IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2423

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 A**[1]
Date of birth:	19 May 1956
Date of death:	23 May 2017
Cause of death:	I(a) Ligature neck compression in the setting of blunt force head trauma
Place of death:	[redacted], Sunshine West, Victoria
Catchwords:	Family violence, homicide, non-accidental injuries

Amended pursuant to s.76 of the Coroners Act 2008 (Vic) on 26 August 2021 by order of the State Coroner, Judge Cain. Various parts of the finding were amended to de-identify the names of the deceased and family members.

[1] The names of the deceased person and their family members have been redacted and replaced with pseudonyms of randomly generated two letter sequences to protect their identity.

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HIS HONOUR:

BACKGROUND

1. Mrs A was 61 years old at the time of her death. Mrs A was born in Bulgaria and met and married her husband, Mr B in Bulgaria around 1976.[2]

2. There are two children from the relationship, C and D, who were both born in Bulgaria and migrated with the family to Australia in 1989. When they first arrived in Australia they lived in Sunshine West.[3]

3. Around 1993-1994, Mrs A separated from and then divorced Mr B due to marital discord arising from an alleged affair Mr B had with another woman. Despite their divorce, they continued living together until the fatal incident.[4]

4. Mrs A was diagnosed with Leukaemia in 2014 and was in remission at the time of her death.[5]

5. Mr B worked in a textile factory throughout most of his life in Australia and ceased employment around 2009 due to a work injury sustained to his back. He received financial compensation for this injury and spent time abroad in countries such as Bulgaria, Turkey, Greece, Fiji, Bali and Thailand.[6] He was unemployed at the time of the fatal incident.

6. Both C and D reported that their father spent extended periods away from the family home and made numerous trips overseas, especially to Bulgaria and Turkey, without the family.[7] They also reported that he was very strict and controlling of the family as they grew up and in their adolescence.[8]

7. Both sons further reported that in the two years prior to their mother's death, the communication between their parents was poor and consisted mostly of arguments about financial issues. Mrs A had entrusted some of her money to her son as she "*didn't want [Mr B] to get his hands on it*".[9] In the weeks prior to the fatal incident, Ms and Mr B's nephew reported witnessing Mr B making threats to kill Mrs A during an argument.[10]

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[2] *Coronial Brief*, Statement of C dated 24 July 2017, 60-62
[3] Ibid
[4] Ibid, 63; *Coronial Brief*, Statement of D dated 11 July 2017, 73
[5] *Coronial Brief,* Statement of C dated 24 July 2017, 64
[6] *Coronial Brief,* Statement of C dated 24 July 2017, 62; Statement of D dated 11 July 2017, 76
[7] Ibid
[8] *Coronial Brief*. Statement of C dated 24 July 2017, 61-62; Statement of D dated 11 July 2017, 74
[9] Ibid, 75.
[10] *Coronial Brief*, Statement of D dated 24 May 2017, 100-101

THE PURPOSE OF A CORONIAL INVESTIGATION

8. Mrs A'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]

    (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

[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)

(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 23 May 2017, Mr E identified the body of the deceased as his aunty Mrs A born 19 May 1956.

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 May 2017, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Baber provided a written report dated 18 August 2017 and concluded that Mrs A died from ligature neck compression in the setting of blunt force head trauma.

20. Dr Baber commented on the following in her written report:

(a) There were multiple areas of blunt force trauma to the head resulting in soft tissue injury, occipital skull and cheekbone fractures. The patterned bruise to the left cheek with underlying cheekbone fracture is likely to have been inflicted by a heavy, straight edged weapon.

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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

(b) There was no evidence of intracranial haemorrhage. Therefore, it is likely that the head injuries resulted in concussive injury to the brain with ligature neck compression (strangulation) as the insult that lead to death.

(c) 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 Baber.

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

23. On 23 May 2017, at around 4.22pm, Mrs A spoke with her son C on the phone.[22] They discussed her health and her desire to travel overseas to her nephew's wedding in Turkey. The conversation was brief and lasted about 5-10 minutes.[23]

24. At a subsequent interview with police, Mr B indicated that he had a disagreement with Mrs A in the lead-up to the attack about his use of a heater. He claimed that she attacked him with the broken leg of a table, hitting him on the leg and the back. Mr B confirmed that he took a piece of wood from her and struck her repeatedly. He did not recall how many times he struck her but claimed that '*I must've lost myself*'.[24]

25. Mr B indicated that Mrs A fell onto the floor unconscious and then he used an extension lead to strangle her. When he believed her to be dead, he packed several items into a suitcase and left the premises, leaving Mrs A on the floor with the cord still wound tightly around her throat.[25]

26. At approximately 8.00 pm, Mr B attended 12 kilometres away in Plumpton at the home of his stepsister, Ms F. He was reported to have said, '*Look, I did something very bad. I kill your sister-in-law"*.[26] He claimed that Mrs A tried, "*to bash him with something, and then he bashed her"*.[27]

