



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002055

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of: Judge Liberty Sanger, State Coroner

Deceased: FSZ

Date of birth: [REDACTED]

Date of death: 24 April 2019

Cause of death: 1(a) Compression of the neck

Place of death: [REDACTED]

Keywords: Family violence; intimate partner violence;
intimate partner homicide; culturally and
linguistically diverse victim

INTRODUCTION

1. On 24 April 2019, FZS was 32 years old when she died from injuries inflicted by her partner, NLU. At the time of her death, FSZ lived in a metropolitan area of Melbourne, Victoria, with her cousin.
2. FSZ was born and lived in an overseas country until the age of 15, when she moved to Australia. FSZ's mother died when she was about 11 years old and her father remained overseas after she left. When she moved to Australia, FSZ lived with her siblings and extended family. She was unemployed at the time of the fatal incident; however, she had commenced an application to work as a ticket inspector. She also had plans to travel to Brisbane.
3. NLU was born in Victoria and lived outside of the Melbourne area. He lived with his mother until January 2019, when he was admitted as a voluntary mental health patient at Latrobe Regional Hospital (**LRH**). After his admission, NLU was homeless and was temporarily staying at the Space Hotel on Russell Street, Melbourne. NLU had a strong family history of mental health disorders, and he had an extensive mental health history. He received numerous diagnoses over several years prior to the fatal incident. This included:
 - a) 2013 – type 2 bipolar disorder
 - b) 2014 – significant personality pathology and depression (differential diagnosis psychotic disorder)
 - c) 2014 – first episode psychosis with cannabis dependence (differential diagnosis schizophrenia, drug-induced psychosis)
 - d) 2015 – attention deficit hyperactivity disorder; multiple reports of paranoid ideation
 - e) 2016 – substance abuse, cluster B personality traits
 - f) 2016 – chronic schizophrenia complicated by drug and alcohol use
 - g) 2016 – substance use disorder (alcohol, cannabis, and methamphetamine), antisocial personality traits
 - h) 2016 – situational stress and substance misuse in the context of personality factors
 - i) 2017 – schizophrenia

4. FSZ commenced a relationship with NLU in August 2018, after meeting while FSZ was celebrating her 32nd birthday. The available evidence indicates that NLU perpetrated emotional, verbal, psychological and physical abuse against FSZ during their nine-month relationship. FSZ disclosed to her cousin that NLU consumed large amounts of alcohol, behaved aggressively and sometimes pressured her to consume alcohol.
5. NLU had a history of perpetrating family violence and breaching Family Violence Intervention Orders (**FVIOs**) in his previous intimate relationships. He was charged with contravention of a FVIO and received a three-month term of imprisonment in March 2017 for same. There were two reported family violence incidents between FSZ and NLU prior to the fatal incident, and FSZ disclosed to police that NLU assaulted her multiple times prior to the first reported family violence incident. These incidents are discussed in further detail below.

THE CORONIAL INVESTIGATION

6. FSZ'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.
7. 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.
8. 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.
9. Victoria Police assigned police officer Detective Sergeant Sean Campbell to be the Coronal Investigator for the investigation of FSZ's death. The Coronal 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.

10. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to his retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.
11. This finding draws on the totality of the coronial investigation into the death of FSZ 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.¹

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

Circumstances in which the death occurred

12. In April 2019, NLU spent ten days as a voluntary patient at LRH's mental health unit. He remained in contact with FSZ during this admission and he advised her that he intended to obtain social housing as he was unable to return to his mother's house. He was discharged from LRH on 17 April 2019 and travelled to Caulfield House, a Supported Residential Service (SRS). He elected not to stay at the SRS and indicated that he intended to find alternative accommodation. NLU and FSZ continued to exchange text messages throughout April 2019 in which they discussed their relationship. NLU indicated that he did not wish to continue his relationship with FSZ any longer. FSZ accused NLU of having a relationship with another woman and NLU suggested that FSZ was "*evil*".
13. FSZ and NLU agreed to meet up in the Melbourne CBD on 21 April 2019. On 22 April 2019, FSZ told her cousin that she had spent the night of 21 April sleeping at a police station following an argument with NLU during which the pair were escorted out of a venue. There was no record of this incident in the material available to the Court.
14. On 23 April 2019, FSZ travelled to the Melbourne CBD where she again met with NLU. In the early hours of 24 April 2019, the pair attended the Exford Hotel bottle shop where NLU attempted to steal a bottle of wine, but he was confronted by a security guard and was asked to leave. NLU and FSZ travelled by taxi to the Golden Nugget Hotel on Lonsdale Street where

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.

FSZ played the ‘pokies’ and NLU spoke to people inside and outside the Hotel. They left the venue together at about 5.00am and walked through the city towards a nearby avenue.

15. At 5.08am, FSZ walked north into the avenue, with NLU following closely behind. Sometime after entering the avenue, NLU assaulted and killed FSZ. FSZ resisted NLU’s attack, resulting in scratches to his left neck. After the assault, NLU left the avenue on foot. FSZ’s body was found about an hour and a half later by a passing motorist. The motorist called Triple Zero, however FSZ was unable to be revived and was declared deceased at the scene.
16. Police apprehended NLU later that day, who initially attempted to lie, however later admitted to killing FSZ. He stated that he “*choked the life out of her until she breathed no longer*”. NLU was arrested and remanded in custody and later pleaded guilty to FSZ’s murder. On 9 October 2020, NLU was sentenced to 21 years’ imprisonment, with a non-parole period of 15 years.

Identity of the deceased

17. On 1 May 2019, FSZ born [REDACTED], was visually identified by her cousin.
18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy on 24 April 2019 and provided a written report of his findings dated 26 September 2019.
20. The post-mortem examination revealed some bruises and abrasions on the front of the neck, associated with bruising to the underlying neck strap muscles and a fracture of the left greater cornu of the hyoid bone. Multiple conjunctival petechiae were seen in the upper and lower lids of both eyes. No genital injuries were identified.
21. Dr Young explained that compression of the neck (‘strangulation’) is a form of asphyxia where there is compression of the neck structures by external pressure on the neck. In this case, the pattern of injuries was more consistent with the pressure having been applied by something broad (such as hands, arms, or another object) rather than a ligature. Death may be due to reflex cardiac arrest, occlusion of blood vessels of the neck, airway obstruction, or a combination of these effects. Signs of neck compression may include haemorrhage in neck

muscles, fracture of neck structures (such as the hyoid bone) and conjunctival petechiae in the eyes.

22. Toxicological analysis of post-mortem samples identified the presence of ethanol (0.15 g/100mL in blood; 0.17 g/100mL in vitreous humour), methylamphetamine and its metabolite, and pheniramine.
23. Dr Young provided an opinion that the medical cause of death was 1(a) Compression of the neck.
24. I accept Dr Young's opinion.

CPU REVIEW – MENTAL HEALTH

25. Due to NLU's recent admission to hospital prior to the fatal incident, I requested the CPU review the mental health treatment he received and whether there were any opportunities for prevention.

Summary of mental health care proximate to fatal incident

26. NLU presented to the Wonthaggi Hospital Emergency Department (**ED**) on 8 April 2019 after calling an ambulance for himself. He reported being unable to sleep for four nights and was experiencing auditory hallucinations. In the ED, NLU received oral olanzapine, and the ED medical officer requested a review by a mental health clinician.
27. NLU was assessed in the ED by a registered psychiatric nurse (**RPN**). NLU described a four-month history of hearing voices that had worsened over the previous four weeks. He also disclosed bizarre beliefs including difficulty sleeping due to people causing "*sound waves*" in his head at night and that his soul had been swapped as a child. He denied current drug or alcohol use, although reported some alcohol withdrawal symptoms since ceasing alcohol use one week prior. The RPN assessed NLU as at moderate risk of aggression and noted that "*due to concern about his current mental illness and poor compliance allowing client to return home was not an option*". NLU accepted a voluntary admission to the Flynn Unit at LRH. He was transferred via ambulance to LRH that same day.
28. At the Flynn Unit, a House Medical Officer (**HMO**) completed a comprehensive risk assessment and considered NLU to have multiple static and dynamic risk factors for aggression, however, did not identify an overall risk status. The HMO provided a provisional

diagnosis of schizophrenia and alcohol withdrawal with a plan for psychiatric review, medication review and social work review. No alcohol withdrawal scale was requested.

