IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 002391

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:	ZSQ
Date of birth:	5 July 1993
Date of death:	Between 29 April and 4 May 2020
Cause of death:	1(a) Multiple stab wounds
Place of death:	360a Park Street, South Melbourne, Victoria, 3205
Keywords:	Intimate partner homicide; family violence; mental illness; substance use

INTRODUCTION

1. On 4 May 2020, ZSQ was 26 years old when she was found deceased at her home in a suburb of Melbourne, Victoria. She died on 29 April 2020 from multiple stab wounds inflicted by her intimate partner, MJD.

Background

2. ZSQ was described as a young woman who lived life to its fullest and was devoted to her family. She was a loving and caring mother to her young son, who was only four years old when she passed. She was raised in Tasmania and moved to Victoria at the age of 18, where she worked as a dancer. Her son was born in 2015 and lived with ZSQ's mother, under an informal arrangement made by the family. ZSQ spoke to her son regularly over the phone and made frequent trip to see him. At the time of her passing, ZSQ was making arrangements to have her son move to Melbourne to live with her full-time.

3. ZSQ's mother, BRE, explained that ZSQ only had one friend in Melbourne, a man named XCV, whom she met through work. XCV explained that ZSQ's diagnosis of borderline personality disorder meant that she struggled to make friends. XCV was 30 years older than ZSQ and occasionally provided financial support to ZSQ and her family.

4. MJD was 33 years old at the time of the fatal incident. He had a challenging childhood and was exposed to traumatic events and violence from an early age. He experienced the murder and suicide of extended family members and was subject to violent assaults. MJD started using cocaine in his mid-twenties and began using it daily in 2016, while also using benzodiazepines. He also regularly drank alcohol to excess.

5. According to evidence available to the Court, MJD perpetrated family violence against at least two partners prior to ZSQ. Police applied for a Family Violence Intervention Order (**FVIO**) against MJD, to protect his former partner and their four children due to "*extreme controlling behaviours*". At the time of the fatal incident, MJD was pursuing contact with his children with the support of a lawyer.

6. At the time of the fatal incident, MJD was unemployed, however he was previously self-employed. Assessments carried out following the fatal incident indicated that MJD was significantly impaired in the areas of processing speed and attentional functioning, that his thinking was rigid and inflexible, and he struggled with problem-solving and reasoning. One assessing clinician opined that he might have an acquired brain injury (**ABI**), but this could not be confirmed. He was diagnosed with alcohol and stimulant use disorder, major depressive disorder and complex post-traumatic stress disorder.

Relationship and family violence history

7. ZSQ and MJD commenced a romantic relationship in late-October 2019. The available evidence suggests that MJD perpetrated family violence against her from the beginning of their relationship, including physical and emotional abuse, threats to kill and controlling behaviour.

8. On 1 November 2019, ZSQ contacted police who attended a family violence incident. Police recorded that MJD allegedly punched the windscreen, sideboard and dashboard of ZSQ's vehicle during an argument, causing extensive damage. ZSQ reported feeling "*terrified*" during the incident. ZSQ later told her mother that MJD allegedly smashed her head on the dashboard and strangled her, and BRE observed that she had a cut above her eye. Police applied for a Family Violence Safety Notice (**FVSN**) in protection of ZSQ which was in full conditions and prevented all contact. MJD was arrested, charged with criminal damage and bailed to attend the Melbourne Magistrates' Court (**MMC**). This matter was still pending at the time of the fatal incident.

9. The FVSN was converted to an interim FVIO with full conditions on 11 November 2020, however both MJD and ZSQ requested that the order be reduced to a 'safe contact' order. MJD was served with the FVIO at court that day. He also met with one of the court's Respondent Practitioners, and expressed remorse for damaging ZSQ's car, however stated that "*he does not agree with the fact that just because he is a man and is physically larger than the AFM that he is intimidating*". The Respondent Practitioner explained to MJD why his behaviour would have been very frightening to ZSQ. MJD told the Respondent Practitioner that he had completed a parenting program and was on a waitlist for a Men's Behaviour Change Program (**MBCP**).

10. MJD's criminal charges returned to the MMC on 9 December 2019 where his bail was extended to 13 January 2020. The interim full FVIO was finalised in limited conditions (not to commit family violence). MJD attended MMC on 13 January 2020 in relation to the criminal charges and his bail was extended to 17 September 2020.

11. On 21 January 2020, ZSQ contacted emergency services after MJD left her home with money that he indicated he would give to her. Police attended and spoke to both parties, who each reported a verbal argument but did not disclose any further abuse. Police did not submit an L17, but did make referrals for both parties to specialist family violence services.

12. In mid-February 2020, ZSQ and MJD took a short trip to Cairns. While in Cairns, MJD allegedly smashed ZSQ's phone and assaulted her at least twice, including by kicking her legs and strangling her. At the time, ZSQ told her mother that she thought MJD was trying to kill her. Queensland Police attended the hotel where the couple was staying on two occasions, and the Australian Federal Police located ZSQ in a distressed state at the airport, trying to return home.

