IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 4796

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the death of Maddison Murphy-West

Delivered on:	17 December 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	17 December 2020
Findings of:	Judge John Cain, State Coroner
Counsel assisting the Coroner:	Nicholas Ngai, Family Violence Senior Solicitor
Catchwords:	Suspected homicide, no one charged with an indictable offence in respect of a reportable death, mandatory inquest.

HIS HONOUR:

BACKGROUND

1. Ms Maddison Murphy-West (**Ms Murphy-West**) was a 20-year-old woman who resided at 14/108 Ahern Road, Pakenham with her then partner, Mr Troy Boothey (**Mr Boothey**) and their 21-month-old son, Noah Boothey (**Noah**).

2. Ms Murphy-West grew up in Cranbourne and Seaford in the South Eastern suburbs of Melbourne and attended school until Year 10. Her parents separated when she was nine years of age and she lived with her mother, Ms Paula Murphy. Ms Murphy-West enjoyed a very close relationship with her mother and was described by family as friendly, active in sports and other social activities.[1]

3. Ms Murphy-West and Mr Boothey commenced their relationship in 2009, Ms Murphy-West was 16 years old at the time. Their son, Noah, was born on the 22 January 2012.

4. Mr Boothey had a long history of regular substance abuse including methamphetamines and Ms Murphy-West was known to use recreational drugs irregularly.[2] The evidence available in the coronial brief suggests that Mr Boothey perpetrated family violence against Ms Murphy-West throughout their relationship and this was exacerbated by Mr Boothey's regular drug use.[3] Mr Boothey was often controlling, possessive and had on several occasions physically assaulted Ms Murphy-West.

5. The first report of family violence was an incident in Collingwood in late 2011, Ms Murphy-West was pregnant with Noah at the time. Mr Boothey lost his temper with Ms Murphy-West and grabbed her throat and forcefully slammed her head into the internal window of the car they we in at the time.[4] Mr Boothey only stopped when an acquaintance who was also in the car intervened. This incident was not reported to police.

6. There was a further incident on 5 September 2012 at approximately 10.30 pm at the Gladstone Park shopping centre. Mr Boothey and Ms Murphy-West argued and in the course of the argument Mr Boothey took hold of Ms Murphy-West's mobile phone and struck her in

---

[1] *Coronial Brief*, Statement of Paula Murphy dated 20 November 2013, 151-152
[2] *Coronial Brief*, Statement of Bianca Sarlo dated 12 November 2013, 164-166; Appendix Y – Troy Boothey Criminal History Record, 864-895
[3] *Coronial Brief*, Appendix Q – Family violence LEAP records,821-837; Statement of Bianca Sarlo dated 12 November 2013, 164-166; Statement of Paula Murphy dated 20 November 2013, 154-159
[4] *Coronial Brief*, Statement of Joshua McKay dated 14 January 2014, 218

the head whilst pushing and shoving her. Security staff at the shopping centre intervened.[5] No report was made to Police. The following day the 6 September 2012 there was a further incident where Mr Boothey and Ms Murphy-West again argued and Mr Boothey became aggressive and he head-butted Ms Murphy-West several times causing her nose to bleed. He then grabbed her throat with both hands and began strangling her to the point where she nearly passed out. In her statement to police at the time Ms Murphy-West stated that it was "*very scary*" and *"I couldn't breathe*" Ms Murphy-West attended Casey Hospital for treatment following this incident.[6]

7. On the 12 December 2012, Mr Boothey was arrested following a car chase and charged with offences in relation to the assault on Ms Murphy-West and for other outstanding matters. Mr Boothey was sentenced to 6-month imprisonment.[7] Upon release from prison in June 2013, he returned to 14/108 Ahern St Pakenham to live with Ms Murphy-West and Noah.