29. On 9 April 2019, a consultant psychiatrist reviewed NLU and noted his overall risk (including risk of aggression) as low and noted that there were no clear signs of psychosis. The impression was “*alcohol abuse, crisis situation, BP [borderline personality] traits*”. The clinical plan was for a short crisis admission, to obtain collateral information from NLU’s mother, involve the social work team, and refer for drug and alcohol and community mental health follow-up.
30. On 10 April 2019, NLU denied hearing voices and reported that he was sleeping better due to the voices settling. He also commenced approved leave from that day, which he utilised throughout the remainder of his admission without incident.
31. On 11 April 2019, a registered nurse (RN) documented that NLU’s mother was concerned about her son’s risk to himself and others. The same day, a medical officer spoke to NLU’s mother over the phone who advised that her son had been diagnosed with paranoid schizophrenia three years earlier by Peninsula Health, and that NLU was not compliant with his medication. She also noted that her son could be aggressive, he responded to his auditory hallucinations, and his symptoms worsened in the context of drug and alcohol use.
32. On 12 April 2019, an HMO assessed NLU who denied auditory hallucinations. The HMO noted there was no evidence of a thought disorder. NLU indicated that he was willing to be linked with drug and alcohol services.
33. On 13 April 2019, hospital staff observed NLU having a series of arguments with his mother over the home, and he requested to self-discharge the following morning. He continued to deny perceptual disturbances and clinicians noted that there was no evidence of a thought disorder.
34. On 14 April 2019, NLU’s mother brought her son’s belongings into the hospital. She advised an RN that she felt that her son was unwell and needed to be on a Community Treatment Order (CTO) as she believed he was “*unsafe in the community*”. NLU described hearing “*friendly*” voices in his head later that day.
35. A consultant psychiatrist and HMO conducted another review on 15 April 2019 where they discussed NLU’s previous admission to Frankston Hospital. NLU confirmed it occurred in the context of becoming unwell, secondary to drug use. He denied hearing voices and his

mood was described as “*fine*” with good insight. It was also noted that he denied that drugs affected him. The clinical plan was to seek collateral information from Frankston Hospital, refer NLU to the social worker regarding accommodation, and discharge midweek, pending receipt of information from Frankston Hospital.

36. On 16 April 2019, the social worker confirmed NLU would be able to stay at the Caulfield SRS upon discharge. He denied perceptual disturbances to nursing staff, was excited about discharge but said he required diazepam for alcohol withdrawal due to his binge drinking prior to admission. He said he experienced “*various stressors*” but refused to elaborate. A medical officer signed a Centrelink Medical Certificate that day which recorded NLU’s diagnoses as borderline personality disorder and schizophrenia.
37. On 17 April 2019, NLU informed nursing staff that he heard female voices at times and that these voices belonged to his current and former partner. Nursing staff completed a risk assessment that placed NLU’s risk of substance abuse and aggression as medium, and his overall risk as medium. He was also reviewed by two HMOs who noted his mood as “*ecstatic*”, that he had good insight and noted that he denied any auditory or visual hallucinations. NLU denied thoughts of self-harm, suicide and violence to others. He reported that he felt safe to be discharged and accepted follow-up with community mental health services. NLU was discharged at about 1.00pm that day, with a plan to travel to Melbourne. The discharge summary completed by an HMO listed NLU’s diagnoses as “*alcohol abuse, crisis situation, BPD traits*”.
38. The medical record also contained a facsimile sent by the discharging HMO to the Inner South Crisis Assessment and Treatment Team (**CATT**). The discharging HMO noted that he had tried to contact the CATT but was unsuccessful, so he noted that LRH was providing the *Transfer of Care* form by fax. The form provided an overview of NLU’s admission to LRH, requested CATT follow-up and a referral to the Australian Community Support Organisation (**ACSO**).
39. On 19 April 2019, an RN entered a note in NLU’s medical records to note that NLU had been discharged to the Melbourne area with no follow-up required.
40. NLU travelled to the SRS in Caulfield, however as noted above, did not stay there. Following the fatal incident, NLU was assessed by forensic psychiatrist, Dr Carroll, who provided a diagnosis of schizophrenia with likely onset in 2014, mixed substance use disorder (currently in remission), and moderate personality disorder with borderline pattern. NLU informed Dr

Carroll that he consumed a significant amount of alcohol and drugs including methamphetamine and pregabalin in the days after discharge, prior to the fatal incident.

Review of assessment, diagnosis and management

Diagnoses received during admission

41. The CPU noted that during NLU's admission to LRH he received various diagnoses including:
 - a) 8 April 2019 - provisional diagnosis of schizophrenia
 - b) 9 April 2019 – alcohol abuse, crisis situation, borderline personal traits
 - c) 16 April 2019 Centrelink Medical Certificate – borderline personality disorder, schizophrenia
 - d) 17 April 2019 – discharge summary – alcohol abuse, crisis situation, borderline personality disorder traits
42. The CPU noted that given alcohol abuse was documented at discharge, it appeared that the treating team considered this as NLU's primary diagnosis. Dr Ian Graham, the LRH Chief Medical Officer, provided a statement about NLU's admission and opined that schizophrenia was not considered an appropriate diagnosis.
43. The CPU also noted that NLU originally presented to the ED complaining of withdrawal symptoms after ceasing alcohol. While NLU was appropriately commenced on diazepam to assist with anxiety and agitation, and received a significant number of doses of same, he was not placed on an alcohol withdrawal scale. The efficacy of the diazepam was not consistently recorded by nursing staff who administered it. There was no evidence of a comprehensive assessment of NLU's alcohol (or other drug) use including assessing his goals for ongoing alcohol use and history of previous withdrawal episodes. No drug screen was requested during his 10-day admission. The CPU opined that it was therefore unclear how the treating team arrived at a primary diagnosis of alcohol abuse. Given the significant period of time that has elapsed since, it would be very difficult for the treating team to now comment on the clinical rationale of their primary diagnosis.
44. When provided with an opportunity to respond to these concerns, LRH advised the Court that it did not wish to make any further submissions.

Role of psychotic symptoms

45. The CPU opined that it was not clear what role NLU's psychotic symptoms played in the diagnosis process. Upon his presentation to the ED, NLU expressed bizarre beliefs and a four-month history of auditory hallucinations that were becoming increasingly distressing and preventing him from sleeping. The perceptual disturbances initially settled with PRN olanzapine, however on 14 and 17 April 2019, he reported hearing voices to nursing staff and denied the symptoms to medical staff. The treating team were aware of his prior diagnosis of schizophrenia, which was confirmed via the Frankston Hospital medical record.
46. The CPU opined that it was possible that NLU's psychotic symptoms were a complication of alcohol withdrawal, however they may have also been indicative of a psychotic disorder. In his statement, Dr Graham opined that the original diagnosis of schizophrenia "*was not substantiated as a diagnosis during the course of NLU's admission*" but the medical record did not contain the clinical rationale for excluding this diagnosis. The CPU concluded that it was unclear what role, if any, NLU's presenting symptoms, the Frankston Hospital medical record and NLU's reports to nursing staff played in the clinical decision making. As above, given the passage of time, it is unlikely that the treating team would be able to recall the reasons for excluding a diagnosis of schizophrenia (or other psychotic disorder).
47. The CPU explained that the decision to consider NLU's symptoms as primarily the result of alcohol abuse meant that he was not prescribed ongoing antipsychotics, and the only medications he was prescribed at discharge were thiamine and a short-term supply of diazepam. If NLU was indeed experiencing a psychotic disorder, in the absence of regular antipsychotics, his mental state may have deteriorated following discharge. However, the CPU was unable to conclude that antipsychotics would have prevented the fatal incident, particularly given NLU's poor compliance with medication in the past.
48. When provided with an opportunity to respond to these concerns, LRH advised the Court that it did not wish to make any further submissions.

