IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 1889

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**JOHN CAIN, STATE CORONER**
Deceased:	**Mrs K**
Date of birth:	15 August 1939
Date of death:	23 April 2017
Cause of death:	I(a) Head and neck injuries
Place of death:	[redacted], Patterson Lakes, Victoria
Catchwords:	Family violence, homicide, non-accidental injuries

TABLE OF CONTENTS

HIS HONOUR:

BACKGROUND

1. Mrs K was 77 years old at the time of her death. Mrs K was born in Slovenia. She met her husband, Mr K in Austria and they got married in Bosnia in 1966.[1]

2. Mr and Mrs K migrated to Australia in 1969 and they had two children, a son named Mr ZK and a daughter named Ms MA.[2] Mr and Mrs K lived in a migrant camp before moving to Brunswick and Flemington, they eventually settled in Patterson Lakes by 1980.

3. Mrs K was originally working in Myer in Melbourne and moved on to work as a housekeeper for a local family since 2002.[3] Mrs K had a physical disability since birth with one leg being a bit shorter than the other causing her to have a distinct limp.[4]

4. Mr K was a dye setter who worked at Stokes Manufacturing in Ringwood until around the mid-1980s when he injured his back in a workplace injury.[5] Mr K was not as mobile after the workplace injury and was reported to stop going out and socialising since this time.[6]

5. Mrs K came from a Catholic religious background and this was different to Mr K who had been raised as a Muslim. This caused some initial conflict in their relationship as Mr K would not let Mrs K continue to practice her religion after they were married.[7]

6. On Saturday 15 April 2017, Mrs K attended Easter Saturday evening mass with her neighbour. Mass on this occasion finished a lot later than usual and Mrs K was reported to appear worried and indicated that she needed to get straight home.[8] Her neighbour drove her home and on the way, Mrs K complained about Mr K's stubbornness and controlling behaviours.[9]

7. The following day on Sunday, 16 April 2017, Mrs K had a close friend visit her and during this visit, she reported to her friend that Mr K was upset about her coming home late and she had, *'had enough, I just want to die'*.[10]

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[1] *Coronial Brief*, Statement of Mr ZK dated 24 April 2017, 74
[2] Ibid
[3] *Coronial Brief*, Statement of TW dated 8 May 2017, 80
[4] *Coronial Brief*, Statement of BM dated 5 May 2017, 94
[5] *Coronial Brief*, Statement of ZK dated 24 April 2017, 74
[6] Ibid
[7] Ibid, 73
[8] *Coronial Brief*, Statement of AR dated 28 April 2017, 86
[9] Ibid
[10] *Coronial Brief*, Statement of BM dated 5 May 2017, 97

THE PURPOSE OF A CORONIAL INVESTIGATION

8. Mrs K's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[11]

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[12] 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 the death occurred.[13]

10. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[14] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[15] or to determine disciplinary matters.

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

12. For coronial purposes, the phrase "*circumstances in which death occurred*,"[16] 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 death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

13. 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.

14. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[17]

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[11] Section 4 Coroners Act 2008
[12] Section 89(4) Coroners Act 2008
[13] See Preamble and s 67, *Coroners Act 2008*
[14] *Keown v Khan* (1999) 1 VR 69
[15] Section 69 (1)
[16] Section 67(1)(c)
[17] Section 72(1)

(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;[18] 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.[19] These powers are the vehicles by which the prevention role may be advanced.

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[20] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[21] 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.

16. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

17. On 27 April 2017, Mr ZK identified the body of the deceased as his mother, Mrs K born 15 August 1939.

18. Identity is not in dispute in this matter and requires no further investigation.

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

19. On 24 April 2017, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Young provided a written report dated 15 September 2017 and concluded that Mrs K died from head and neck injuries.

20. Dr Young commented on the following in his written report:

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[18] Section 67(3)
[19] Section 72(2)
[20] Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152
[21] (1938) 60 CLR 336

(a) Of the blunt force injuries to the head, one (Injury A) had the appearance of a 'chop' injury associated with a linear skull fracture. A 'chop' injury may be caused by a rather heavy object with a sharp edge and has features of both blunt and sharp force. Another blunt force injury (Injury B) was associated with a depressed skull fracture. Other evidence of blunt force injuries included subdural and subarachnoid haemorrhage, and contusions in the brain.

(b) The sharp force injuries to the left side of the neck included injuries to the left carotid artery, thyroid cartilage, trachea, oesophagus, thyroid, left 1st rib (bone) and C6 and C7 cervical vertebrae (bone). The sharp force injuries, by definition, have been caused by a sharp implement such as a knife.

