact on the likelihood of family violence occurring and the severity of family violence that is likely to occur.[6] These risk factors are divided into three categories: those which relate to the victim of family violence, those which relate to the perpetrator, and those which relate to the relationship.

31. I confirm that the CRAF has recently been replaced by the *Family Violence Multi-Agency Risk Assessment and Management Framework* (**MARAM**).[7] The aim of the MARAM framework is to increase the safety and wellbeing of Victorians by ensuring all relevant services are contributing effectively to the identification, assessment and management of family violence risk. To achieve this, the MARAM has been established in law under the *Family Violence Protection Act 2008* (Vic). This requires organisations that are prescribed through regulations, as well as organisations providing funded

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[5] These risk factors were identified using the Family Violence Risk Assessment and Risk Management Framework (also known as Common Risk Assessment Framework). This tool is used by service providers commonly assisting victims and perpetrators of family violence.

[6] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition.

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

services relevant to family violence risk assessment and management, to align their policies, procedures and practice guidance to the new MARAM framework.

32. I have considered the risk factors present in this case using the CRAF as that was the risk assessment tool available to support services at the time they had contact with Ms Burke and her family.

33. As they relate to this case, the CPU identified four victim specific risk factors applicable to Ms Burke in this matter, specifically alcohol misuse/abuse, prior suicidal ideation, isolation, and mental health issues. Such factors can increase a victim's vulnerability to family violence and impact on the likelihood and severity of family violence occurring against them. Further, the CRAF notes that '*suicidal thoughts or attempts indicate that the victim is extremely vulnerable and the situation has become critical.*'

34. The CPU also identified five perpetrator specific risk factors applicable to Mr Mather in this case. Specifically, his prior abuse of Ms Burke, his breach of the FVIO Ms Burke held against him, his alcohol misuse/abuse, his jealous behaviour towards Ms Burke, and his controlling behaviour. Four of these, excluding the prior breach of the FVIO, can '*indicate an increased risk of a victim being killed, or almost killed.*'

35. With respect to relationship specific risk factors, the CPU identified two relationship specific risk factors, specifically recent/pending separation and financial difficulties. The CRAF notes that recent separation can indicate a heightened risk for a family violence victim. In this case, the family violence incidents between Ms Burke and Mr Mather often immediately preceded a separation between the two. In early January 2016, Ms Burke and Mr Mather also appeared to be suffering financial difficulties due to Mr Mather being unable to work due to a broken hand.

COMMENTS

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

1. A finding of suicide can impact upon the memory others hold of a deceased person and can reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation.

2. It is often difficult to determine what may have precipitated a decision to end one's own life. There are sometimes issues known only to the deceased person; sometimes events in the person's life suggest a reason.

3. On the available evidence, there were several significant factors affecting Ms Burke on and proximate to 17 March 2017. Ms Burke had a history of alcohol abuse and experiences of family violence across most of her adult relationships including her relationship with Mr Mather.

4. Whilst Ms Burke had engaged with several service providers who were supporting her and her children, it appears that their records indicate a failure to make proper enquiries, adequately assess risks of self-harm and share relevant information concerning serious risk factors before closing their investigations or discontinuing support.

5. Specifically, DHHS had a long history of involvement with Ms Burke and her children, prior to Ms Burke's relationship with Mr Mather. This prior involvement related to reports of the children being neglected, subjected and/or exposed to family violence and mental health concerns for Ms Burke.

6. With respect to Ms Burke's relationship with Mr Mather, DHHS received three VP Form L17 referrals (**L17 referral**)[8] from Victoria Police in relation to Ms Burke's children following incidents of family violence between Ms Burke and Mr Mather.

7. On 9 November 2015 DHHS received a report that the children were exposed to an incident of family violence on 6 November 2015 between Ms Burke and Mr Mather.

[8] Victoria Police members who attend a family violence incident can make formal referrals to community agencies and/or reports to Child Protection by completing and forwarding a Victoria Police Risk Assessment and Risk Management Report (L17 referral).

DHHS also received additional information on 23 November 2015 in relation to a family violence incident that had occurred the weekend prior where Mr Mather had punched holes in walls at their home. At this time, DHHS received information that there had been a number of prior instances of family violence. As a result of these reports, and given the children's history of involvement with DHHS, DHHS assessed that further Child Protection intervention was required to ensure the ongoing physical and emotional wellbeing and safety of the children in Ms Burke's care and that the case would proceed to initial investigation.

8. At an initial interview with Ms Burke, Ms Burke admitted that a family violence incident had occurred on 6 November 2015 when both she and Mr Mather were intoxicated and that there had only been one other family violence incident between them. DHHS were advised by Ms Burke that there was an interim FVIO in place, and that Ms Burke would not allow another situation like this occur and if she felt things were escalating she would contact Police immediately. Ms Burke also advised DHHS that she wanted to continue her relationship with Mr Mather and continue residing with him.