Discharge planning

49. The CPU noted that the *Transfer of Care* form provided to the CATT did not contain a diagnosis. There were some references to NLU's use of alcohol, but no confirmation that the team considered it his primary issue. The form repeated the mental state examination completed by medical staff on discharge, which considered that NLU was at low risk of

substance use. That same day, the nursing staff reported his risk of substance use to be medium. The *Transfer of Care* form advised CATT to refer NLU to ACSO, however no further details were provided about NLU's treatment goals, nor the nature of his clinical or psychosocial support needs. There was also no indication of the urgency of the referral. Given NLU's planned relocation to Melbourne, it was appropriate to suggest that the Inner South CATT progress a referral to the geographically appropriate alcohol and other drugs (AOD) service. However, the CPU opined that best practice would have been to provide the receiving service with a comprehensive update on NLU's use of alcohol (and other substances), his treatment goals and support needs.

50. There was no reference to NLU's history of family violence on the *Transfer of Care* form, nor that a FVIO was recently implemented. In his statement, Dr Graham opined that a history of perpetrating family violence is important clinical information, however the only information provided to CATT was that NLU had a "*forensic history*", that he denied thoughts of violence to others on discharge and the treating team considered him a low risk of harm to others. As noted by Dr Graham, NLU showed no evidence of aggressive behaviour while in the Flynn Unit, however upon his admission, he was noted to have multiple static and dynamic risk factors for aggression and nursing staff considered him to be at medium risk of same on discharge. NLU's mother noted her concerns to staff that her son might harm others. The treating team were aware that NLU's risk escalated in the context of alcohol and substance use, but this information was also not conveyed to the CATT. The CPU opined that best practice would have included documentation of a comprehensive risk of harm to others assessment and inclusion of this information to the receiving service.
51. The CPU explained that NLU's discharge from LRH involved transferring him to a community-based service in another mental health service locality. The *National Standards for Mental Health Services* require mental health services to facilitate continuity of care across services with appropriate communication and documentation. It notes that the transfer of a consumer between service providers "*is a negotiated enterprise between the consumer, carer or family, referring doctor, community mental health team and the inpatient unit*" and that the discharge plan includes medical information and the desired outcomes of treatment.
52. Dr Graham indicated that standard practice at LRH was to fax a referral if it was not possible to conduct a warm handover. However, the CPU opined that in order to ensure an adequately negotiated transfer of care, it would be reasonable to expect LRH to confirm receipt of a referral with the receiving service. There was no indication that LRH confirmed with the Inner

South CATT that they received the fax, nor ascertained when the CATT would be able to action the referral.

53. Upon clarification with Alfred Health (who are responsible for the Inner South CATT), they confirmed that they received the referral from LRH, and it was referred to the Alfred Health Psychiatric Triage Team.
54. According to the Alfred Health Triage Team screening registrar, the referral was received on 18 April 2019 and NLU was called by a clinician. He did not answer the call and called back less than an hour later. He reported to the clinician that he felt “good” and had arrived at the Caulfield SRS but decided not to stay. He explained that he had arranged accommodation in the CBD instead. The Alfred Health clinician noted that the CBD was outside their catchment area, so they provided NLU with contact details for the geographically correct mental health service and the case was closed.
55. The CPU noted their concerns that upon discharge, the treating team provided limited information to the Inner South CATT and did not check that the faxed referral was received. As only one week elapsed between discharge and the fatal incident, the CPU could not determine with certainty that an appropriate referral would have prevented the fatal incident, however assertive community follow-up *may* have assisted.
56. When provided with an opportunity to respond to these concerns, LRH advised the Court that it did not wish to make any further submissions.

CPU REVIEW – FAMILY VIOLENCE

57. As FSZ’s death occurred in circumstances of family violence, Judge Cain requested that the Coroner’s Prevention Unit (**CPU**)² examine the circumstances of FSZ’s death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)³
58. I make observations concerning service engagement with FSZ as they arise from the coronial investigation into her death and are thus connected thereto. However, the available evidence

² 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.

³ 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.

does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and FSZ's death.

59. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".⁴ I make observations about services that had contact with FSZ to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Victoria Police

60. Victoria Police responded to two reported family violence incidents between FSZ and NLU, prior to the fatal incident. Victoria Police completed a Family Violence Related Death Assessment (**FDA**) following the fatal incident, which is a desktop review of the police contact with FSZ and NLU. As it is a desktop review, it is completed within the competing pressures and time constraints facing the members who attend family violence incidents.

15 October 2018

61. On 15 October 2018, Victoria Police were called to a hostel in the Melbourne CBD by a witness who reported that NLU had assaulted FSZ. On this occasion, FSZ reported to police that NLU had assaulted her by "*holding her down on the bed and hitting her in the face*". Police arrested NLU and photographed FSZ's injuries.
62. Police also attended the location of the incident and interviewed witnesses who indicated that both parties had behaved violently. Police appear to have considered charging NLU in relation to FSZ's claim that he had thrown and damaged her mobile phone. However, police noted that the damage to her phone did not appear to correspond with her narrative and appeared "*as if it has been in someone's back pocket and they have sat down hard on their backside*". Consequently, police sought advice that charges not be issued and the criminal investigation was not pursued further.
63. Both FSZ and NLU claimed that they were the Affected Family Member (**AFM**) in this incident. Police assigned FSZ as the AFM due to experiencing "*more severe injuries*" and issued a Family Violence Safety Notice (**FVSN**) for her protection.

⁴ *Adameczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

64. NLU claimed that he had only “*mounted*” FSZ to prevent her from assaulting him. In response, police provided him with information about applying for a FVIO for his own protection in the event of future concerns for his safety. Police completed risk assessments and submitted formal referrals for both parties via the L17 portal.
65. On 22 January 2019, the FVSN was converted to an interim FVIO with limited conditions, prohibiting NLU from committing family violence against FSZ. This remained active and served until FSZ’s death.

15-16 March 2019

66. On 15 March 2019, FSZ travelled via public transport from Geelong to a regional Victorian town to spend time with NLU. The pair were at NLU’s flat where they consumed alcohol. FSZ alleged that NLU started a verbal argument, pushed her onto the bed, pushed his forearm to her throat and punched her to the face, injuring her bottom lip. After the alleged assault, FSZ left the flat and contacted him by phone to request a return of her personal belongings.
67. FSZ later observed NLU outside a late-night venue, and they engaged in a verbal argument. During this argument, a security guard heard FSZ yelling “*I can’t believe you fuckin’ hit me*” and she showed the security guard her lip injury. She alleged that NLU was responsible for the injury and stated that she had no way of getting back home to Geelong. The security guard intervened when NLU allegedly attempted to assault a patron. There was a physical altercation between NLU and the security guard, who told police that he pushed NLU to the ground outside the venue multiple times, before NLU agreed to leave.
68. FSZ later attended NLU’s flat and sat outside it for some time before NLU left the flat, allegedly pushed her to the ground and bit her on the cheek. NLU’s neighbours reported hearing yelling that sounded “*very violent*”, including a female voice saying, “*don’t hit me, get off me, get off me*”. The neighbours contacted police to report their concerns.
69. Police attended at about 2.30am and spoke to FSZ, who alleged that NLU assaulted her. The police noted that NLU was intoxicated at the time and appeared to be asleep. FSZ was conveyed to the local Police Station where she gave a formal statement and had her injuries photographed.
70. The attending members also completed a risk assessment and submitted formal referrals for both parties via the L17 Portal. Later that morning, the Officer in Charge (**OIC**) of the Police Station (who also performed the FVLO role) reviewed the investigation file lodged by

attending members and authorised for NLU to be charged with unlawful assault against the security guard and contravention of the FVIO.