(c) It is not possible to determine the order in which the injuries were inflicted. However, given the absence of sharp force 'defence' type injuries, it is possible the head injuries preceded the neck injuries. Death was likely to be due to a combination of factors, including exsanguination and air embolism.

(d) There was no evidence of any 'defence' type injuries to the arms or hands.

(e) There was no evidence of natural disease that may have caused or contributed to death.

21. Toxicological analysis of samples of postmortem blood detected no traces of alcohol or common drugs or poisons.

22. I accept the cause of death proposed by Dr Young.

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

23. On 23 April 2017, at around 3.30pm, Mr K reports that he laid down in bed as he was feeling unwell and had an earlier fight with Mrs K in the backyard.[22]

24. Mr K further reported that at around 4.30pm, he got angry and proceeded to the laundry where he picked up an axe and returned to the bedroom where he struck Mrs K twice to the right temple area.[23]

[22] *Coronial Brief,* Appendix H – Transcript of police interview with Mr K on 23 April 2017, 228-238
[23] Ibid

25. He reportedly attempted to clean the blood and the axe but then rang his daughter stating that, '*your mum's passed*'.[24] Mrs K's daughter confirmed that this call was received around 8.30pm that evening and that her partner called the police after the phone call.

26. Mr K reported that after he spoke with his daughter, he then made a call to emergency services, and he stated during the call that, '*I killed my wife*'.[25]

27. Victoria Police and Ambulance officers arrived on scene at around 9.17pm and confirmed that Mrs K was deceased.[26] Mr K was subsequently arrested and charged with Mrs K's murder.

Criminal investigation outcome

28. On 19 October 2018, her Honour, Justice Jane Dixon determined that Mr K was not fit to stand trial within the next 12 months and on 14 November 2018, in the Supreme Court of Victoria, a general order was made declared Mr K liable to a period of supervision and that he be remanded into custody in a prison as there was no practicable alternatives in the circumstances.[27]

29. Mr K passed away whilst in custody at Port Phillip Prison on 19 October 2019 before a term of supervision could be set by the Supreme Court of Victoria.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

30. 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.

31. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr and Mrs K was one that fell within the definition of '*family member*'[28] under that Act. Mr K's act of fatally assaulting Mrs K constituted '*family violence*'.[29]

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[24] *Coronial Brief*, Statement of MA dated 23 April 2017, 55
[25] *Coronial Brief*, Appendix F – Transcript of call made to 000 by Mr K, 187
[26] *Coronial Brief*, Statement of Constable Darren Jordan dated 24 April 2017, 110-111
[27] Coronial brief of evidence, Appendix 2, Extract from Supreme Court of Victoria, General Form of Order, 14 November 2018, Indictment no H11120346.
[28] Family Violence Protection Act 2008, section 8(1)(a)
[29] Family Violence Protection Act 2008, section 5(1)(a)(i)

32. In light of Mrs K's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[30] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[31] A review of the available evidence identified a history of family violence, however no evidence of that family violence being disclosed to services who had proximate service contact with Mr and Mrs K.

Family violence risk factors

33. To determine the presence of any family violence risk factors in the circumstances leading up to the fatal incident, I have referenced the *Family Violence Risk Assessment and Risk Management Framework*, also known as *The Common Risk Assessment Framework* (**CRAF**)[32].

34. The CRAF was first introduced in 2007 to assist service providers from a wide range of fields to understand and identify risk factors associated with family violence and respond consistently. Practitioners like Child Protection workers, Victoria Police members, mental health clinicians and medical professionals utilise 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.

35. The CRAF contains several evidence-based risk factors which have been found to impact on the likelihood of family violence occurring and its severity.[33] 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. The CRAF also identifies several additional factors which can impact on the options and outcomes available to family violence victims.[34]

36. In applying the CRAF to assess the level of risk of a fatal family violence outcome in this case, I note that four perpetrator specific risk factors relate to Mr K. Specifically, he had previously threatened harm against Mrs K, was unemployed, exerted controlling behaviours and had a

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[30] 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

[31] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

[32] The Victorian Government recognised the need for an integrated and consistent approach to providing family violence services and in 2008, commissioned a consortium composed of agencies including the Domestic Violence Resource Centre Victoria, Swinburne University and No to Violence to develop and deliver the *Family Violence Common Risk Assessment and Risk Management Framework* (CRAF).