[22] Statement of C dated 24 July 2017, 64
[23] Ibid
[24] *Coronial Brief*, Exhibit 49 – Police record of interview transcript dated 27 May 2017, 369-379
[25] Ibid
[26] *Coronial Brief*, Statement of FA dated 24 May 2017, 84
[27] Ibid

27. Ms F told Mr B to go to the police and to take the suitcase with him. Mr B was reported to have said, "*after a couple of days I am going to go to the police*".[28] Mr B then left the house, leaving the suitcase with Ms F. The suitcase was later found to contain clothing and other items, including currency in various denominations.[29]

28. In the meantime, Ms F notified the police. They attended at the marital home address in Sunshine West to be greeted by the other son of Ms F, Mr G.[30] The police gained access to the house when Mr G smashed a glass sliding door. They observed Mrs A lying lifeless on the floor in the living room of the house with the table leg not far away.[31] She had a white extension cord wrapped tightly twice around her neck with a looped knot to the side. So tightly wound was the cord that a policeman was unable to cause any gap between the cord and the skin of Mrs A's neck.[32] The police removed the cord and attempted to resuscitate Mrs A without success. Ambulance officers attended and confirmed she was deceased.[33]

Criminal investigation

29. On 12 August 2019, in the Supreme Court of Victoria, Mr B was found guilty and convicted for the murder of Mrs A. He was sentenced to 25 years' imprisonment with a non-parole period of 20 years.[34]

[28] Ibid, 85
[29] *Coronial Brief*, Statement of Detective Leading Senior Constable Joseph Paul Strachan dated 31 August 2017, 214
[30] *Coronial Brief*, Statement of YY dated 24 May 2017, 91
[31] *Coronial Brief*, Statement of First Constable Alice Campbell dated 6 July 2017, 125
[32] Ibid, 126
[33] *Coronial Brief*, Statement of Robert Simpson dated 30 May 2017, 130
[34] *R* [redacted] [2019] VSC 530, 1

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 Mrs A and Mr B was one that fell within the definition of '*family member'*[35] under that Act. Mr B's act of fatally assaulting Mrs A constituted '*family violence'*.[36]

32. In light of Mrs A's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[37] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[38] 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 B and Mrs A.

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**)[39].

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.

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[35] Family Violence Protection Act 2008, section 8(1)(a)
[36] Family Violence Protection Act 2008, section 5(1)(a)(i)
[37] 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
[38] 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
[39] 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).

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.[40] 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.[41]

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 B. Specifically, he had previously threatened harm against Mrs A, was unemployed, exerted controlling behaviours and had a history of mental health issues with depression. Two of these risks (controlling behaviours and unemployment) indicated an increased risk of the victim being killed or almost killed.[42]

37. One relationship specific risk factor that is relevant to Mr B and Mrs A's relationship is financial difficulties. Statements from Mr B and Mrs A's children confirm that financial issues plagued their parent's relationship up until the fatal incident and Mr B was reported to have difficulties managing money and, on several occasions, asking his sons for money.[43]

38. In addition, Mr B and Mrs A were both unemployed.[44] The CRAF identifies that financial difficulties can result in financial stress which, in turn, can increase the risk of future or ongoing family violence.[45]

39. Mr B and Mrs A were also from a culturally and linguistically diverse background, being of Turkish descent and originally Bulgarian nationals. Mrs A potentially may have faced barriers in accessing services for support due to limited English and unfamiliarity with the family violence service system.[46]

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[40] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition.
[41] Ibid, 30.
[42] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition, 75
[43] *Coronial Brief*, Statement of D dated 11 July 2017, 73-80; Statement of C dated 24 July 2017, 64-68
[44] *Coronial Brief*, Statement of D dated 11 July 2017, 73; Statement of C dated 24 July 2017, 64
[45] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition.
[46] Ibid, 32-33

Mr B's mental health and GP treatment

40. In the proximate period leading to the fatal incident, Mr B was receiving treatment from a private psychologist who he was referred to by his General Practitioner (**GP**). Mr B previously saw a private psychologist between 2010 and 2011 for depression, insomnia, adjustment disorder and chronic sciatica arising from work related injuries suffered in 2009.[47]

41. Mr B's last psychologist saw him over 20 counselling sessions from 8 May 2015 until 26 April 2017.[48] The focus of the counselling was on issues of chronic pain arising from the 2009 workplace injury, marital discord and assistance with obtaining public housing accommodation.