71. The LEAP records indicated that on 17 March 2019, NLU was conveyed to the local Police Station where he declined to be interviewed. In contrast, the FDA noted that NLU was interviewed at his home on the same day. It is not clear from the records available to the Court where NLU was interviewed or what the contents of the interview were.
72. I note some aspects of this service contact that may not have been in compliance with the Victoria Police Code of Practice for the Investigation of Family Violence (**‘Code of Practice’**). According to LEAP records, when police attended on 16 March 2019, they were aware that there was a FVIO in place against NLU and made a note to interview him in relation to the breach of the FVIO, as well as the assault on the security guard. In the FDA, Victoria Police noted that attending officers may not have arrested and interviewed NLU at the time, due to concerns that they had commenced overtime on their shift and/or may have held concerns about NLU’s level of intoxication.
73. I note that the Code of Practice promotes a pro-arrest and pro-charge response, stipulating *“police will investigate all family violence incidents reported to them, ensuring that appropriate use is made of criminal and civil powers and responsibilities”* and *“police may use an arrest power for criminal offences or holding powers for civil matters to provide immediate safety for the AFM”*. As noted in the FDA, officers did not achieve compliance with the Code of Practice in their initial response to this incident. These alleged duty failures are now the subject of a Professional Standards Command (**PSC**) investigation.
74. I also note that the attending members incorrectly recorded risk and vulnerability factors in their risk assessment, including failing to record the use of choking in the assault of FSZ, and the increase in severity and frequency of the violence and controlling behaviours exhibited by NLU. While formal referrals were made for both parties, Victoria Police acknowledged in the FDA that the attending officers failed to identify and convey the significant level of risk posed by NLU to FSZ. I note that while these oversights are concerning, there have also been significant reforms since this time.
75. As per standard procedure, the family violence response provided by the Police Station members was reviewed by the district Family Violence Investigation Unit (**FVIU**), who identified that the Police members did not take appropriate civil and criminal action in relation to the family violence incident on 16 March 2019. Following this review, police applied to

vary the conditions of the FVIO, which was heard on 12 April 2019. A new FVIO was made with full, no contact conditions. NLU was aware of the court date; however, he was admitted to LRH at the time and therefore did not attend. The LEAP records indicate that NLU was served the application to vary the FVIO in person prior to his admission and received a summons to court for 2 May 2019 in relation to the assault and FVIO contravention charges.

76. On 16 April 2019, a Senior Constable was tasked with serving the varied FVIO on NLU while he was an inpatient at LRH. On this occasion, the Senior Constable contacted the relevant ward and spoke to the nurse in charge and requested that the hospital staff notify the nearby Police Station when NLU was being discharged so that the FVIO could be served. However, this did not occur and the FVIO went unserved. In explaining why in-person service did not occur during NLU's hospital admission, the Senior Constable explained that the high dependency unit, where NLU was located, was a *"very uncomfortable place to speak with the person given there are generally 5 or 6 other patients with significant mental health/drug issues freely walking around and most of whom we have regular dealings with and hate police"*. The Senior Constable further noted that they were working alone on that occasion, and it would not have been appropriate for them to attempt service with an additional officer present.
77. The Victoria Police Manual (VPM) – Family Violence states that *"if a respondent listed in a FVIO is in a mental health facility, members may request advance notice of their imminent release to assist with serving the FVIO"* and that Victoria Police members must follow the process outlined in the Department of Health and Human Services – Victoria Police protocol for mental health, which stipulates that members must *"submit [a] request in writing to the person nominated by the emergency department or the Director of Clinical Services where the respondent is being assessed or receiving treatment"*. This does not appear to have occurred, although the FDA noted attempts made by police to maintain communication with LRH by telephone. Police contacted LRH on 24 April 2019 and learned that NLU had been discharged on 17 April 2019. Consequently, police attempted to serve NLU at his forwarding address, unaware that he sourced alternative accommodation. He was not served with the varied FVIO prior to the fatal incident, and it is unclear from the material available to the Court as to whether FSZ was aware of the application to vary the FVIO.
78. The FDA included three recommendations:

- a) Greater emphasis to in-person training over online training, which is likely to be achieved with the implementation of divisional Family Violence Training Officers (**FVTOs**; Senior Sergeants located within each Division across the state).
 - b) Enhanced intrusive supervision and governance for family violence reports regarding risk management and offender accountability in accordance with the Code of Practice.
 - c) Continued organisational transition to the Case Prioritisation Risk Management (**CPRM**) model, with accompanied in-person training.
79. The CPRM model replaced Victoria Police’s Common Risk Assessment Framework (**CRAF**), which previously informed risk assessments. The CPRM is utilised by Victoria Police to triage responses to, and management of, family violence incidents. The CPRM model was not in place at the time of these family violence incidents. The FDA noted that under the new CPRM model, this incident of family violence would have been prioritised for “*immediate FVIU intervention*” based on NLU’s prior history. Consequently, the FVIU would have held responsibilities for case management and risk management strategies. I support and endorse the changes made by Victoria Police in the FDA, with an expectation that their continued implementation will result in a more uniform response to family violence from all members.

Natural justice response – Victoria Police

80. Victoria Police acknowledged that the initial response by police to the March 2019 family violence incident did not comply with the Code of Practice and, in particular, there were significant shortfalls with respect to appropriate risk management and ongoing protection for FSZ.
81. In relation to the service of the updated FVIO, Victoria Police noted that at the relevant time, its policy and guidelines did not direct a member to seek advanced notice of a respondent’s release from a mental health facility to assist with FVIO service. The member in this instance was being proactive in attempting to ensure that NLU received the updated FVIO. Victoria Police submitted that these guidelines have since been updated, which is discussed further below.
82. Victoria Police submitted that there have been a number of significant reforms to their policies and procedures, which includes:

- a) In 2019, the Victoria Police Family Violence Response Model (**FVRM**) was implemented which includes four key components:
 - i. Introduction of FVIUs which provide statewide specialist response to family violence related incidents, including dedicated intelligence officers and specialist detectives.
 - ii. Creation of the Family Violence Report (**FVR**) which was developed by Swinburne University and Forensicare and is a thorough, evidence-based, actuarial family violence risk assessment and management tool.
 - iii. Replacement of the CRAF with the CPRM, as noted above.
 - iv. Enhancements to family violence education with the establishment of the Centre of Learning for Family Violence (**CFV**) and the appointment of 21 Senior Sergeants as FVTOs. The FVTOs and the CFV are responsible for delivering contemporary family violence training and education to all members.
- b) Victoria Police has published a number of practice guides to support the FVRM and has implemented 21 targeted family violence related training packages at all levels of the organisation.
- c) In 2021, the Victoria Police Manual – Policy (**VPMP**) and the Victoria Police Manual – Procedures and Guidelines (**VPMG**) for family violence were revised and consolidated into a single policy document – the VPM – Family Violence. This is now the mandatory compliance document for police members responding to family violence related incidents.
- d) The Code of Practice has been extensively reviewed and revised since April 2019.

83. Victoria Police noted that in relation to the recommendations contained within the FDA:

- a) Greater emphasis to in-person training – this continues to be implemented through the new FVTOs and the ongoing training delivered by the CFV and FVTOs.
- b) Enhanced intrusive supervision and governance of family violence incidents – the FVRM includes embedded positions within police divisions who provide subject matter expertise to members responding to family violence. This includes Family

Violence Liaison Officers (**FVLOs**) and Family Violence Court Liaison Officers (**FVCLOs**). The FVLOs provide subject matter expertise, advice and quality assurance in family violence matters. There is a FVLO at every 24-hour police station in Victoria. The FVCLOs help to coordinate civil and criminal family violence matters when they reach the courts.

- c) Continued organisational transition to the CPRM – implementation of the CPRM commenced in June 2019 as part of the broader FVRM. A refined version of the CPRM (version 3) was developed by Swinburne University in partnership with the Family Violence Command, which was trialled and evaluated in 2022, with positive results.