8. On the 7 August 2013 a domestic dispute at 108 Ahern St Pakenham was reported to police. Police attended but could not locate Mr Boothey or Ms Murphy-West so left and took no further action.[8] There was also a further incident reported on the 30 September 2013 and police attended but were told by Mr Boothey and Ms Murphy-West that there were no issues and police assistance was not required.[9]

Maddison's relevant medical history

9. Dr Vanessa Haller from the Carrum Downs Medical Centre was Ms Murphy-West's long-time treating doctor. Ms Murphy-West had been a patient of Dr Haller since she was a child.[10] Her last appointment with Dr Haller was on the 16 July 2013 where she spoke with Dr Haller about her home situation and her intent to end the relationship with Boothey.[11] Dr Haller assessed her for a mental health plan which focussed on both her mental and physical health as Dr Haller observed that Ms Murphy-West was both timid and frail.

10. Ms Murphy-West told Dr Haller that she had previously had suicidal thoughts although she had no suicidal plan or intent. Dr Haller did not believe that she was a suicide risk and stated '*on 23 October 2013 I received a phone call from my work and was advised that Maddison*

---

[5] *Coronial Brief,* Appendix Q – Family violence LEAP records, 827-828
[6] Ibid
[7] *Coronial Brief*, Appendix O – Brief of Evidence, 774-820
[8] *Coronial Brief,* Appendix T – Transcript of Milner 000 call, 842-853
[9] *Coronial Brief*, Appendix W – Transcript of D'Cruz 000 call, 854-863
[10] *Coronial Brief*, Statement of Dr Vanessa Haller dated 3 November 2013, 207
[11] Ibid, 209

had committed suicide. My initial impression was that she would never do that as she never had suicidal intent and she had a baby that she absolutely adored'[12]

11. Further Dr Heller did not consider that Ms Murphy-West possessed the mental or physical strength to commit suicide especially knowing that Noah was in the house.[13] Dr Heller had known Ms Murphy-West as a patient for most of her life and was privy to her medical and social history.

THE PURPOSE OF A CORONIAL INVESTIGATION

12. Ms Murphy-West's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Ms Murphy-West ordinarily resided in Victoria[14] and the death appears to have been unexpected and violent.[15]

13. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the 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.

14. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[16] 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.[17]

15. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[18] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[19] or to determine disciplinary matters.

16. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

17. For coronial purposes, the phrase "*circumstances in which death occurred*,"[20] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the

---

[12] Ibid, 207
[13] Ibid, 210
[14] Section 4 *Coroners Act 2008*
[15] Section 4(2)(a) *Coroners Act 2008*
[16] *Coroners Act 2008* (Vic) s 89(4),
[17] *Coroners Act 2008* (Vic) preamble and s 67.
[18] *Keown v Khan* (1999) 1 VR 69.
[19] *Coroners Act 2008* (Vic) s 69 (1).
[20] *Coroners Act 2008* (Vic) s 67(1)(c).

death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

18. 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 Court's "*prevention*" role.

19. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[21]

    (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;[22] 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.[23] These powers are the vehicles by which the prevention role may be advanced.

20. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[24] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[25] 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.

IDENTITY OF THE DECEASED PURSUANT TO S.67(1)(a) OF THE ACT

21. On 25 October 2013, Sampath Yapa visually identified the deceased to be his partner's daughter, Maddison Murphy-West, born 16 July 1993.

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

---

21 *Coroners Act 2008* (Vic) s 72(1).
22 *Coroners Act 2008* (Vic) s 67(3).
23 *Coroners Act 2008* (Vic) s 72(2).
24 *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
25 (1938) 60 CLR 336.

MEDICAL CAUSE OF DEATH PURSUANT TO S.67(1)(b) OF THE ACT

23. Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Maddison Murphy-West and provided a written report of his findings dated 15 January 2014. Post-mortem examination revealed a transverse abrasion to the left side of the neck and upwards on the right side of the neck. There was also sparing over the posterior aspect of the neck. There was no evidence of any localised or discoid bruising to the neck.

24. Homicide squad provided a cloth belt present at the scene which was compared to the injury to the deceased's neck. The belt showed a region of "folding" which would then approximate the width of the injury of the neck. With folding of the belt, and with the weight of the deceased's body, the cloth belt could cause the injury to the neck.

