IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 1876

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Judge John Cain, State Coroner
Deceased:	VT
Date of birth:	28 January 1941
Date of death:	26 April 2016
Cause of death:	1(a) Multiple injuries including stab wounds to the chest
Place of death:	42 London Street, Bentleigh, Victoria
Catchwords:	family violence homicide

INTRODUCTION

1. Mrs VT was 75 years old and living on her own in Bentleigh, Victoria at the time of her death. Mrs VT is survived by her three children, a son, ST, and her two daughters.

2. Mrs VT was born and raised in Greece where she also met her husband, GT. The couple immigrated to Australia in 1962 and got married in 1964.

3. Mrs VT had three children with her husband, MT, born in 1965, TT, born in 1968, and ST, born in 1971. The couple spent most of their time in Prahran until 1975 when they moved to the Bentleigh area.

4. Mrs VT worked in a factory until she retired in 1999 and her husband passed in May 2001. Mrs VT remained in the residence in Bentleigh until the fatal incident.

THE CORONIAL INVESTIGATION

5. Mrs VT's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mrs VT's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Mrs VT, including evidence contained in the coronial brief and further evidence obtained under my

direction. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities. [1]

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

Circumstances in which the death occurred

10. The available evidence indicates that in the weeks and months prior to the fatal incident, ST' friends and family observed a deterioration in his mental health.[2] ST reportedly made allegations that Mrs VT was using '*black magic*'[3] and had asked him for sexual favours. ST had also reportedly written nonsensical messages on the wall of his mother's garage and was observed talking to people who were not present.[4] ST also sent a series of incoherent text messages to his family and friends.[5]

11. Evidence from mobile telephone service data indicates that on the morning of 26 April 2016 at approximately 6.22am to 7.56am, ST attended Mrs VT's address.[6] Whilst there, ST fatally stabbed and assaulted Mrs VT before fleeing the scene and travelling west along McKinnon Road, near the intersection of Tucker Road, McKinnon.[7]

12. Mrs VT's morning routine was to visit her friend Anastasia Kasidiaris for coffee and then pick up her grandchildren from school.[8] When Mrs VT failed to pick up her grandchildren on 26 April 2016, Mrs VT's daughter, TT, tried to contact her without success. TT then attended Mrs VT's residence in Bentleigh around 4.00pm.[9]

13. TT entered the residence through the backdoor and discovered Mrs VT's body on the floor of her bedroom at the front of the house.[10] TT called emergency services who attended at

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[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.
[2] Coronial Brief, Statement of G Tsirmbas, 131; Coronial Brief, Statement of TT, 78; Coronial Brief, Statement of M Kominakis (2), 104; Coronial Brief, Statement of A Fitz, 167.
[3] Coronial Brief, Statement of TT, 78.
[4] Coronial Brief, Statement of G Tsirmbas, 131
[5] Coronial Brief, Appendix 3 – Cellbrite Mobile Phone Extraction Report, 311, 326-327.
[6] *Coronial Brief,* Optus phone records and location data dated 15 August 2016, 137
[7] *Coronial Brief,* Exhibits 47 and 48 - CCTV data
[8] *Coronial Brief*, Statement of Anastasia Kasidiaris dated 21 December 2016, 135
[9] *Coronial Brief*, Statement of Dimitra Kotsabouikis dated 26 April 2016, 77
[10] Ibid

approximately 4.03pm. The attending ambulance paramedics pronounced Mrs VT deceased on site and a police investigation was commenced.[11]

14. Police arrested ST on 27 April 2016 and he was charged with the murder of Mrs VT.[12]

15. On 20 November 2018 in the Supreme Court of Victoria, ST was found not guilty by reasons of mental impairment and was sentenced to a custodial supervision order for a nominal period of 25 years.[13]

Identity of the deceased

16. Upon reviewing the available evidence, Coroner Audrey Jamieson completed a Form 8 *Determination by Coroner of Identity of Deceased* dated 28 April 2016, concluding that the identity of the deceased was VT born 28 January 1941.

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

Medical cause of death

18. Forensic Pathologist Dr Stephen Cordner from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 27 April 2016 and provided a written report of his findings dated 20 July 2016.

