IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6328

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Darren J. Bracken, Coroner
Deceased:	PFS[1]
Date of birth:	1967
Date of death:	17 December 2017
Cause of death:	1(a) Hanging
Place of death:	A residential address near Bendigo, Victoria

[1] The name of the deceased has been replaced by a randomly generated sequence of letters so that she cannot be identified. Other information that may tend to identify her has been omitted.

INTRODUCTION

1. PFS was 50 years old when she was found deceased in the home that she shared with her partner CAL[2] near Bendigo, Victoria, on 17 December 2017.

2. PFS is survived by her children and at the time of her death was working as a carer in Bendigo.

THE CORONIAL INVESTIGATION

3. PFS' 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.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the deceased's identity, the 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.

5. 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.

6. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of PFS' 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.

7. This finding draws on the totality of the coronial investigation into the death of PFS, including evidence contained in the coronial brief. 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. [3]

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[2] The name of the deceased's partner has been replaced by a randomly generated sequence of letters so that he cannot be identified.

[3] 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.

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

Circumstances in which the death occurred

8. On the evening of 16 December 2017, PFS was reported to have been at home with CAL having a few drinks after working on the garden earlier in the day. On the same evening, nearby neighbours reported that they heard yelling around 11pm for a short period of time.[4]

9. At approximately 11:45pm, CAL went outside the residence to the front yard to look for PFS and found her hanging from a nearby tree branch.[5] CAL reportedly moved PFS' body to the ground before contacting emergency services.

10. At approximately 12.24am on 17 December 2017, ambulance paramedics and police members attended PFS' residence and she was pronounced deceased at the scene.[6]

Identity of the deceased

11. On 17 December 2017, CAL identified the deceased as PFS, born on a particular date in 1967, his partner.

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

Medical cause of death

13. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on PFS' body 18 December 2017 and provided a written report of his findings dated 18 January 2018.

14. The autopsy revealed an abraded injury and furrow to the neck in keeping with a hanging. No unusual injuries were seen on external or internal examination and there was no evidence of any other significant injury.

15. Toxicological analysis of post-mortem samples identified the presence of alcohol at a concentration level of 0.20 g/100mL, cannabis and therapeutic concentration levels of sertraline[7] at 0.1 mg/L.

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[4] *Coronial Brief*, Statement of neighbour dated 17 December 2017, 8.
[5] *Coronial Brief,* Record of interview with CAL.
[6] *Coronial Brief*, Statement of Detective Sergeant Stephen Sheahan dated 3 March 2018, 28-30.
[7] Sertraline is an anti-depressant drug for use in cases of major depression.

16. Dr Burke provided an opinion that the medical cause of death was '1(a) Hanging'.

17. I accept Dr Burke's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

18. As PFS' death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**) [8] examine the circumstances of the death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[9]

19. PFS' relationship with CAL met the definition of them being '*partners'* under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).[10]

20. An in-depth family violence investigation was conducted in this case, and I requested materials from several key service providers that had contact with PFS and CAL prior to her death.

History of family violence between CAL and PFS

21. PFS met CAL in approximately 2009 and they commenced an intimate relationship thereafter.[11] The available evidence suggests that CAL perpetrated family violence against PFS during their relationship.[12]

22. In the eighteen months prior to PFS' death, Victoria Police attended five incidents of reported family violence between CAL and PFS.[13]

23. On 23 June 2016, was one such incident and police attended.[14] Notes from this attendance suggest that PFS and CAL had begun arguing and that this had escalated to a physical

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[8] 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.

[9] 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.

[10] Section 8(1)(a) of the *Family Violence Protection Act 2008*

[11] *Coronial Brief*, Statement of CAL, 21.

[12] Victoria Police, Law Enforcement Assistance Program (LEAP) Records; Bendigo Magistrates Court of Victoria, Family Violence Intervention Order and related documentation.

[13] Victoria Police, Law Enforcement Assistance Program (LEAP) Records; Bendigo Magistrates Court of Victoria, Family Violence Intervention Order and related documentation; *Coronial Brief*, Statement of Senior Constable TM, 18-19; Victoria Police, Statement of First Constable JA.

[14] Victoria Police, LEAP Records, 1-6.

altercation, whereby CAL and PFS pushed each other.[15] Notes indicate that CAL pushed PFS to the face, causing her to fall backwards. A family member, present at the time, contacted Victoria Police in relation to this incident and advised that they were fearful for PFS' safety.[16] Property was also observed to have been damaged during the incident, however, attending police were unable to ascertain who had caused the damage.[17] PFS informed police that the physical violence was ongoing and attending members issued a Family Violence Safety Notice (**FVSN**) to protect her.[18]

24. On 24 June 2016, a twelve-month Family Violence Intervention Order (**FVIO**) was granted by the Magistrates' Court with conditions that CAL not perpetrate further family violence against PFS or damage her property.[19] The FVIO did not exclude CAL from continuing to live and communicate with PFS.