25. Dr Burke further observed that whilst the autopsy examination did not show features to diagnose ligature strangulation, there were features that also did not support a finding of hanging. Dr Burke commented that most cases of ligature strangulation have transverse abrasions/bruises to the neck with "crossing over" of the injury posteriorly. This was not seen with Ms Murphy-West. Furthermore, in cases of ligature strangulation one expects bruises within the "strap muscles" of the neck, Dr Burke confirmed that this was not observed in the autopsy.

26. Dr Burke concluded that a reasonable cause of death was:

I(a) Neck Compression

27. Toxicological analysis of post-mortem specimens revealed the presence of methylamphetamine, amphetamine and the presence of ibuprofen. There was also detected raised levels of amiodarone which was administered by Ambulance paramedics during the attempted resuscitation.

28. I accept the cause of death proposed by Dr Burke.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO S.67(1)(c) OF THE ACT

29. On the morning of the 23 October 2013, at 6.30am, Ms Murphy-West was at her residence on Ahern Street, Pakenham with Noah when Mr Boothey's friend, Troy Stork, arrived home from work. Mr Stork had been residing with Ms Murphy-West and Mr Boothey at their residence for approximately two weeks prior to this date.[26]

30. Mr Boothey also arrived home around the same time, he had been out all night and appeared drug affected.[27] Mr Stork went to his bedroom to sleep and Ms Murphy-West returned to her bedroom and an argument ensued between Ms Murphy-West and Mr Boothey about his activities from the evening prior. This argument awoke Mr Stork who confronted the couple and declared that he couldn't take their arguing anymore and would be moving out.[28]

31. At 7.30am, as Mr Stork was in the process of packing to move out, Mr Boothey approached him in an aggressive manner and there was a physical altercation between the two that resulted in Mr Boothey headbutting Mr Stork and Mr Stork punching Mr Boothey who fell to the ground twice during the altercation.[29] Ms Murphy-West tried to intervene and asked Mr Boothey to stop fighting. Mr Stork left the premises and drove to his partner's home in Endeavour Hills.[30]

32. Mr Boothey stated to police in a later interview that he returned to the garage where he and Ms Murphy-West had an argument about how they were going to be able to afford the rent now that Mr Stork had moved out. Ms Murphy-West was reported to have stated that she was over it, over not being able to pay for rent and she couldn't handle it anymore.[31] Ms Murphy-West was reported to then return inside the house leaving Mr Boothey alone in the garage Mr Boothey stated that he remained in the garage for some time before he entered the house, either because he heard a bang like a door slamming, or because he heard Noah crying.[32]

33. At 8.48am, Mr Stork called Ms Murphy-West's mobile telephone. Mr Stork spoke with Ms Murphy-West at this time to explain why he left and to see if Mr Boothey was alright.[33] Mr Stork handed the phone to his partner who remained on the phone for approximately 30

---

[26] *Coronial Brief*, Statement of Troy Stork dated 29 October 2013, 65
[27] Ibid
[28] Ibid, 66
[29] Ibid
[30] Ibid
[31] *Coronial Brief*, Appendix N – Transcript of interview with Troy Boothey, 680
[32] Ibid, 681-682
[33] *Coronial Brief*, Appendix H – Telephone records (STORK), 389-392

minutes. Ms Murphy-West was reportedly upset and stated that Mr Boothey was blaming her for the fight between Mr Boothey and Mr Stork.[34] Mr Stork's partner advised Ms Murphy-West to leave the house and go to her mother's house. Ms Murphy-West reportedly stated that Mr Boothey just wouldn't let her go.[35] Prior to ending the call, Mr Stork requested that Ms Murphy-West ask Mr Boothey if he wanted Mr Stork to take him to his doctor's appointment that evening. Ms Murphy-West agreed to speak to Mr Boothey and undertook to call Mr Stork back.[36]

34. Ms Murphy-West never called Mr Stork back and he unsuccessfully attempted to reach Ms Murphy-West multiple times between 9.58am to 10.03am.[37]

35. At 10.11am, Mr Boothey called Mr Stork and stated that, "*Troy help me, Madi has just hung herself, what do I do, what do I do? I just gave her mouth to mouth and pumped on her chest. Get here and help me*".[38] Mr Stork advised Mr Boothey to contact emergency services and that he would head over to the premises to assist.