- 84. Given the extensive reforms that have since occurred, I am satisfied that I do not need to make any further recommendations.

The Orange Door

- 85. The Orange Door (**TOD**) received three L17 referrals in relation to FSZ from October 2018 to March 2019. On 15 October 2018, police referred FSZ to TOD in response to the first family violence incident between her and NLU. The referral was assessed as high risk, requiring immediate response and was assigned to TOD – Barwon. The assigned worker attempted to contact FSZ by phone that same day without success. The assigned worker also noted that FSZ’s phone might be damaged, so they also sent an email, as an alternative contact method. The worker attempted to contact her again the following day, however they were unable to reach her, so they closed the referral.
- 86. On 21 November 2018, an additional referral was recorded by TOD Barwon which included the same narrative for the family violence incident on 15 October 2018. The assigned worker contacted FSZ by telephone, but due to an unclear phone line, arranged to call her back the following day. The assigned worker called FSZ twice on 3 December 2018 but was unsuccessful. They sent a text message which included resources and referral information, then closed her case on 6 December 2018.
- 87. On 17 March 2019, a second referral was made to TOD Barwon via the L17 portal following the 16 March 2019 family violence incident. Notes provided by TOD indicate that FSZ was not contacted in relation to this referral before an additional referral was received via the L17 portal in relation to family violence perpetrated against FSZ by her brother in her home.

88. TOD attempted to contact FSZ on 18 March 2019, however, did not reach her and left a voicemail. TOD successfully spoke to her on 19 March 2019 and arranged motel accommodation and a taxi to transport FSZ to a TOD hub on 20 March 2019. FSZ attended TOD hub on 20 March 2019 and met with a worker to discuss the family violence incident between herself and her brother, explored her family relationships, risk and housing. TOD worker completed a risk assessment in relation to the risk from FSZ's brother and TOD funded seven nights of emergency accommodation, provided food vouchers and encouraged her to apply to Centrelink for a crisis payment after she disclosed financial stress. TOD referred FSZ to the Salvation Army for support to find longer-term housing after clarifying that TOD were unable to provide same.
89. On 27 March 2019, FSZ attended TOD and informed them that she had attended the Salvation Army for an assessment on 25 March 2019 and that they were not helpful. She asked for additional motel accommodation, noting her limited funds and that the Salvation Army had advised her that they were unable to assist her with ongoing accommodation. The worker advised FSZ that TOD might be able to assist her to relocate to Queensland or that if "*she was prepared to go to Melbourne*", the Salvation Army may be able to assist her with housing locally. After the worker discussed these options, they recorded that they advised FSZ "*there wasn't much more [TOD] could assist with now it was primarily housing that was the issue and she was safe*" and advised that the case would be closed.
90. I note that during the March 2019 contact with TOD, it does not appear that the worker discussed the recent family violence incident perpetrated by NLU. The two referrals received on 17 March 2019 were recorded as two separate screenings; however, they were grouped together as one 'case' assigned to the same worker. The L17 referral received by TOD included police's intention to interview NLU in relation to the alleged assault and subsequent FVIO breach. However, despite holding this information, there was no documented discussion, family violence risk assessment or safety plan in relation to the family violence risk posed by NLU.
91. At the time of FSZ's engagement with TOD, it was prescribed under the Multi-Agency Risk Assessment and Management (**MARAM**) framework as a risk assessment entity (**RAE**). Under the MARAM, RAEs are required to conduct comprehensive risk assessment and safety plans with victim-survivors who access their service.

92. A failure to identify the ongoing family violence risk posed by NLU meant that FSZ may not have been offered the full range of supports that are available to victim-survivors through TOD and the broader family violence service sector.
93. A comprehensive risk assessment and safety plan may have led to TOD and FSZ having a deeper understanding of the seriousness of the risk of violence perpetrated by NLU. This is especially pertinent given that NLU attempted to choke her in the most recently reported incident of family violence prior to her death, and that being her ultimate mechanism of death. Without a review of this information, FSZ was discharged from TOD on the grounds that she was 'safe' and that her only outstanding support need was housing. I note however that housing and family violence risk are related and should not be treated as separate issues by support services. FSZ was assaulted by her brother in the home she was temporarily staying in with him, and her other housing option – staying with NLU – also posed a risk of further family violence victimisation.
94. Evidence available in the brief indicates that FSZ reunited with NLU in part because she had no accommodation and she could stay with him. If TOD identified and explored the violence perpetrated by NLU, it is possible that FSZ's support period with TOD would have been extended. Alternatively, she might have been referred to a specialist family violence service. Either way, she might have been able to access a Flexible Support Package (**FSP**), which are designed to assist victim-survivors to escape and recover from family violence. At the relevant time, the maximum amount of funding available in a single FSP would have been \$5,000. This could have been used to cover a range of expenses, including rent and bond.
95. In addition to this issue, TOD referred FSZ to the Salvation Army for housing support by instructing her to present at their Belmont office. This is not compliant with best practice and does not promote inter-agency collaboration to reduce the onus on victim-survivors to re-tell their story and self-advocate for support. TOD could have provided FSZ with a 'warm referral' to the Salvation Army, wherein they could have proactively contacted the Salvation Army to provide collateral information about FSZ's experience of family violence and its effect on her housing instability. This form of referral may have resulted in FSZ receiving additional, targeted support through the Salvation Army, thereby possibly increasing her safety.
96. In response, TOD explained that it accepted that staff did not complete a risk assessment in relation to the March 2019 family violence incident, they did not offer FSZ the full range of

support available, including referral to a culturally specific family violence service or a FSP, and did not provide a warm referral to the Salvation Army for housing support.

97. At the time that FSZ received support from TOD, there were three key pieces of statewide practice guidance - the Interim Integrated Practice Framework, the TOD Service Model and the Client Experience Tool Kit. Since that time, TOD have undertaken significant work to develop and deliver additional statewide operational guidance and practice directions. Additionally, there have been significant improvements in the mandatory training program for practitioners. In 2019, the training was comprised of three half-day sessions, and one day introducing people to the service model. During 2022, this was significantly revised in consultation with practitioners, agency partners, sector peak bodies and people with lived experience. This was implemented from January 2023.
98. In circumstances where significant improvements and reforms have occurred, I am satisfied that I do not need to make any further recommendations with respect to TOD specifically. However, I note the ongoing issue of motels being used as family violence emergency accommodation, which leads to high unsafe exit rates. This issue is discussed further below.

Salvation Army

99. On 19 March 2019, FSZ presented at the Salvation Army without an appointment and was seen as a 'walk-in' client. She advised the Salvation Army that she had been living with her brother but was unable to return there due to his use of violence and the resulting FVIO. She further advised that she had two nights of accommodation funded by TOD but did not have accommodation beyond this period. The Salvation Army booked the next available housing assessment appointment for FSZ; however, the time and date of this appointment was not recorded in the case notes that were provided to the Court.
100. FSZ returned to the Salvation Army on 23 March 2019 and met with another worker who noted that FSZ cried throughout their engagement. Her housing options were discussed, and the worker highlighted the limited number of housing options available and suggested that FSZ try to find shared accommodation. She expressed frustration and emphasised the difficulties of trying to find shared accommodation at short notice. The Salvation Army agreed to fund a further two nights at a motor inn, and FSZ advised she would return to TOD for further support.

101. FSZ presented for a third time on 27 March 2019 and advised that she had found accommodation in Melbourne (the Space Hotel) and required assistance with funding. She reported that she had her first day of work at a new job in West Footscray, her Newstart payments from Centrelink were \$133 and that she was unsure when she would receive payment from her new employer. The Salvation Army contacted the Space Hotel who advised the cost of accommodation, but that they did not accept payment from organisations. The worker emphasised that the cost of accommodation at the Space Hotel was not sustainable, and that the Salvation Army would be unable to fund ongoing accommodation at same. The worker directed FSZ to contact other accommodation providers using details provided to her by the Salvation Army and suggested that she try to find accommodation that she could self-fund.
102. I do not criticise housing services in relation to these interactions and note that resourcing limitations and housing availability have a significant impact on services' ability to assist clients with housing. However, I wish to reiterate the significant link between family violence risk and the housing crisis. This link is discussed further below.