25. On 21 December 2016, PFS began attending counselling sessions to address her relationship and workplace issues. This counselling was part of an Employee Assistance Program provided by her employer and she spoke to a counsellor who was also a social worker.[20]

26. During their first session, the social worker/counsellor, identified that PFS' relationship with CAL was contributing to her mental distress but that she felt safe.[21] In response, the counsellor recommended that PFS invite CAL to attend relationship counselling, an invitation which he ultimately declined.[22]

27. PFS continued to discuss her relationship issues throughout her engagement with her counsellor and on 24 January 2017, she advised that CAL had physically assaulted her and that a FVIO had been issued.[23]

28. On 5 March 2017, PFS contacted police in relation to a second incident of family violence between herself and CAL.[24] Upon police attendance, PFS reported that CAL had verbally abused her and threatened her with a barstool.[25] PFS also notified attending police of several

[15] Ibid 5-6.
[16] Ibid.
[17] Ibid.
[18] Ibid, 6; Bendigo Magistrates Court of Victoria, Family Violence Intervention Order and related documents.
[19] Ibid.
[20] *Coronial Brief*, Statement PFS' counsellor/social worker, 37; Case notes provided to the Court by PFS' counsellor/social worker, 2.
[21] Case notes provided to the Court by PFS' counsellor/social worker, 1.
[22] *Coronial Brief*, Statement of PFS' counsellor/social worker, 37.
[23] Case notes provided to the Court by PFS' counsellor/social worker, 4.
[24] Victoria Police, Law Enforcement Assistance Program (LEAP) Records, 8-10.
[25] Ibid.

other incidents that had occurred but had not been reported to police.[26] The FVIO was still in force at the time of this incident[27] and attending police applied to extend the FVIO for a further twelve months and include a condition preventing CAL from living or communicating with PFS (an exclusion condition).[28] Attending police also charged CAL with contravening a FVIO and unlawful assault, offences for which he was subsequently sentenced to a 12-month Community Corrections Order.[29]

29. The police application to vary and extend the existing FVIO resulted in a 12-month extension of the FVIO, however the exclusion condition was not included in the order.[30] It is noted that in incidents where Affected Family Members are unsupportive of a FVIO or an exclusion condition, an exclusion condition may not be made.[31]

30. On 13 April 2017, Victoria Police responded to a further incident of family violence between CAL and PFS. Victoria Police LEAP[32] records suggest that CAL and PFS were both intoxicated on this occasion[33] and that both parties reported that a verbal argument had taken place. CAL and PFS did not disclose any physical or verbal violence on this occasion[34] and offers by attending members to refer the parties to support services were declined.[35]

31. Later the same day, CAL contacted police citing concerns for PFS' welfare. Upon attendance, PFS was located walking down the street alone.[36] PFS advised attending members that she had argued with CAL about his 'jealousy while they were both drinking'.[37] PFS advised that she was planning to end the relationship and declined to provide further information regarding the incident. Police suggested that PFS vary the current FVIO to include an exclusion condition and offered to refer her to a support service; offers that she declined.[38] Attending police identified that this was the third incident of family violence reported to police in the then previous 12 months and contacted the Family Violence Unit.

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[26] Ibid.
[27] Bendigo Magistrates Court of Victoria, Family Violence Intervention Order, 24 June 2016.
[28] Ibid.
[29] Victoria Police, Law Enforcement Assistance Program (LEAP) Records, 16.
[30] Ibid, 10.
[31] *Family Violence Protection Act 2008* (Vic) s 75.
[32] The Law Enforcement Assistance Program (LEAP) is an electronic database that is fully relational and stores information about all crimes bought to the notice of police as well as family violence incidents and missing persons. It also includes details on locations and persons involved.
[33] Victoria Police, Law Enforcement Assistance Program (LEAP) Records, 11.
[34] Ibid.
[35] Ibid.
[36] Ibid.
[37] Victoria Police, Law Enforcement Assistance Program (LEAP) Records, 18.
[38] Ibid.