36. At 10.13am, Mr Boothey contacted emergency services and was guided to perform cardiopulmonary resuscitation **(CPR)** until Ambulance paramedics arrived.[39] Ambulance paramedics arrived at 10.24am and were led into the premises but were unable to resuscitate Ms Murphy-West and she was pronounced deceased at the scene.[40] Police arrived shortly after and commenced their investigations.

VICTORIA POLICE INVESTIGATION

37. Following Ms Murphy-West's death, the Homicide Squad commenced a criminal investigation due to the nature of the injuries she sustained. As part of the investigation Mr Boothey made various statements to police. In summary he states that he walked to the house from the garage as he heard Noah crying and found Ms Murphy-West hanging from the bedroom door by her dressing gown cord. He tried to cut her down but couldn't. He then removed the ligature from her neck and carried her to the shower. He placed her under the shower to try to awaken her. This was unsuccessful and so he moved her back to the bedroom

[34] *Coronial Brief,* Statement of Jodie Leanne Dennis dated 23 October 2013, 222
[35] Ibid
[36] Ibid
[37] *Coronial Brief,* Appendix H – Telephone records (STORK), 389-392
[38] *Coronial Brief,* Statement of Troy Stork dated 29 October 2013, 67
[39] *Coronial Brief,* Appendix A – 000 call transcript, 332-334
[40] *Coronial Brief,* Statement of Andrew James Bishop dated 2 January 2014, 90

and made a call to Mr Stork and then called emergency services. The 000-call taker instructed him to commence CPR which he did before paramedics arrived at the scene.[41]

38. Blood pattern analysis and biological examination of samples collected at the scene were undertaken as part of the criminal investigation.

39. The Homicide squad engaged forensic investigators to assist in reviewing the crime scene and provide expert advice on the circumstances of death. The focus of this part of the investigation was on the ligature and the blood pattern analysis at the scene.

Analysis of Ligature

40. The ligature consisting of the dressing gown cord tied to the coaxial cable was examined to address the following questions:[42]

- were the knot/s used to join the dressing gown cord to the coaxial cable able to support Ms Murphy-West's weight or would they have slipped or failed when weight was applied.?
- would the coaxial cable as it was tied to the door handle have released or slipped when weight was applied?
- when Ms Murphy-West was removed from the ligature by Mr Boothey, would the coaxial cable have remained tied to the door handle or would it have come free once the pressure was released?

41. Senior Sergeant Andrew Gardner, an experienced member of the Water Police with a strong knowledge of ropes and knots, was engaged to assist in this aspect of the investigation.[43] Senior Sergeant Gardner in conjunction with investigating police undertook a re-enactment of the events at the scene using a dummy which was a similar weight to Ms Murphy-West, coaxial cable and cable equivalent to a dressing gown cord. They undertook a series of re-enactments to test the likelihood of various scenarios. Having conducted numerous experiments applying different tests and scenarios, Senior Sergeant Gardner concluded as follows:

'in conclusion it is my belief that if the ligature was found as shown in the photographs and allowing for the description given by the reporting person, it would have been very improbable that the deceased would have succeeded in hanging herself in that manner.

[41] *Coronial Brief,* Appendix D – Statement of Troy Boothey dated 23 October 2013, 363
[42] *Coronial Brief,* Statement of Senior Sergeant Andrew Robert Gardner dated 16 October 2014, 273-274
[43] Ibid

It would have been more improbable that the deceased would have been able to have been removed from the door while the ligature remained in place. The ligature was not what I would describe as secure. A round turn without any half hitches is more than likely to come undone when pressure is applied"[44]

Blood pattern investigation

42. Expert advice was sought about the blood pattern and blood splatter in the area of the bedroom and ensuite bathroom. Forensic officer Mark Gellatly undertook a review of bloodstains at the scene.[45] Mr Gellatly is a Senior Case Manager with the Biological Examination Branch of the Forensic Services Department at the Victorian Police Forensic Services Centre.