Latrobe Regional Hospital

103. As noted above, NLU was an inpatient at LRH when there was a court hearing to vary up the conditions of the FVIO against him. He informed LRH clinicians on 15 April 2019 that there was a court hearing on 12 April 2019. The clinician did not appear to ask any further questions about the outcome of the hearing or the conditions of the FVIO.
104. Victoria Police contacted LRH on 16 April 2019 to advise them about the updated FVIO and the need to serve NLU upon discharge. As noted above, police asked LRH to notify them prior to his discharge so that they could arrange for service, however this did not occur.
105. While LRH were aware that NLU was subject to an FVIO in protection of FSZ and he disclosed that his deteriorating mental health was (in part) due to the end of his relationship, it does not appear that LRH staff explored this further. The hospital was aware that NLU had a history of perpetrating family violence, and his mother disclosed that he was domineering and a risk to others. However, it does not appear that LRH staff explored the FVIO with NLU or discussed the recent change to vary the conditions.
106. LRH acknowledged that in response to a written request from police that complies with section 207 of the *Family Violence Protection Act 2008*, it must provide the requested

information. In this case, police did not give LRH a written request for information about NLU for the purpose of serving the FVIO.

107. Nevertheless, LRH recognised that this case “*revealed a deficiency in the collaborate arrangements between [LRH] and Victoria Police*”. LRH advised that it would engage with local police command to develop a protocol regarding requests for discharge notifications for the purposes of serving FVIOs.
108. The RCFV emphasised the need for enhanced collaboration between health services and family violence specialist services to support victim-survivors and increase visibility and accountability for people who use violence. Specifically, the RCFV recommended:

Recommendation 98 – *The Victorian Government fund the establishment of specialist family violence advisor positions to be located in major mental health and drug and alcohol services. The advisors’ expertise should be available to practitioners in these sectors across Victoria.*

Recommendation 99 – *The Victorian Government encourage and facilitate mental health, drug and alcohol and family violence services to collaborate by:*

- *Resourcing and promoting shared casework models*
- *Ensuring that mental health and drug and alcohol services are represented on Risk Assessment and Management Panels and other multi-agency risk management models at the local level.*

109. In response to recommendations 98 and 99, the Victorian Government funded the establishment of Specialist Family Violence Advisor (SFVA) positions across 17 areas in 2017. The positions are embedded in public mental health and alcohol and other drug services across Victoria, supporting the services to align to the MARAM through training and tailored policies and procedures. The SFVAs also assist by providing specialist family violence expertise and advice to designated mental health services to improve their response to victim-survivors and people who use violence.
110. I support the continuation of the SFVA program, with a hope that it will continue to improve the mental health sector’s identification of, response to and management of family violence.
111. LRH noted it did not disagree with recommendations 98 and 99. It explained that it does not employ any SFVAs that are directly funded by the State Government and understands that

these individuals are employed by the Latrobe Community Health Service. LRH explained that it introduced a specific Family Violence Worker role in 2018 and in 2020, introduced a Strengthening Hospital Responses to Family Violence (SHRFV) Educator to implement the SHRFV approach. In 2021, Family Violence was embedded in the LRH mandatory training program, which all staff must undertake.

112. LRH also outlined a range of other changes that have occurred since 2019 including implementing an electronic health record which offers new risk formulation and intervention tools, including the Dynamic Appraisal of Situational Aggression tool. It has also implemented a new mental health discharge transition nurse who specifically supports mental health patients in discharge planning to ensure they are linked with appropriate supports and services, including family violence services.

Contacts with general practitioners

113. NLU attended an appointment with a GP on 16 October 2018. The notes from this appointment demonstrate that NLU indicated that he was assaulted by his partner over the weekend and that he presented with injuries to his right hand, shins, neck and upper back. NLU disclosed recent suicidal ideation and reported that he was managing this with “*lifestyle measures*”.
114. NLU’s general practitioner (GP) observed “*grazes to right flank consistent with nail marks*” and a haematoma under the right index fingernail, citing the cause as a “*bite*”. The GP discussed engaging a psychologist due to NLU’s disclosure of depression and suicidal ideation. The GP provided a referral letter to a psychologist, however upon contacting this psychologist, the Court was informed NLU never contacted her.
115. The GP did not record any further discussion with NLU about his disclosure of assault. The GP wrote a letter confirming his examination of NLU and that his presentation was “*consistent with [a] recent assault*”. The letter also included a copy of the GP’s clinical notes from the appointment, but it was not addressed to a specified recipient and it is not documented why NLU may have requested the letter.
116. NLU presented for another appointment on 20 December 2018 and reported a “*human bite*” to his right index finger. He received analgesia and tetanus and diphtheria vaccinations. On this occasion, he saw a different GP from the same clinic. There was no discussion during this appointment about the October 2018 appointment, in particular, no discussion about the

psychologist referral or suicidal ideation. There also did not appear to be any discussion about the repeat presentations for assault-related injuries.

117. I note that when NLU reported injuries sustained in an assault, he purported to be a victim of an assault, however it does not appear that either GP explored this further or enquired about his safety. This suggests a lack of understanding about family violence and how to respond to such disclosures.
118. GPs are guided by the Royal Australian College of General Practitioners (**RACGP**)’s manual, *Abuse and Violence: Working with our Patients in General Practice* (also known as the ‘**White Book**’), which was published in 2014. The White Book contains a table of potential presentations of intimate partner abuse and lists 18 indicators of family violence under two categories – psychological and physical. The White Book also provides guidance to GPs about what to do if they suspect family violence is occurring.
119. In 2017, the RCFV undertook a review of Victoria’s service system response to family violence. In their review, the RCFV highlighted the important role that GPs play in responding to family violence. The RCFV found that women are most likely to disclose their experience of family violence to their GP outside of their social network. Despite this, the RCFV noted the significant knowledge gap among health professionals in identifying and responding to family violence. In response to these concerns, the RCFV made several recommendations aimed at increasing the capacity of the health sector workforce to respond to family violence. These recommendations have all since been ‘implemented’ with a joint statement released by the RACGP, the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) and the Office of the Chief Psychiatrist (**OCP**). The joint statement confirmed:

...a commitment to promoting a learning agenda on family violence a priority for each organisation and to exert any influence possible on undergraduate and graduate University training.

120. Since this time, the RACGP has established the *Professional Development Program on Family Violence*, which aims to improve GPs skills and knowledge in responding to family violence.
121. In Victoria, the best practice for GPs suggests that they should follow the guidance provided in the MARAM Framework. However, unlike publicly funded health services, GPs are not

prescribed under the MARAM and therefore are not legally obliged to align their services with same.

122. In my finding into the death of Fatima Batool, I recommended:

With the aim of promoting public health, preventing deaths and supporting medical practitioners to address family violence, I recommend that the National Federation Reform Council (NFRC) review the current registration standards required of medical practitioners with a view to updating CPD requirements for General Practitioners. A specific portion of CPD training undertaken by General Practitioners should be dedicated to family violence to reach an occupation-specific level of family violence understanding and referrals for further support where a patient is identified as experiencing or suspected to be experiencing family violence.⁵

123. In response, the Prime Minister of Australia, the Honourable Anthony Albanese, wrote to the Court to advise that his government would consider the recommendations and that he was committed to addressing the social, cultural, political and economic factors that underpin gendered violence.