19. Dr Cordner noted the following:

    (a) Mrs VT had sustained numerous injuries including 12 stab wounds to her back, five to her left shoulder and upper arm, at least seven incised type wounds to the top and back of her head and at least seven blunt impacts to her left forearm;

    (b) The stab wounds to the chest have caused injuries to the lungs and the aorta in the heart. These injuries were not survivable. There was not large amount of blood within the chest but some blood may have escaped through the numerous chest wall defects;

    (c) There was extensive bruising of both arms with superficial lacerations to the left forearm. These blunt force injuries are compatible with something like a rolling pin being used. The

[11] *Coronial Brief,* Statement of Constable Michelle Krause dated 17 May 2016, 177-178
[12] *Coronial Brief,* Statement of Senior Constable Rachel Frost dated 24 May 2016, 190
[13] The Queen v ST SCR 2017 0006

extent of the bruising and injury location suggests that these occurred during attempts at self-defence; and

(d) The existence of a pre-existing medical condition being heart disease means that Mrs VT may have died earlier in the assault than a person without such heart disease.

20. Toxicological analysis of post-mortem blood samples did not identify the presence of any alcohol or common drugs or poisons.

21. Dr Cordner provided an opinion that the medical cause of death was '1(a) Multiple injuries including stab wounds to the chest'.

22. I accept Dr Cordner's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

23. As Mrs VT's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**) [14] examine the circumstances of Mrs VT's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[15]

24. Mrs VT's relationship with ST met the definition of '*family member'* under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).[16] The family violence perpetrated by ST towards Mrs VT during the fatal incident, specifically fatally assaulting her, met the definition of '*family violence'* in the FVPA.

25. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with Mrs VT and ST prior to Mrs VT's death.

[14] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[15] 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.

[16] Section 8(1)(d) of the *Family Violence Protection Act 2008*

26. The available evidence suggests that Mrs VT and ST' relationship was tumultuous and characterised by numerous family violence incidents primarily perpetrated by ST. Importantly none of the significant threats of family violence were reported to Victoria Police or treatment providers engaged to assist ST in the lead up to the fatal incident.

History of ST' mental health and family violence against Mrs VT

27. ST first began using cannabis as a teenager and this continued until the time of the fatal incident. Between approximately 1990 and 1992, ST became unwell with depression and his mental health was observed to deteriorate over the proceeding years.[17]

28. In approximately 1996, ST was diagnosed with schizophrenia and schizoaffective disorder, characterized by persecutory beliefs regarding his family with high levels of distress and agitation.[18] Between 1997 and 2012 ST was hospitalized 24 times due to his mental health.[19] Records obtained from Monash Health indicate that ST did not believe that he suffered from a mental illness, had a history of aggression towards his mother when he was unwell, had a conflictual relationship with his mother, and frequently appealed his involuntary patient status.[20]

29. On 6 January 2007, Victoria Police were contacted by Mrs VT who alleged that ST had become verbally abusive towards her. At the time, ST was living in the garage of his mother's property.[21] During attendance, police noted that ST had 'chronic psych issues' and referred both parties to support services, encouraging them to also contact ST' mental health case manager.[22]

30. On 8 July 2012, ST attended Mrs VT's home to collect a cheque from the State Trustees Fund.[23] Mrs VT hesitated in providing the money to ST, noting that he already owed her money. ST became aggressive and reportedly hit Mrs VT in the head with a shoe, causing Mrs VT to flee the property in fear.[24] On 9 July 2012, ST contacted Mrs VT by phone and made threats to kill her.[25] Mrs VT remained afraid to return to her home and contacted police, noting that ST often became aggressive and violent when he had not taken his medication.[26]

[17] Ibid, 102.
[18] St Kilda South Medical Clinic, Medical Records of ST, 70.
[19] Ibid.
[20] Monash Health, Medical Records of ST.
[21] Victoria Police, LEAP records of ST, 4.
[22] Victoria Police, LEAP records of ST, 4.
[23] Victoria Police, LEAP records of ST, 6-7.
[24] Ibid.
[25] Ibid.
[26] Ibid.

31. ST was subsequently conveyed by police to Monash Health under section 10 of the *Mental Health Act 2014* (Vic), however, Mrs VT did not wish to proceed with any criminal charges against him.[27] A 12-month Family Violence Intervention Order (FVIO) was issued on 13 August 2012 in protection of Mrs VT with conditions that ST must not commit family violence, must not damage property and must only attend Mrs VT's address upon invitation.[28]

32. On 13 September 2014, Mrs VT contacted Victoria Police alleging that her son was being verbally aggressive towards her. Mrs VT informed police that she did not believe her son was taking his medication and that this had increased his '*anger/temperament'*. Following their attendance Victoria Police appear to have checked ST' history and noted that he had a history of being clinically assessed. They appear to have taken no further action.[29]

33. On 12 January 2016, Mrs VT believed that ST stole her purse containing $1500. This incident was reported to police however, Mrs VT did not disclose that ST had been present prior to the money being taken.[30]