43. Mr Gellatly conducted an extensive review of the available evidence with particular focus on whether the distribution of bloodstains and the bloodstain pattern could corroborate or refute the account of events provided by Mr Boothey. He concluded after extensive testing that the evidence was inconclusive regarding the degree of involvement of Mr Boothey in the death of Ms Murphy-West.[46]

Confessions by Mr Boothey during periods of incarceration

44. In the years following Ms Murphy-West's death, Mr Boothey spent various periods in custody either on remand or as a sentenced prisoner. He was in custody between 20 April 2014 and 7 March 2016, from 8 August 2016 to 8 December 2016 and from 7 May 2017 to 17 May 2017.[47] During these periods of custody, admissions were made by Mr Boothey to other prisoners.

45. Sometime in late 2015 or early 2016, Mr Boothey shared a cell with WW. WW provided a sworn statement to Police to the effect that Mr Boothey would occasionally talk in his sleep and mention Ms Murphy-West. WW states that he asked Mr Boothey about Ms Murphy-West and Mr Boothey stated that he had "*knocked her*" that he didn't mean to but he just "*lost it and that he had 'choked her'*."[48] A sworn statement was provided by WW to police on the 19 September 2019.

---

[44] Ibid, 284
[45] *Coronial Brief*, Statement of Mark Gellatly dated 7 March 2014, 213-214
[46] Ibid, 123-124
[47] *Coronial Brief*, Appendix Y – Troy Boothey Criminal History Record, 864-895
[48] *Coronial Brief*, Statement of WW dated 19 September 2019, 286-288

46. Mr Boothey shared a cell with another prisoner JW at Port Phillip prison in late 2015 early 2016. JW also provided a statement to police where he recounts a conversation with Mr Boothey where he agrees with a statement made by JW that he (Mr Boothey) "*strung her up*"(referring to Ms Murphy-West) .[49] JW provided a statement to police on 23 February 2018.

47. In May 2017, Mr Boothey shared a cell with WI at Wangaratta where they had a conversation in relation to Ms Murphy-West's death. WI states that he and Mr Boothey spoke about rumours that were circulating that Mr Boothey was involved in Ms Murphy-West's death, Mr Boothey stated that it could not be proved. WI in his sworn statement to police states that Mr Boothey told him that to the effect that he had killed Ms Murphy-West and that he gotten away with it.[50]

Death of Mr Boothey

48. On 25 May 2019, Mr Boothey was found deceased at his residence in Hastings, Victoria. His death was treated as not suspicious and was the subject of another coronial investigation.[51]

COMMENTS

49. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.

50. On the basis of the physical evidence as well as Dr Burke's opinion, I am satisfied to the coronial standard that Mr Boothey was capable of the actions necessary to cause Ms Murphy-West's death and that she did not end her own life.

51. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Ms Murphy-West and Mr Boothey was one that fell within the definition of 'de facto partner'[52] under that Act. Moreover, Mr Boothey's physical and emotional abuse of Ms Murphy-West and controlling behaviour constitutes 'family violence'.[53]

---

[49] *Coronial Brief*, Statement of JW dated 13 February 2018, 290-292
[50] *Coronial Brief*, Statement of WI dated 21 June 2017, 297-300
[51] COR 2019 2636
[52] Family Violence Protection Act 2008, section 9
[53] Family Violence Protection Act 2008, section 5(1)(a)(i)

52. In light of Ms Murphy-West's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (CPU)[54] examine the circumstances of Ms Murphy-West's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[55]