32. On 15 July 2017, PFS presented to Bendigo Health Emergency Department in a '*distressed and overwhelmed state'*.[39] PFS was described as suffering from depressive symptoms and experiencing suicidal ideation at the time of her presentation. PFS was placed on new medication and referred to the short-term treatment team '*for ongoing treatment and support'*.[40]

33. PFS was subject to a psychological review with the Bendigo Health Short Term Treatment Team on 17 July 2017, which was forwarded to her treating GP at Strathfieldsaye Primary Health (**SPH**).[41] This document notes that PFS believed that her relationship with CAL was '*unsavable'*[42], but that she still loved him. The review also noted that PFS' main concern was her relationship with CAL and that she was '*amenable to couples counselling'*.[43] No history of family violence was recorded during this review and PFS was diagnosed with major depression and having a low risk of suicide.[44]

34. On 28 July 2017, SPH created a mental health plan for PFS.[45] The case notes from this attendance recorded that PFS was 'living with partner who has issues of his own…feeling trapped and would like to escape and talk to no-one.'[46]

35. On 14 December 2017, Victoria Police attended another incident of family violence between PFS and CAL. This incident was reported by PFS' neighbour, who described hearing loud arguing, verbal abuse and a woman who had possibly been assaulted threatening suicide.[47] Upon arrival, police members found PFS at the entrance to the property; she was teary and distressed.[48] Upon inquiry, PFS informed police that she was doing '*okay'* and was not suicidal.[49] PFS also purportedly informed police that she had been drinking all night with CAL who was now asleep.[50] PFS declined offers for referrals or further assistance and said she '*had been around a long time, involved with mental health network and that they haven't helped her ever'*.[51] PFS further advised that she was waiting for a friend to retrieve her[52].

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[39] Bendigo Health, Emergency Department Record of PFS, 1.
[40] Ibid, 1-2.
[41] Bendigo Health, Letter from Bendigo Health to Strathfieldsaye Primary Health, 1.
[42] Ibid.
[43] Ibid.
[44] Ibid, 1-2.
[45] Strathfieldsaye Primary Health, Medical Record of PFS, 2.
[46] Ibid, 19-20.
[47] *Coronial Brief*, Statement of Senior Constable TM, 18-19; Victoria Police, Statement of First Constable JA, 2.
[48] Ibid.
[49] *Coronial Brief*, Statement of Senior Constable TM, 18.
[50] *Coronial Brief*, Statement of Senior Constable TM, 18-19; Victoria Police, Statement of First Constable JA, 2.
[51] Victoria Police, Statement of First Constable JA, 2.
[52] Ibid.

Review of Victoria Police service contact

36. PFS did not disclose any experience of family violence during police attendance on 13 April 2017 or 14 December 2017. These incidents were reported as verbal incidents only. During their attendance, police took steps to speak to both parties individually, as per the requirements of the *Code of Practice for the Investigation of Family Violence* (Code of Practice). Parties were also offered referrals to support services and police provided the option to vary the existing FVIO to provide PFS with more protection.

37. The CPU Family Violence Team note however, that attending members failed to complete a VP Form L17 (or family violence report) following these incidents which would have facilitated a referral to support services.

38. The Code of Practice in place at the time of this incident states that '*before leaving the scene, police must conduct a family violence risk assessment [VP Form L17]to ensure that all issues have been considered in relation to the safety and welfare of all persons'*[53] The completion of the VP Form L17 requires police to consider historical incidents of family violence, the victim's level of fear and a family violence risk assessment. Upon completion of this form, police are required to utilise the Options Model, in tandem with the completed VP Form L17 to determine what course of action is required.[54]

39. The available evidence suggests that a VP From L17 should have been completed in response to the reports of family violence on the 14 April 2017 and 14 December 2017.

40. Had a VP Form L17 been completed on these occasions, police may have gained greater insight into the level of risk posed to PFS, which, in turn, may have prompted them to take further action to support her safety and could have resulted in formal referrals being made to support services for PFS and CAL. Had this occurred, CAL may have been linked in with a Men's Behaviour Change Program, which, if completed may have assisted in addressing the relationship issues experienced by the couple.

41. PFS may have also been given a further opportunity to engage with support, however, given her reluctance to access services on both 14 April 2017 and 14 December 2017, this may have been an unlikely outcome.

[53] Victoria Police, *Code of Practice for the Investigation of Family Violence*, Version 3 (2017), 21.
[54] Victoria Police, *Code of Practice for the Investigation of Family Violence*, Version 3 (2017).