124. In addition to mandatory family violence training for GPs, Professor Kelsey Hagerty (joint Chair of the Centre for Family Violence Prevention, Royal Women's Hospital and Department of General Practice, University of Melbourne) has continued to call for the Australian Government to “develop special GP Medicare item numbers (similar to the Mental Health Assessment or Diabetes or Asthma item numbers) to develop family safety plans and follow up for women and children experiencing family violence”. This suggestion acknowledges the complexity of skills and additional time required by GPs to appropriately respond to disclosures of family violence.

125. Prof Hagerty's statement informed Recommendation 105 of the RCFV:

The Victorian Government, through the Council of Australian Governments, encourage the Commonwealth Government to consider a Medicare item number for family violence counselling and therapeutic services distinct from a general practitioner mental health treatment plan. In the longer-term consideration should be given to establishing a Medicare item number or a similar mechanism that will allow

⁵ [Finding into death without inquest – Fatima Batool \(COR 2018 3266\).](#)

medical practitioners to record a family violence–related consultation or procedure and so more accurately ascertain the public cost of family violence [within 12 months]

126. Then Victorian State Premier, Daniel Andrews, raised the need for introducing specialised Medicare item numbers in 2016. However, the then Federal Minister for Health, Sussan Ley, rejected the recommendation and indicated that existing Medicare item numbers should be used.
127. While existing Medicare numbers *could* be used, having a specific one for family violence related consultations would ensure that GPs are appropriately reimbursed for the additional time and care required to support people experiencing family violence. It may also allow the Commonwealth Government to collect more accurate data on the demand for family violence support and the associated cost to the public health system. I therefore intend to re-state Prof Hagerty’s recommendation.

Systemic issues

Family violence crisis accommodation

128. As noted above, FSZ accessed one week of crisis family violence accommodation approximately one month before NLU killed her and was discharged from TOD without safe and long-term accommodation. Evidence available in the brief indicates that FSZ reunited with NLU in part because she had no accommodation and she could stay with him.
129. In Victoria, people escaping family violence who are in need of alternative accommodation can access short term family violence crisis accommodation, otherwise known as refuge. Entry into crisis accommodation is primarily accessed through Safe Steps, a 24/7 statewide family violence response centre, following an initial family violence risk assessment.
130. Victoria’s supply of designated crisis accommodation beds falls short of meeting the demand from women escaping violence. Whilst the number of beds available does not meet current demand, supply is further limited by delays in transitioning women out of crisis accommodation due to the limited availability of long-term affordable housing options. In recent years, the CPU FV Team have reviewed several family violence homicides where the

impacts of these barriers have forced women to remain in violent relationships due to a lack of safe and accessible housing options.⁶

131. Due to the scarcity of funded crisis accommodation, housing and family violence services are forced to rely on hotels and other improvised accommodation arrangements, such as tents, to house victim survivors. Safe Steps report that every night in Victoria, there are as many as 300 people in hotels fleeing family violence. Using hotels as emergency accommodation is expensive, potentially harmful⁷, and has poor results, with Safe Steps noting that 35% of people in hotel accommodation leave via an ‘unsafe exit’, such as returning to the perpetrator of violence. Hotel emergency accommodation is also more likely to be ineffective for victim survivors with multiple intersecting needs⁸, and inadequate provision of disability-inclusive crisis accommodation represents a significant challenge for women with complex needs.⁹
132. In a bid to address this issue and in response to the findings of the Royal Commission into Family Violence, the Victorian Government announced an investment of \$25 million as part of the Family Violence Housing Blitz package in 2016 “*to support construction of 180 new units of crisis accommodation and upgrades to existing accommodation*”.¹⁰ In 2019–20 and 2020–21, the Victorian Government provided an additional \$4.07 million to enable the Safe Steps statewide service to place more victim survivors in crisis accommodation and cover associated motel costs.¹¹
133. Following these additional investments, the Victorian Government advised that by 2025 there would be a total of 35 family violence refuges across Victoria with a capacity to support approximately 197 households.¹² In addition to State funding, the 2022 – 2023 Federal Budget

⁶ [Finding into death without inquest - Bekkie-Rae Curren COR 2019 6509](#); [Finding into death without inquest - DCF COR 2022 2405](#), [Finding into death without inquest - PLM COR 2021 6564](#).

⁷ Campell, Fernando, Gassner, Hill, Seidler and Summers, *Unlocking the Prevention Potential: accelerating action to end domestic, family and sexual violence 2024*; *Inquiry into Homelessness in Victoria (final report, March 2021)*.

⁸ Safe Steps submission to the Strong Foundations: Building on Victoria’s work to end family violence online consultation February 2024 - [Safe-Steps-response-to-Strong-Foundations-Consultation-Feb-24.pdf](#)

⁹ Maher, J. Met al., [Women, disability and violence: Barriers to accessing justice: Final report](#) (ANROWS Horizons, 02/2018), 25; Safe Steps, [Submission to the Strong Foundations: Building on Victoria’s work to end family violence online consultation](#) (February 2024) 2.

¹⁰ Family Violence Reform Implementation Monitor, ‘Report of the Family Violence Reform Implementation Monitor, (PDF 1 November 2020), 71.

¹¹ Family Violence Reform Implementation Monitor, ‘Report of the Family Violence Reform Implementation Monitor, (PDF 1 November 2020), 70.

¹² Victorian Government, ‘Victorian Government response to the Legal and Social Issues Committee Inquiry into Homelessness in Victoria’, (PFD, February 2024), 30.

committed \$100 million over 5 years to the Safe Places initiative to fund an additional 720 “new safe places” across Australia.¹³

134. It is unclear whether this projected supply meets current or forecasted demand, however data from Homes Victoria indicates that Specialist Family Violence Services¹⁴ were unable to provide emergency accommodation to 101 of 743 households in June 2021¹⁵ and as of May 2024, Safe Steps reported that they were still reliant on motel accommodation to house clients fleeing family violence.¹⁶
135. In March 2021, the Legal and Social Issues Committee *Inquiry into Homelessness in Victoria* recommended that Victorian Government improve access to specialist family violence crisis accommodation facilities, including by:
- a) conducting demand modelling for family violence crisis accommodation across the state in order to ascertain need
 - b) providing additional funding for accommodation facilities, including for core and cluster models of accommodation
 - c) ensuring regional areas have access to family violence crisis accommodation to allow persons experiencing violence to remain in or close to their communities.¹⁷
136. The Victorian Government response supported this recommendation in full,¹⁸ but has advised the Court that there is “no timeframe for full implementation”¹⁹ and recent budget

¹³ Ministers for the Department of Social Services, ‘More emergency accommodation and support for women and children experiencing family and domestic violence’, (Web Page), < <https://ministers.dss.gov.au/media-releases/15206>>.

¹⁴ These are services which provide front line support for women and children experiencing family violence. These services only support victim-survivors. Victim-survivors can request a range of services from these providers, including short-term/crisis accommodation, medium-term/transitional accommodation and long-term housing. It is unclear whether this data exclusively includes specialist family violence services who manage crisis accommodation facilities or also references specialist family violence services who may use brokerage to provide emergency accommodation.

¹⁵ Homes Victoria, ‘Reporting: unmet housing demand among people affected by family violence, Attachment 1: Data showing unmet housing demand among people affected by family violence – June 2021’, (Excell, Jun 2021).

¹⁶ Ibid; ‘Housing’ (Web Page), < <https://www.vic.gov.au/family-violence-reform-rolling-action-plan-2020-2023/priorities-for-2020-2023/housing#progress-since-2016>>, The Age, ‘Getting family violence victims out of motels key to suicide prevention, premier told’ (May 23, 2024).

¹⁷ Legal and Social Issues Committee, *Inquiry into Homelessness in Victoria* (final report, March 2021), 216.

¹⁸ Victoria State Government, *Victorian Government response to the Legal and Social Issues Committee Inquiry into Homelessness in Victoria* (February 2024), 30.

¹⁹ COR 2019 6509; Department of Families, Fairness and Housing, Response to recommendations from the finding into the passing of Ms Bekkie-Rae Curren, <https://www.coronerscourt.vic.gov.au/sites/default/files/2025-02/2019%206509%20Response%20to%20Recommendations%20from%20DFFH_CURREN.pdf>.

announcements suggest that the Government has missed opportunities to address the unmet demand for crisis accommodation.