9. DHHS interviewed Mr Mather on 8 December 2015. During this interview Mr Mather advised that he and Ms Burke were going to start relationship counselling and that he did not believe that they had a problem with alcohol, although he admitted that they were assisting each other to stop drinking. Mr Mather also noted that he could not recall what they had been arguing about during the family violence incident in November and denied assaulting Ms Burke. The DHHS worker suggested DHHS work with Mr Mather to develop a safety plan for the Christmas period, given it was a time-period that often involved raised levels of alcohol consumption. Case notes from DHHS suggest that Mr Mather indicated that he did not believe that he had an issue with alcohol and did not feel that a safety plan was needed. However, he ultimately agreed to a safety plan and signed a written undertaking to comply with the plan.

10. On 29 December 2015 another L17 referral was received by DHHS. This one was in relation to the family violence incident that occurred on 25 December 2015. The referral stated that both Mr Mather and Ms Burke had been drinking alcohol, that Mr Mather had breached the FVIO by assaulting Ms Burke, and that the children were present in the house at the time of the incident.

11. DHHS contacted Ms Burke and a case plan was developed which included conducting an unannounced home visit, referring Ms Burke and her children to South Eastern Centre Against Sexual Assault, requiring both parties to adhere to the FVIO and safety plan and completing referrals for an alcohol program for Ms Burke and Mr Mather and a men's behaviour change program for Mr Mather. In addition, the case plan stipulated that workers would follow up with police regarding the charges against Mr Mather for breaching the FVIO and assaulting Ms Burke.

12. A DHHS worker conducted an unannounced home visit to Ms Burke's residence on 25 January 2016. Mr Mather was present at the time and Ms Burke advised that there was a limited FVIO in place which permitted Mr Mather to reside in the home.

13. A further meeting took place between the DHHS and Ms Burke on 3 February 2016. Ms Burke advised that she had separated from Mr Mather but that they were living together for financial reasons, and that financial concerns were her primary stressor at the time. Ms Burke also advised that they were attending counselling separately. During this meeting, the worker explained that as there had been a serious family violence incident and that Mr Mather was still living in the family home, they strongly recommended that a protection application be put in place to keep Ms Burke and the children safe. Ms Burke was quite distressed by this suggestion and said that her financial concerns were more pressing than ensuring that Mr Mather was out of the home.

14. On 26 February 2016 a letter was sent to Ms Burke advising her that the protective investigation in relation to family violence had been closed and that DHHS would not continue to be involved with Ms Burke's family.

15. On 19 July 2016 DHHS received another L17 referral from Victoria Police in relation to the family violence incident that occurred between Ms Burke and Mr Mather on 16 July 2016. The referral stated that both parties were alcohol affected at the time of the incident and that both children were home. Given the extensive history of DHHS involvement the matter was referred for initial investigation on 19 July 2016 and an investigation plan was developed.

16. A home visit was conducted on 15 September 2016 by DHHS, where Ms Burke and Mr Mather were both present. During this interview they stated that they had both attended counselling and things had been going well. They also denied that the argument had

been between them, saying that it had occurred between Ms Burke and Mr Mather's ex-partner over the phone. The DHHS notes from this meeting indicated that there were no immediate safety concerns for either child and a closure letter was sent to Ms Burke on 23 September 2016.

17. I have identified several missed opportunities for intervention with regards to DHHS engagement with Ms Burke and her family. Firstly, although the report received by DHHS in November 2015 and the L17 referral sent to DHHS indicated that Ms Burke had self-harmed as a result of family violence, and that a mental health clinician had been called to assess Ms Burke, DHHS did not appear to have taken steps to contact the relevant mental health provider to obtain information regarding the outcome of this assessment.[9]

18. Furthermore, the DHHS L17 referral record states that a mental health clinician attended and spoke to Ms Burke regarding her self-harming. However, in subsequent DHHS records this is changed to state that Ms Burke was '*assessed but [sic] a Mental Health Clinician at the time of the incident with no immediate significant concerns noted.*'[10] I note that this determination was made despite no indication that any services were contacted by DHHS.

19. I note that had DHHS made proper enquiries with the relevant mental health service, they may have become aware of the mental health assessment completed which stated that Ms Burke was '*likely to present an increased risk to self with impulsive [deliberate self-harm] if situation escalates.*'[11] This information would have been of assistance to DHHS in their ongoing support of Ms Burke, and in ensuring that she received appropriate mental health support, in circumstances where the family violence appeared to be escalating.