Review of mental health service contact

42. PFS was engaged in counselling as part of an Employee Assistance Program (EAP) offered by her employer.[55] Records provided by PFS' employer indicate that she accessed the EAP due to personal issues and had displayed an observable level of stress whilst at work.[56]

43. During her first appointment with her assigned counsellor/social worker, PFS advised of issues in her relationship with CAL and reported that he '*just wants to change me'*.[57] In response to these issues, the treating practitioner suggested that CAL attend the following session so that they may engage in relationship counselling. CAL ultimately declined to participate, and PFS informed her treating practitioner that the relationship had '*further deteriorated'*.[58] PFS also notified her treating practitioner that a FVIO had been issued following an incident of violence in which CAL had assaulted her.[59] There does not appear to be any further exploration or assessment of this disclosure in the notes pertaining to this or subsequent counselling sessions attended by PFS.

44. In subsequent discussions, PFS disclosed that she had previously been a victim of family violence and was noted as having ongoing relationship difficulties and low self-esteem and confidence issues. PFS also made several further references to controlling behaviours exhibited by CAL and advised that she believed that CAL was controlling.[60]

45. At the final appointment on 21 December 2017, PFS continued to recount issues with her relationship with CAL and relationship counselling was offered[61] again by the treating practitioner, '*as a means of addressing certain tensions that lie within the union of this couple'*.[62]

46. Whilst certain '*tensions'* in the relationship between CAL and PFS were recounted during PFS' counselling sessions, it was inappropriate for the counsellor to suggest relationship counselling given the disclosure of family violence and controlling behaviours. Family violence specialists generally do not recommend relationship counselling for people who are experiencing family

[55] *Coronial Brief*, Statement of PFS' counsellor/social worker, 37.
[56] PFS' Employer, 'PFS' (Employment Record, No 1, 20 December 2017), 167; Statement of L Winning, 31.
[57] Case notes provided to the Court by PFS' counsellor/social worker, 1.
[58] Case notes provided to the Court by PFS' counsellor/social worker.
[59] Ibid, 2.
[60] Case notes provided to the Court by PFS' counsellor/social worker, 2.
[61] Ibid, 13.
[62] Ibid, 13.

violence.[63] This is because, at its core, relationship counselling aims to provide parties with a therapeutic space to address relationship issues and operates on the premise that there is an equal balance of power between the parties involved. Family violence, however, is characterised by the use of power and control by one family member over another family member. The resulting imbalance of power renders relationship counselling unsuitable and unsafe for victims of family violence.

47. The Department of Health practice guidelines for family violence counselling[64] indicate that joint counselling can be utilised in some contexts but only based on zero tolerance for violence and a commitment to safety, accountability, equity and requires a distinction between the crime of violence and any notion of 'relationship issues'.

48. The available evidence suggests that PFS' counsellor did not appropriately address her disclosure of family violence during the counselling sessions. Despite several risk factors being present indicating that PFS was at risk of experiencing ongoing family violence and had disclosed CAL's use of physical violence, the counsellor diverted attention to mending the relationship and exploring PFS' other complaints. Whilst the counsellor did provide a referral to the Centre for Non Violence, there was adequate information available to the counsellor to consider the risks posed to PFS and a missed opportunity to provide her with direct support to manage the family violence she was experiencing.[65]

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was PFS, born in 1967;

    (b) the death occurred on 17 December 2017 at a residential address near Bendigo, Victoria from I(a) Hanging; and

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

[63] See https://probonoaustralia.com.au/news/2019/05/equal-blame-the-dangers-of-couples-counselling-in-a-domestic-violence-situation/ and https://www.womenssafetynsw.org.au/impact/campaigns/stop-endangering-domestic-violence-victims-through-couples-counselling/

[64] Grealy, C., Humphreys, C., Milward, K., and Power, J. (2008) Urbis, Practice guidelines: women and children's family violence counselling and support program, Department of Human Services, Victoria, 5, available online at: https://www.dhhs.vic.gov.au/sites/default/files/documents/201706/practice-guidelines-women-and-children-fv-counsell-support.pdf

[65] Letter provided to the Court by PFS' counsellor/social worker dated 28 February 2020, 1-2

50. I am satisfied that PFS intentionally took her own life.

COMMENTS

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

Victoria Police

51. Since PFS' death, there has been a significant number of reforms in Victoria Police policies and procedures as they relate to investigating family violence. The current policies indicate that Family Violence Liaison Officers are responsible for providing quality assurance by monitoring and reviewing VP Form L17 reports completed by police members attending to family violence incidents and for reporting on VP Form L17 compliance rates to ensure that L17s are completed correctly. Family Violence Training Officers (Senior Sergeants located within each Division across the state) are also required to assist their respective Family Violence Investigation Units in addressing inadequate Family Violence Reports (L17)[66] submitted by frontline or other areas. This includes incorrect scoring, poor narratives, override issues, as well as poor or inadequate response to the incident. Family Violence Training Officers also address any identified deficiencies in L17 reports completed with the responsible police member involved and coach/mentor them to ensure future compliance with policy and procedure. It is hoped that these changes will assist in ensuring that attending police officer's complete VP Form L17s so as to accurately reflect the level of risk of family violence.