53. The Police *Code of Practice for the Investigation of Family Violence* (Code of Practice) in place at the time of this incident,[56] specified compulsory police action to be taken in responding to an incident of family violence. It stipulates that police must "*investigate all family violence incidents coming to their notice by gathering background information and physical evidence, including photographs, clothing and statements from direct and indirect witnesses*".[57] Police are also instructed to "*make perpetrators accountable by pursuing criminal and/or civil options where there is sufficient evidence to do so and regardless of whether an arrest has been made and/or whether the Affected Family Member is reluctant*".[58]

54. The Code of Practice further requires police members in assessing current and future risk of family violence to consider the history of violent behaviour outside the family and whether the perpetrator has ever harmed or threatened to harm or kill children and/or other family members.[59]

55. A review of the available evidence by the CPU did identify some opportunities for improvement in the practice of police members in the proximate period prior to Ms Murphy-West's death. Specifically, police members attended two incidents reported by Ms Murphy-West's neighbours but did not take further steps to investigate the safety of Ms Murphy-West on 7 August 2013 when police attended and found the unit unoccupied[60] and on 30 September 2013, they did not provide any referrals for support to both Ms Murphy-West and Mr Boothey in light of an active Family Violence Intervention Order in effect at the time to protect Ms Murphy-West.[61] In considering these issues I am cognisant that there have been significant reforms to the family violence service system since Ms Murphy-West's death in 2013.

---

[54] 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

[55] 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

[56] Victoria Police, *Code of Practice for the Investigation of Family Violence* (2014) 3rd Edition, Version 2.

[57] Ibid, 8

[58] Ibid

[59] Ibid, 18

[60] *Coronial Brief*, Appendix V, 840-851

[61] *Coronial Brief,* Appendix X, 852-863

56. In 2016, the Royal Commission into Family Violence **(the Royal Commission)** made 227 recommendations with respect to the family violence service system, including a significant number directed towards improving the Victoria Police response to family violence.[62] These included recommendations directed at updating, and ensuring compliance with, policies and procedures including the *Code of Practice for the Investigation of Family Violence*, to ensure that appropriate risk assessments and actions are undertaken by police responding to incidents of family violence.

57. In response to these recommendations, Victoria Police have implemented a variety of changes to strengthen their response to family violence. This includes testing and implementing a new family violence risk assessment tool, the Family Violence Report (FVR). This tool incorporates a variety of risk factors from the Multi Agency Risk Assessment and Management framework and contains 39 questions which are required to be completed every time a family violence report is taken. New and updated information sharing protocols also ensure this information is passed on to appropriate family violence support services and Child Protection as required.

58. Victoria Police have also updated the *Victoria Police Manual* and are reviewing the *Code of Practice for the Investigation of Family Violence*. They have also introduced changes to ensure best practice and compliance with these new policies and procedures, including establishing the Family Violence Centre of Learning, and introducing specialist family violence roles and compulsory family violence training. There are also new systems in place for the review and monitoring of FVRs, reporting of compliance rates, and processes for addressing any identified deficiencies.[63]

FINDINGS AND CONCLUSION:

59. Having held an inquest into the death of Ms Murphy-West, I make the following findings, pursuant to section 67(1) of the Act:

a) The identity of the deceased was Maddison Murphy-West, born on 16 July 1993;

b) That the death occurred on 23 October 2013 at the 14/108 Ahern Road, Pakenham, Victoria from I(a) Neck compression; and

c) That the death occurred in the circumstances set out above.

---

[62] *Royal Commission into Family Violence* (Final Report, March 2016)
[63] *Victoria Police, Practice Guide - Family Violence Roles and responsibilities, 3-4, 11-12.*

60. I convey my sincerest sympathy to Ms Murphy-West's family.

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

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

Ms Paula Murphy, Senior Next of Kin

Detective Senior Constable Luke Farrell, Coroner's Investigator

Senior Sergeant Susan Mintern, Civil Litigation Unit, Victoria Police

Signature:

JUDGE JOHN CAIN
STATE CORONER
Date: 17 December 2020

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 inquest. 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.