137. A clear example of this is the absence of funding for Safe Steps Sanctuary model in the 2025–2026 State Budget.
138. In October 2023, Safe Steps launched a pilot of the Sanctuary model of emergency accommodation which provides a trauma-informed alternative to hotel emergency accommodation with 24/7 on-site family violence specialist support, and assistance to access wrap-around services to address immediate needs.²⁰ This model aims to increase the supply of crisis accommodation by providing crisis accommodation to the people at the “*highest risk of harm from domestic and family violence*”.²¹ The Sanctuary Model locates a part-time nurse on-site, as well as a child support worker, and is designed to include in-reach of a range of support services.²² Pets can also be accommodated with some restrictions, and the average length of a stay is three weeks.
139. This pilot was funded through a mixture of federal government and philanthropic funding²³ and evaluations of the Sanctuary model show that:
- a) Victim survivors were overwhelmingly happy with their experience, and reported positive outcomes including improved health and wellbeing, increased financial stability, and greater social inclusion.²⁴
 - b) Children were able to continue to engage in education while at Sanctuary and thereafter, which itself is a protective factor against adverse childhood events.²⁵
 - c) 97% of adults who exited Sanctuary made safe transitions including to refuges, the homes of friends/family and other safe accommodation, including private rentals. This is a drastic improvement on hotel emergency accommodation safe exit rates of 60–70%.²⁶

²⁰ Safe Steps submission to the Strong Foundations: Building on Victoria’s work to end family violence online consultation February 2024 - [Safe-Steps-response-to-Strong-Foundations-Consultation-Feb-24.pdf 6](#);

²¹ Safe Steps, ‘Safe Steps Sanctuary Funded Under Safe Places Emergency Accommodation Program’ (media release), <<https://safesteps.org.au/safe-steps-sanctuary-funded-under-safe-places-emergency-accomodation-program/>>.

²² Urbis, [Sanctuary Pilot Program Evaluation](#) (Final report, 18 December 2024), 17.

²³ Safe Steps, [Sanctuary Expansion Operating Funding Budget Submission FY 25-26](#), 3.

²⁴ Safe Steps, [Sanctuary Expansion Operating Funding Budget Submission FY 25-26](#), 7; Urbis, [Sanctuary Pilot Program Evaluation](#) (Final report, 18 December 2024), 7.

²⁵ Safe Steps, [Sanctuary Expansion Operating Funding Budget Submission FY 25-26](#), 8; Urbis, [Sanctuary Pilot Program Evaluation](#) (Final report, 18 December 2024), 7.

²⁶ Urbis, [Sanctuary Pilot Program Evaluation](#) (Final report, 18 December 2024), 7, 20.

- d) Victim survivors reported feeling safe and secure in their subsequent housing indicating improved housing pathways.²⁷
 - e) It is cheaper to provide than hotel emergency accommodation,²⁸ and is estimated to have saved the government between \$1.9 to \$4.6 million due, for example, due to avoided medical and mental health costs, avoided return to perpetrator, reduced impact on children and avoided homelessness costs.²⁹
 - f) As there is constant specialist support available onsite at Sanctuary emergency accommodation, issues of “*client compliance with behavioural guidelines*” are better able to be managed as staff can “*ensure clients fully understand the conditions of stay*” and intervene in a timelier way.³⁰
140. Whilst Commonwealth capital funding has been secured to expand the number of Sanctuary apartments from seven to 35, the Victorian Government did not provide Safe Steps with the \$3.9 million required in operational funding for the Sanctuary program for the year 2025-2026, nor the \$9.6 million in ongoing funding requested.³¹ As a result, Safe Steps advise that the 28 extra units which are under construction will sit empty rather than housing more than 1000 women and children per year.³²
141. Had Sanctuary accommodation been available to FSZ this may have had a preventative impact. I therefore intend to make the following recommendations:
- a) The Victorian Government provide a roadmap to implementation of the recommendation 35 of the Legal and Social Issues Committee *Inquiry into Homelessness in Victoria*.
 - b) The Victorian Government provide Safe Steps with the funding requested for the Sanctuary accommodation model in their budget bid for 2025-26,³³ noting that this aligns with the recommendations of the March 2021 the Legal and Social Issues Committee *Inquiry into Homelessness in Victoria*.

²⁷ Safe Steps, [Sanctuary Expansion Operating Funding Budget Submission FY 25-26](#), 7.

²⁸ Safe Steps, [Sanctuary pilot initial funding submission](#), 4, 8; Safe Steps, [Sanctuary Expansion Operating Funding Budget Submission FY 25-26](#), 3, 4; Urbis, [Sanctuary Pilot Program Evaluation](#) (Final report, 18 December 2024), 8.

²⁹ Urbis, [Sanctuary Pilot Program Evaluation](#) (Final report, 18 December 2024), 8.

³⁰ Safe Steps, [Sanctuary pilot initial funding submission](#), 5.

³¹ Safe Steps, [Sanctuary Expansion Operating Funding Budget Submission FY 25-26](#), 11.

³² Wendy Tuhoy, ‘[New high-security shelters for women in crisis to sit empty during family violence epidemic](#)’, *The Age* (29 May 2025).

³³ Safe Steps, [Sanctuary Expansion Operating Funding Budget Submission FY 25-26](#), 11.

- c) The Victorian Government consult with Safe Steps on further expansion of the Sanctuary model to provide a range of Sanctuary facilities across metropolitan and regional communities to give greater choice and access pathways to people experiencing domestic and family violence, and for provision of specialist Sanctuary facilities to accommodate people with complex needs such as mental health and misuse of substances.
- d) The Victorian Government scale up long term investment in supported accommodation projects like Sanctuary to replace the hotel model.

FINDINGS AND CONCLUSION

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

- a) the identity of the deceased was FSZ, born [REDACTED];
- b) the death occurred on 24 April 2019 at [REDACTED] from compression of the neck; and
- c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

- (i) The Victorian **Department of Health**, through the Council of Australian Governments, encourage the Commonwealth Government to consider a Medicare item number for family violence counselling and therapeutic services distinct from a general practitioner mental health treatment plan. In the longer-term consideration should be given to establishing a Medicare item number or a similar mechanism that will allow medical practitioners to record a family violence-related consultation or procedure and so more accurately ascertain the public cost of family violence.
- (ii) The **Department of Families, Fairness and Housing** provide a roadmap to implementation of the recommendation 35 of the Legal and Social Issues Committee *Inquiry into Homelessness in Victoria*.
- (iii) The **Department of Families, Fairness and Housing** provide Safe Steps with the funding requested for the Sanctuary accommodation model in their budget bid for 2025-

26, noting that this aligns with the recommendations of the March 2021 the Legal and Social Issues Committee *Inquiry into Homelessness in Victoria*.

- (iv) The **Department of Families, Fairness and Housing** consult with Safe Steps on further expansion of the Sanctuary model to provide a range of Sanctuary facilities across metropolitan and regional communities to give greater choice and access pathways to people experiencing domestic and family violence, and for provision of specialist Sanctuary facilities to accommodate people with complex needs such as mental health and misuse of substances.
- (v) The **Department of Families, Fairness and Housing** scale up long term investment in supported accommodation projects like Sanctuary to replace the hotel model.

I convey my sincere condolences to FSZ's family for their loss.

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:

██████████, Senior Next of Kin

Department of Families, Fairness and Housing

Department of Health

Family Safety Victoria

Hon. Harriet Shing, Victorian Minister for Housing

Latrobe Regional Health

Safe Steps

Simon Newport, Chief Executive Officer of Homes Victoria

Victoria Police (C/- Victorian Government Solicitor's Office)

Detective Sergeant Sean Campbell, Coronial Investigator

Signature:



Judge Liberty Sanger, State Coroner

Date: 08 November 2025

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.