Social workers and counsellors

52. In Australia, counsellors and social workers are self-regulated and registration with a professional body similar to the Australian Association of Social Workers (**AASW)** is voluntary. As such, the requirements to hold oneself out as and to practice as a counsellor or social worker are unregulated. In 2014 the AASW estimated that there are approximately 26,000 social workers in Australia, only 8,000 of whom had chosen to be members of the AASW and so subject to regulation by the organisation.[67] As part of their core work, the AASW has been vocal in advocating for the inclusion of social workers under the National Registration and Accreditation Scheme for health professionals.[68]

[66] Victoria Police introduced changes to the L17 on 22 July 2019 to rename them L17 (Family Violence Reports). The reports include additional risk assessments based on the MARAM risk framework that was developed after recommendations made by the 2016 Royal Commission into Family Violence report.
[67] Australian Association of Social Workers, *AASW Submission to the Review of the National Registration and Accreditation Scheme for health professionals*, (2014), 3.
[68] Ibid.

53. Counsellors and social workers are often employed to work with vulnerable communities. The lack of accountability in this work raises concerning implications for their clients. In 2016, the AASW commented on the benefits of registration for social workers in Australia. In their submission to the Council of Australian Governments (**COAG**), the AASW noted among other things, that national registration and accreditation of social workers would, assist in defining and protecting professional educational and practice standards; defining safe and competent scopes of practice for social works; requiring mandatory hours of annual continuing professional development in order to ensure skills and knowledge remain up to date.[69]

54. One of the key benefits of registration and accreditation is an ongoing obligation to maintain and update their knowledge in their field of practice. Without these obligations social workers and counsellors are not currently required to undertake professional development or engage in education outside of the requirements placed on them by their employers resulting in social workers and counsellors being at risk of not being aware of innovations in their respective fields of work to the detriment of their clients.

55. This is especially true in the context of family violence, where the sector has recently seen the introduction of an array of new information regarding best practice and practice standards for workers engaging with victims and perpetrators of family violence. In light of these reforms, the Victorian Government has stated the importance of ensuring that those who engage with victims and perpetrators of family violence are resourced to provide appropriate responses.[70]

56. The COAG met in 2016 to discuss the proposal to include social work in the National Registration and Accreditation Scheme. After considering further advice, COAG decided not to include social work in the National Scheme.[71]

[69] Australian Association of Social Workers, *Additional rationale for the registration of social workers,* (2016), 5.
[70] Family Safety Victoria, *Responding to Family Violence Capability Framework* (December 2017), available online at: https://www.vic.gov.au/sites/default/files/2019-05/Responding-to-family-violence-capability-framework_0.pdf
[71] Australian Association of Social Workers, *Latest Campaign Actions- Registration of Social Work*, < https://www.aasw.asn.au/social-policy-advocacy/latest-campaign-actions>.

57. I further note that South Australia has enacted the *Social Workers Registration Act 2021* (SA) recently to address the need for standards of professional practice. The CEO of Australian Association of Social Workers confirmed that:

> *"This legislation is all about public protection and professional accountability. Social workers need to be held to the same high standards as other health practitioners. Nothing is more important than the safety of children and the protection of vulnerable people."*[72]

58. The need for oversight demonstrated by PFS' social worker/counsellor in promoting the use of relationships counselling despite the presence of family violence, evidences the need for regulation of counsellors and social workers in Australia. Counsellors and social workers often treat the most vulnerable members of the community and there is considerable merit in regulating them based on national standards of practice.

RECOMMENDATIONS

59. Pursuant to section 72(2) of the Act, I make the following recommendations to:

That the Australian Government consider making counsellors and social workers subject to the National Registration and Accreditation Scheme so that their practices are regulated and underpinned by standards, guidelines and an educational framework facilitating family violence best practice, as it develops over time.

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.

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

CAL, Senior Next of Kin

Unit Manager, Civil Litigation Unit, Victoria Police

The Honourable Scott Morrison MP, Chair, Council of Australian Governments

[72] Australian Association of Social Workers, *South Australian social workers the first state in Australia to be registered*, available online at: https://www.aasw.asn.au/news-media/2021/south-australian-social-workers-the-first-in-australia-to-be-registered

Ms Gill Callister PSM, Chair, Australian Health Practitioner Regulation Agency

Detective Senior Constable Jessie Uren, Coroner's Investigator

Signature:

Darren Bracken

CORONER

Date: 10 March 2022

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.