20. I further note that despite having clear evidence that Mr Mather had breached multiple conditions of the undertaking that he signed on 8 December 2015, and that there were five additional family violence risk factors that had been brought to their attention (specifically Mr Mather's unemployment, his breach of the FVIO, his physical assault, the couple's financial difficulties and their recent separation), DHHS closed their

[9] The relevant mental health provider was Peninsular Health.
[10] Child Protection records provided by DHHS.
[11] Medical records of Fiona Burke provided by Peninsula Health, 30.

investigation on 26 February 2016 without taking any further steps to ensure the safety of Ms Burke or her children.

21. The decision to close the investigation on 26 February 2016 appears to have been made on the basis of Ms Burke's claim that Mr Mather would be leaving the house within a fortnight, her agreement that she would contact the police if he attended her home under the influence of alcohol and the fact that Mr Mather had been charged in relation to the most recent family violence incident. I note that DHHS, however, did not appear to take any steps to confirm that Mr Mather had moved out of the property before they closed their investigation. Had DHHS lodged a protective application on this occasion, or alternately remained involved with the family until they had confirmation that Mr Mather had moved out of the family home, they would have been able to put in place more significant and ongoing measures to protect Ms Burke and her children. This could have included measures such as legally mandated alcohol and drug or mental health treatment, orders preventing Mr Mather from residing at the property, and ongoing monitoring of the safety and wellbeing of the family.

22. I also note that the records provided to the Court by DHHS do not indicate that a family violence risk assessment was ever undertaken with respect to Ms Burke and her children's ongoing risk of family violence. As stated above, there were numerous family violence risk factors raised in discussions between Ms Burke, Mr Mather and DHHS, none of which appear to have been acknowledged as family violence risk factors that indicated that Ms Burke was at increased risk of family violence. A family violence risk assessment may have prompted DHHS to undertake further action to ensure the safety of Ms Burke and her children.

23. Another agency that Ms Burke had contact with was WAYSS Ltd (**WAYSS**)[12] this was for both family violence and housing support. Ms Burke contacted WAYSS for family violence support on 12 November 2015. The intake worker who assisted Ms Burke assessed her as being at risk, due to there being only a limited FVIO in place to protect her. The notes from this assessment identified that there were safety issues in relation to Ms Burke's safety, and protective actions needed to be implemented. The notes also

[12] WAYSS Ltd is a service provider who assist individuals who are homeless or at risk of homelessness and they also operate a Family Violence Outreach Program assisting victims with information, referral, advocacy and support.

identify that the worker assisting Ms Burke during this conversation discussed a safety plan and reporting FVIO breaches with her.

24. WAYSS also received an L17 referral from Victoria Police following the family violence incident on 25 December 2015. It appears from records provided by WAYSS that on 30 December 2015 they contacted Ms Burke via text message although there is no information as to the content of the text message or any follow up actions after receiving the L17 referral.

25. On 6 January 2016 Ms Burke presented again to WAYSS but was seeking housing support. Mr Mather was also present with her. During this visit she disclosed that Mr Mather was no longer working and that they were having financial difficulties. In completing an intake assessment and referral sheet, the section marked 'Family Violence and Safety' was marked "N/A" despite Ms Burke's prior attendance with a family violence support worker at WAYSS and the L17 referral in December 2015.

26. Whilst the WAYSS family violence support initially provided to Ms Burke was appropriate, the failure to follow up the family violence experienced by Ms Burke and explore her support and safety needs when she presented at WAYSS for housing assistance was a missed opportunity for intervention. In a statement to the Court, WAYSS noted that housing workers have access to previous notes and the information about Ms Burke's prior family violence contact and risk was available to them at the time of her presentation to the service in January 2016.

27. If the WAYSS housing worker had looked at the previous notes, they would have been aware that Ms Burke had been assessed as being at risk of family violence from Mr Mather. This information, in combination with the subsequent L17 referral received on 25 December 2015 and the additional family violence risk factors identified by Ms Burke during her presentation to the housing office, should have prompted WAYSS to undertake a further family violence risk assessment and engage in further safety planning with Ms Burke. I note, however, that Mr Mather's attendance at this appointment with Ms Burke may have made this impractical and unsafe.

28. In correspondence to the Court, WAYSS have confirmed that since their engagement with Ms Burke, '*immediate staff training has been conducted to ensure all appropriate information is accessed and looked at by all in accordance with our SHIP procedural*

manual and IAP procedure manual.' WAYSS have also advised that they are looking at ways to record partner details in SHIP, and investigating putting in safety processes to enable workers to speak to clients one on one when they present with other persons.

29. Research indicates that the effects of family violence can extend well beyond the relationship of violence. Family violence has been linked to poor mental and physical health outcomes, including an increased risk of mental health issues, the misuse of alcohol and drugs, and suicide.[13] Between 2009 and 2012, almost 35 per cent of women who died through suicide had a reported history of family violence, accounting for approximately 50 deaths a year.[14]

30. In recognition of the harm family violence causes, the Victorian Government established the Royal Commission into Family Violence (**the Royal Commission**) on 22 February 2015. The Royal Commission published their findings and recommendations in March 2016. The Victorian Government released in March 2017 a ten-year rolling action plan to implement all 227 of the Royal Commission recommendations.