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

[34] Ibid, 30.

history of alcohol abuse. Two of these risks (controlling behaviours and unemployment) indicated an increased risk of the victim being killed or almost killed.[35]

37. One relationship specific risk factor that is relevant to Mr and Mrs K's relationship is financial difficulties. Statements from Mr and Mrs K's children confirm that financial issues plagued their parent's relationship up until the fatal incident and Mr K was reported to have difficulties managing money and would gamble money and blame Mrs K for spending all his money.[36]

38. The CRAF identifies that financial difficulties can result in financial stress which, in turn, can increase the risk of future or ongoing family violence.[37]

39. Mr and Mrs K were also from a culturally and linguistically diverse background, being originally Bosnian and Slovenian nationals respectively. Mrs K potentially may have faced barriers in accessing services for support due to limited English and unfamiliarity with the family violence service system in Australia.[38]

Third party reporting of family violence

40. Statements of friends and family describe Mr and Mrs K's relationship as one characterised by a long-standing history of family violence perpetrated by Mr K. Mr and Mrs K's children reported that Mr K was both verbally and physically abusive, abused alcohol, was more aggressive when intoxicated, would physically assault them and Mrs K, was very controlling of Mrs K, and had gambling problems.[39]

41. It is reported that these issues increased following a work-related incident in approximately the 1980's, whereby Mr K injured his back and was unable to continue working.[40] Mr K's son reported that the escalation in family violence was a contributing factor for him to move out of the family home at 17 years of age to reside with his older sister, who was already living independently.[41]

42. Mr K reportedly accused Mrs K for a number of years of having unsubstantiated affairs with several males, extended family members, and tradesmen that had attended the marital home to

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[35] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition, 75
[36] *Coronial Brief*, Statement of ZK dated 24 April 2017, 75
[37] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition.
[38] Ibid, 32-33
[39] *Coronial Brief*, Statement of ZK dated 24 April 2017, 75; Statement of MA dated 23 April 2017, 56
[40] *Coronial Brief*, Statement of ZK dated 24 April 2017, 74
[41] Ibid, 76

complete repairs.[42] Mr K was described to have been jealous and extremely controlling of Mrs K.[43] This had a significant impact on Mrs K's relationship with her children as she was limited to visiting her daughter once a week, and her son very rarely, only for the children's birthdays, as she had to lie to Mr K about where she was going.[44]

43. The available evidence suggests that those close to Mrs K, specifically her children, her close friends and her employer were all aware of the abuse Mr K perpetrated against her and noted that Mr K was *'a totally different person in public.'*[45]

44. Mrs K's son recalled an incident 10-15 years prior to the fatal incident, where Mrs K presented to his sister's home with injuries to her nose following an assault by Mr K.[46] Mrs K returned home following this incident, despite both her children urging her to leave the marriage. Mrs K's daughter states that she had always '*told [Mrs K] to leave [Mr K], she was worried about what people would think...that he would find her anyway...that she was too old to leave.*'[47] Mrs K's daughter also recalled that her mother had disclosed previously that she was '*afraid that [Mr K] would kill her [Mrs K] while she was asleep'*, however she never thought her father was capable of killing her mother.[48]

45. Mrs K's death, and deaths similar to hers, highlight the difficult and often dangerous predicament that family violence presents to family, friends and others who either become aware of it, or suspect it is occurring. Coupled with this is the reoccurring indication within the relevant research, that female victims of family violence are more likely to disclose the violence to family or friends, rather than to authorities or specialist services. Many times, third parties feel, understandably, ill-equipped to assist or are concerned that any intervention may increase the danger for the victim or themselves.

46. 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 of family violence, the Royal Commission into Family Violence (**the Royal Commission**)[49] reviewed the available resources for third parties.

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[42] *Coronial Brief* of evidence, Statement of MA dated 23 April 2017, 56; Statement of ZK dated 24 April 2017, 77; Statement of BM dated 5 May 2017, 94; Statement of Jason Allen dated 23 May 2017, 69
[43] *Coronial Brief*, Statement of ZK dated 24 April 2017, 76
[44] Ibid
[45] Ibid, 77
[46] Ibid
[47] *Coronial Brief*, Statement of MA dated 23 April 2017, 56.
[48] Ibid, 57
[49] Victoria, Royal Commission into Family Violence, Final Report, March 2016

47. At its conclusion, predominantly by way of recommendations 10 and 37, the Royal Commission encouraged the adoption of a model whereby third parties (as well as victims and perpetrators of family violence) can access information via a website to assist in recognising family violence and how to seek help, both in the crisis period and during longer term recovery.[50]

48. This Court is advised that the Victorian Government has selected the Orange Door[51] website as the most suitable existing site with the capacity to develop into a space for the delivery of accessible information for those experiencing, witnessing and being affected by family violence. The Court is also informed that, in line with the Royal Commission's recommendation, the website is now currently in operation.[52]