42. Mr B is reported to have left the family home '*whenever he felt like there was going to be any aggravation*'[49] however, further information pertaining to the marital discord is not available and a statement from the relevant psychologist indicates that Mr B did not disclose any signs of violent behaviour. It is also noted that marital discord was reported in the treating psychologist's notes throughout the numerous sessions up until August 2016.[50]

43. This case illustrates that while there was no legal mandate to make further enquiries about Mr B's marital discord or gather further information to identify increasing family violence risk, the findings of the Royal Commission into Family Violence[51] (**the Royal Commission**) confirm that health professionals such as general practitioners; as well as specialist health services, such as mental health services, are in a unique position to identify family violence and to intervene early.[52]

44. The Royal Commission by way of recommendations 102 and 103, specifically address the training and workforce development needs of general practitioners and mental health professionals through a formalised family violence learning agenda and mandatory CPD training for GPs.[53]

45. The findings of the Royal Commission indicate that GPs, psychiatrists and psychologists are not expected to become family violence specialists, they are expected however, to be skilled

[47] *Coronial Brief*, Statement of John Karamanos dated 28 August 2017, 54
[48] *Coronial Brief*, Statement of RM dated 15 August 2017. 58
[49] *Coronial Brief*, Statement of RM dated 15 August 2017, 59.
[50] *Coronial Brief,* Appendix F – History of RM treatment of the accused, 239-241
[51] Victoria, Royal Commission into Family Violence, *Final Report* (2016) available at: http://www.rcfv.com.au/Report-Recommendations
[52] Victoria, Royal Commission into Family Violence, *Final Report* (2016), Volume 19, 1
[53] Ibid, 55

in understanding, recognising and responding to family violence.[54] Health and mental health professionals and those in private practice have opportunities to support victims of family violence and their children. Health professionals providing treatment to those who perpetrate family violence are also in a position to assess the risk they may pose to their familial members, hold the individual accountable for their behaviour and provide appropriate referral supports.[55]

46. To further education in the GP sector, the Royal Australian College of General Practitioners (**RACGP**) developed the white book, *Abuse and Violence*, currently in its fourth edition which provides health practitioners' with evidence-based guidance on appropriate identification and response in clinical practice to patients experiencing abuse and violence.[56]

47. The RACGP guidelines also recommend that providing a perpetrator with a referral is not the end of a GP's involvement. Supporting the perpetrator's change and monitoring the safety of the family is an important and ongoing task.[57]

48. If a GP is also seeing the victim and the perpetrator for medical care (not counselling), it is important to check with the victim as to how they perceive the perpetrator is progressing. It is evident from Mrs A's medical records that she was also a patient of the same medical practice and saw Mr B's GP from time to time.[58] RACGP's guidelines note that it is very important to do the best possible to ensure that the victim is receiving counselling and support from a specialist family violence service.[59]

Third party reporting of family violence

49. Mrs A'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

[54] Office of the Chief Psychiatrist (Victoria), *Commitment to a family violence learning agenda*, 2
[55] Ibid
[56] RACGP, *Abuse and Violence 4th Edition online*, available at: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book/dealing-with-perpetrators-in-clinical-practice
[57] Ibid
[58] Medicare records for FS received by the Court
[59] RACGP, *Abuse and Violence 4th Edition online*, available at: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book/dealing-with-perpetrators-in-clinical-practice

may increase the danger for the victim or themselves.

50. 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 reviewed the available resources for third parties.

51. 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.[60]

52. This Court is advised that the Victorian Government has selected the Orange Door[61] 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.[62]

The introduction of Support & Safety Hubs (Orange Doors)

53. 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)[63] 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;

[60] Victoria, Royal Commission into Family Violence, Recommendation 10
[61] http://orangedoor.vic.gov.au
[62] 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
[63] Victoria, Royal Commission into Family Violence, Recommendation 37

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 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.[64]

54. 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;[65] 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.[66]

55. 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.[67] 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.[68]

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[64] Victoria, Royal Commission into Family Violence, *Summary and Recommendations* (2016) 55
[65] Victorian Government, *Support and Safety Hubs: Statewide Concept 2017*, 19
[66] Ibid
[67] Bayside Peninsula, North Eastern Melbourne, Inner Gippsland, Barwon and Mallee
[68] 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>

56. 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>
- Burndawan: <http://burndawan.com.au>
- The Safe and Together Institute (US): <http://safeandtogetherinstitute.com/wp-content/uploads/2020/05/A4_AllyDoc_web.pdf

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

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

58. 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.

59. In Mrs A'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.

60. I recommend that the 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

61. 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 A, born 19 May 1956;

    b) the death occurred on 23 May 2017 at [redacted] Sunshine West, Victoria, from ligature neck compression in the setting of blunt force head trauma; and

    c) the death occurred in the circumstances described above.

62. I convey my sincerest sympathy to Mrs A's family.

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

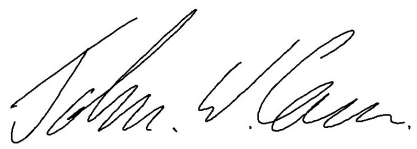
64. I direct that a copy of this finding be provided to the following:

    a) Mr C, senior next of kin;

    b) Ms Eleri Butler, Chief Executive Officer, Family Safety Victoria; and

    c) Sergeant Joseph Strachan, Coroner's Investigator, Victoria Police.

Signature:



JOHN CAIN
STATE CORONER
Date: 26 August 2021