34. In the weeks and months prior to the fatal incident, friends and family observed a deterioration in ST' mental health.[31] ST reportedly made allegations that Mrs VT was using 'black magic'[32] and had asked him for sexual favours. ST had also reportedly written nonsensical messages on the wall of his mother's garage and was observed talking to people who were not present.[33] ST also sent a series of incoherent text messages to his family and friends.[34]

35. Whilst ST resided separately from his mother, he would occasionally stay in Mrs VT's garage.[35] Neighbours reported to police that ST and Mrs VT were regularly heard arguing.[36] An immediate neighbour of Mrs VT alleged that ST was often abusive towards Mrs VT and made repeated threats to '*kill'* her during an argument approximately one to two weeks prior to the fatal incident.[37]

36. Ms Amanda Fitz, an acquaintance of ST, stated that ST had told her that he wanted to kill Mrs VT, that he was unable to stop thinking about it and that 'he may not be able to prevent himself

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[27] Ibid.
[28] Ibid; Email from Sergeant Anthony Hupfeld dated 9 July 2021.
[29] Ibid, 9.
[30] Coronial Brief, Summary of Facts, 9; Victoria Police, LEAP Records of ST, 25-31.
[31] Coronial Brief, Statement of G Tsirmbas, 131; Coronial Brief, Statement of TT, 78; Coronial Brief, Statement of M Kominakis (2), 104; Coronial Brief, Statement of A Fitz, 167.
[32] Coronial Brief, Statement of TT, 78.
[33] Coronial Brief, Statement of G Tsirmbas, 131
[34] Coronial Brief, Appendix 3 – Cellbrite Mobile Phone Extraction Report, 311, 326-327.
[35] Coronial Brief, Statement of G Tsirmbas, 123.
[36] Coronial Brief, Statement of A Kumar, 111; Coronial Brief, Lauren Factor, 115; Coronial Brief, Statement of R Kurzel, 121.
[37] Coronial Brief, Statement of R Kurzel, 121.

from carrying out the idea'.[38] ST repeated these threats to several acquaintances in the years prior to Mrs VT's death.[39]

37. In the lead up to the fatal incident, ST was being treated by a General Practitioner (GP) until 2 April 2016 and a private psychologist until 4 January 2016. During his appointments with both his GP and private psychologist, he did not disclose any family violence between himself and his mother. Given that ST does not appear to have presented with any escalation of delusional thinking during his appointments with his private psychologist or his GP, and that he did not make any disclosures that indicated he may be a risk to himself or others, there was no missed opportunity for these services to have intervened in the circumstances of this case.

COMMENTS

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

Third party reporting of family violence

38. Mrs VT's death, and deaths similar to hers[40], 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.

39. 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[41] reviewed the available resources for third parties.

40. 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.[42]

[38] Coronial Brief, Statement of A Fitz, 167.
[39] Coronial Brief, Statement of TT, 87.
[40] COR 2017 2423 and COR 2017 1889
[41] Victoria, Royal Commission into Family Violence Final Report (March 2016).
[42] Victoria, Royal Commission into Family Violence, Recommendation 10

41. This Court is advised that the Victorian Government has selected the Orange Door[43] 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.[44]

The introduction of Support & Safety Hubs (Orange Doors)

42. 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)[45] 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 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.[46]

[43] http://orangedoor.vic.gov.au
[44] 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
[45] Victoria, Royal Commission into Family Violence, Recommendation 37
[46] Victoria, Royal Commission into Family Violence, *Summary and Recommendations* (2016) 55

43. In Mrs VT'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.

44. The Orange Doors are 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:

(1) 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;[47] and

(2) 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.[48]

45. 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.[49] 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.[50]

46. 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>

[47] Victorian Government, *Support and Safety Hubs: Statewide Concept 2017*, 19
[48] Ibid
[49] Bayside Peninsula, North Eastern Melbourne, Inner Gippsland, Barwon and Mallee
[50] 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>

- 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

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

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

48. 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.

49. 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

50. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:

    (a) the identity of the deceased was VT, born 28 January 1941;

    (b) the death occurred on 26 April 2016 at 42 London Street, Bentleigh, Victoria from 1(a) Multiple injuries including stab wounds to the chest; and

    (c) the death occurred in the circumstances described above.

51. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.

52. I convey my sincere condolences to Mrs VT's family for their loss.

53. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ms TT, Senior Next of Kin

Ms Genevieve Thornton, Acting Director, Family Violence Reform, Department of Fairness, Families and Housing

Ms Eleri Butler, CEO, Family Safety Victoria

Detective Sergeant Tony Hupfield, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 3 August 2021

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 investigation. 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.