The introduction of Support & Safety Hubs (Orange Doors)

49. A central feature of the State Government's response to the Royal Commission's recommendations is the introduction of the Orange Doors (also known as Support and Safety Hubs)[53] at locations across Victoria, a central point for the family violence response network which will:

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

b) 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;

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

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

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

f) book victims into emergency accommodation and facilitate their placement in crisis

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[50] Victoria, Royal Commission into Family Violence, Recommendation 10
[51] http://orangedoor.vic.gov.au
[52] http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=12>; *The Lookout* website can be found at http://www.thelookout.org.au
[53] Victoria, Royal Commission into Family Violence, Recommendation 37

accommodation;

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

h) offer a basis for co-location of other services likely to be required by victims and any children.[54]

50. The Orange Doors are also required to be safe and inclusive and be designed to meet the diverse needs of the community. Specific requirements for the Orange Door accessibility will be to:

(a) actively tailor their services to the needs of CALD communities in their Local Area – including through the use of interpreting services, safe meeting places, having workers in the Hubs from CALD communities and embedding appropriate cultural practices;[55] and

(b) have the capability to recognise and meet the specific needs of people with disabilities, LGBTI people, older people experiencing violence, and adolescents who use violence in the home.[56]

51. This Court is informed that the Department of Premier and Cabinet, along with Family Safety Victoria, is currently collaborating with partner agencies to design and implement the Orange Doors State-wide. Orange Doors currently operate in five areas across Victoria.[57] The Orange Door network will continue to expand and is forecast to be completed by 31 March 2021, by which time an additional three Orange Door sites will have been rolled out across Victoria.[58]

52. There are also a range of other websites which contain information and resources for third party supporters like friends and family to assist potential family violence victims. Some examples include:

- DVRCV: <https://www.dvrcv.org.au/help-advice/guide-for-families-friends-and-neighbours>
- Safe Steps: <https://www.safesteps.org.au/understanding-family-violence/information-for-family-friends/>
- 1800 respect: <https://www.1800respect.org.au/violence-and-abuse/domestic-and-family-violence/support>
- My Safety: <http://mysafety.org.au>

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[54] Victoria, Royal Commission into Family Violence, *Summary and Recommendations* (2016) 55
[55] Victorian Government, *Support and Safety Hubs: Statewide Concept 2017*, 19
[56] Ibid
[57] Bayside Peninsula, North Eastern Melbourne, Inner Gippsland, Barwon and Mallee
[58] Loddon, Central Highlands and Goulburn. Further information can be found online at: <http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=220>

- Burndawan: <http://burndawan.com.au>
- The Safe and Together Institute (US): <http://safeandtogetherinstitute.com/wp-content/uploads/2020/05/A4_AllyDoc_web.pdf

53. I am satisfied, having considered all available evidence, that no further investigation is required.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

54. 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.

55. In Mrs K's case, education and information via a website, such as the Orange Door website may have provided an initial avenue for family members and friends to assist her, while the Orange Doors may have provided an opportunity to report concerns and create more tangible opportunities for intervention and prevention. The challenge for informal supporters assisting persons affected by family violence is often knowing what information and services are available and how to access these supports.

56. I recommend that the Victorian Government and Family Safety Victoria develop a research-based strategy, in consultation with victim survivors, informal supporters and priority communities, to provide targeted information and services to informal supporters assisting persons affected by family violence.

FINDINGS AND CONCLUSION

57. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Mrs K, born 15 August 1939;

    b) the death occurred on 23 April 2017 at [redacted], Patterson Lakes, Victoria, from head and neck injuries; and

    c) the death occurred in the circumstances described above.

58. I convey my sincerest sympathy to Mrs K's family.

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

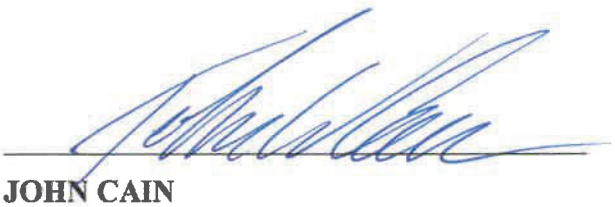
60. I direct that a copy of this finding be provided to the following:

a) Ms MA, senior next of kin;

b) Ms Annette Lancy, Acting Chief Executive Officer, Family Safety Victoria; and

c) Detective Senior Constable Vincent Schalken, Coroner's Investigator, Victoria Police.

Signature:



JOHN CAIN
STATE CORONER
Date: 10/11/2020