31. I have considered the Royal Commission's report and relevant recommendations as they apply to the circumstances of this case. The Royal Commission made several recommendations to improve the way that service providers respond to family violence and operate within the wider family violence prevention system.

32. I note that many of the service issues discussed in this finding regarding both DHHS and WAYSS have been subsequently addressed internally by the agencies themselves, or by recommendations of the Royal Commission. I endorse support for Royal Commission recommendations two, three, 26, 27 and 29 that are of relevance to this case.

33. Specifically, I endorse Recommendation 2 which suggests that the *Family Violence Protection Act 2008* (Vic) (**the FVPA**) be amended to require prescribed agencies to align their risk assessment policies, procedures, practices and tools with the MARAM. This recommendation has been implemented and Child Protection are a prescribed agency.

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[13] The Royal Commission into Family Violence Report (March 2016), Vol. 1, 41
[14] *Ibid*

34. I also endorse Recommendation 3 which suggests a sustained workforce development and training strategy which includes whole-of-workforce training for Child Protection in relation to minimum standards to guide identifying, risk assessment and risk management practice in relation to family violence.[15] I note that the MARAM guidelines were completed on 27 September 2018 and the workforce development and training strategy is currently in progress.

35. Further to this, Recommendation 26 suggests that Child Protection strengthen their practice guidelines in cases where family violence is reported to and investigated by Child Protection but the statutory threshold for protective intervention is not met. This ensures that comprehensive and robust safety planning is undertaken, either by Child Protection or a family violence service and formal referrals are made to relevant services such as specialist family violence services.[16]

36. I confirm that Child Protection have developed a Child Protection Family Violence Steering Committee to drive the implementation of this recommendation, and new practice advice and procedures have been developed to strengthen case planning which require practitioners to consider family violence as part of Child Protection risk assessments.[17]

37. I endorse Recommendation 27 which suggests that DHHS improve its risk management guidelines and procedures when family violence is indicated in a report to ensure that the practitioner obtains relevant information such as all VP Form L17's and risk assessments completed by Victoria Police and specialist family violence services, records this information appropriately in CRIS and provide information regarding their own risk assessments to Victoria Police.[18]

38. I also endorse Recommendation 29 which suggests that Child Protection institute training and professional development regarding family violence and the Child Protection practice guidelines for dealing with family violence for all Child Protection practitioners.[19]

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[15] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 1, 141.
[16] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 2, 204.
[17] *Ibid*
[18] *Ibid.*
[19] *Ibid*, 205.

39. Whilst I note that Recommendation 29 is still in the implementation stage, the training will ensure that any practice changes arising from the above recommendations are communicated to, and actioned by, the relevant practitioners. I further note that all Child Protection staff from newly inducted practitioners to those in practice leadership and management roles, are required to attend the training proposed in Recommendation 29.

FINDINGS

The investigation has identified that Ms Burke had a long history of alcohol abuse and suffered mental ill health. My investigation has also identified that Ms Burke had self - harmed and suffered suicidal ideation in the past.

I note that the service issues discussed in this finding regarding both DHHS and WAYSS have been subsequently addressed internally by the agencies themselves, or by recommendations of the Royal Commission into Family Violence. I make no additional adverse findings.

The evidence available to me indicates that Ms Burke's history of family violence in past relationships, financial difficulties and social stressors – including substantial family violence between herself and her partner, Mr Mather, were precipitating factors that led her to adopt the course of action she ultimately chose on 17 March 2017.

I accept and adopt the medical cause of death ascribed by Dr Almazrooei and I find the cause of Fiona Kellie Burke's death to be hanging, in circumstances where I find that she intended to end her own life.

Pursuant to section 73(1A) of the **Coroners Act 2008**, I order that this finding be published on the internet.

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

Mr Darren Mather

Mr John Burke

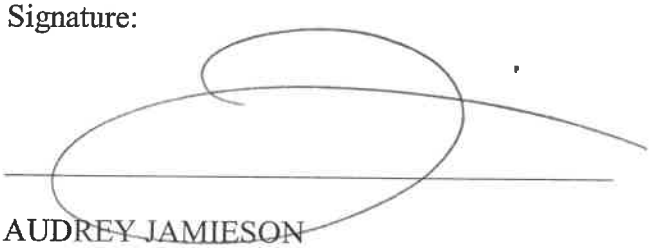
Senior Constable Jonathan Weisshardt

Ms Amber Salter, Legal Counsel, Peninsula Health

Leng Phang, Principal Solicitor, Department of Health and Human Services

Ms Belinda Blair, Manager of Women's Services, WAYSS

Signature:



AUDREY JAMIESON

CORONER

Date: **8 January 2019**