13. On 23 February 2020, MJD and ZSQ attended a winery tour in Victoria and MJD physically assaulted her. On the way home, he assaulted her again, and braked heavily, causing ZSQ to hit her head and sustain a laceration and bruising. MJD also threatened to kill ZSQ and her family. At one point, ZSQ managed to escape the car at an intersection. MJD drove the car towards her at high speed while ZSQ was standing on a median strip. ZSQ and the other people standing on the median strip had to move in order to avoid being hit. After this incident, MJD called ZSQ's sister and told her that ZSQ had hit her own head on the dashboard and caused the injury herself.

14. After this incident, ZSQ attended the Royal Melbourne Hospital (**RMH**), where she was treated for a deep laceration to her eyebrow, and disclosed that MJD punched her multiple times. She initially told RMH staff that MJD was the only person who cared for her, and he had offered to pay for her laceration to be operated on by a plastic surgeon, so she was willing to forgive him. However, prior to discharge, ZSQ expressed an intention to separate from MJD and to stay with her family who lived in another State. While in hospital, ZSQ was temporarily placed on an Assessment Order, after disclosing suicidal ideation.

15. While in hospital, ZSQ spoke to a social worker and alleged that MJD attacked her recently in Cairns and "*attempted to strangle and kill*" her. She repeatedly declined referrals to support services, stating that she was not ready, but accepted information on family violence and legal supports, and some support with safety planning. Prior to discharge, police offered to escort ZSQ home to gather her possessions in order to stay with her family, however she declined.

16. Police arrested MJD on 29 February 2020, and he was charged and remanded in custody. Police also applied for a complaint and warrant to vary the limited FVIO to full conditions, preventing MJD from having any contact with ZSQ.

17. On 6 March 2020, the FVIO was varied to full conditions, as requested by police. On the same day, ZSQ's general practitioner provided a referral for her to see a psychiatrist, noting that she was recently assaulted by MJD and was "*apprehensive in general*". During MJD's time in custody, ZSQ told BRE that she wanted him out of her life. She moved to a new apartment with the financial support of XCV, as she was afraid of MJD.

18. On 27 March 2020, MJD pleaded guilty to reckless conduct endangering serious injury, making a threat to kill and driving whilst his authorisation was suspended. ZSQ amended her statement to police to reflect that her injuries were sustained through "*misadventure*", and therefore the assault charges against MJD were withdrawn. MJD was sentenced to 27 days' imprisonment (equivalent to pre-sentence detention). He was not placed on a community corrections order (**CCO**) upon release and was therefore not subject to any monitoring or proactive engagement upon his release.

THE CORONIAL INVESTIGATION

19. ZSQ'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.

20. 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.

21. 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.

22. Victoria Police assigned Detective Senior Constable Mathew Evans to be the Coronial Investigator for the investigation of ZSQ's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, neighbours, friends, and investigating officers – and submitted a coronial brief of evidence.

23. 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.

24. This finding draws on the totality of the coronial investigation into the death of ZSQ 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

Identity of the deceased

25. On 6 May 2020, Coroner Jacqui Hawkins, made a formal determination identifying the deceased as ZSQ born 5 July 1993, based on fingerprint identification and other identity information.

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

[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.

Medical cause of death

27. Forensic Pathologist Dr Sarah Parsons, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 5 May 2020 and provided a written report of her findings dated 11 September 2020.

28. The post-mortem examination revealed six sharp force injuries. The mechanism of death included blood loss, haemoperitoneum, pneumothorax and airway obstruction. There was no natural disease identified at autopsy that could have caused or contributed to the death.

29. Toxicological analysis of post-mortem samples identified the presence of ethanol, cocaine and its metabolites, amitriptyline and its metabolite, pholcodine, quetiapine and cannabis metabolites.

30. Dr Parsons provided an opinion that the medical cause of death was 1(a) Multiple stab wounds.

31. I accept Dr Parsons' opinion as to the medical cause of death.

Circumstances in which the death occurred

32. On 21 April 2020, XCV visited ZSQ at her home, and she alleged that MJD had strangled her the night before, causing bruises to her neck. ZSQ told XCV that she did not want to report the incident to police and said that MJD wanted $25,000 from her. ZSQ reportedly called XCV later that evening and threatened to report him to police if he did not transfer the money. The pair had an argument, and he eventually transferred the money as requested on 24 April 2020.

33. On the afternoon of 28 April 2020, ZSQ and MJD were at ZSQ's residence. She had a video call with her family and spoke to her mother and young son. BRE opined that ZSQ appeared to be in good spirits.

34. That afternoon, ZSQ and MJD travelled to a Medical Centre where the latter was seen by a general practitioner (**GP**). MJD requested a mental health care plan (**MHCP**) and reported problematic cocaine use as well as symptoms of anxiety and depression.

35. In the early hours of 29 April 2020, MJD violently assaulted ZSQ in various rooms of her home. During the assault, ZSQ resisted and scratched MJD on the upper right triceps and chest. During the assault, three of ZSQ's false nails were broken and parts of her hair extensions were pulled out. MJD inflicted six stab wounds on ZSQ, and she died at the scene as a result. MJD fled the address at about 4.30am in ZSQ's vehicle.

36. BRE attempted to contact ZSQ several times over the following days, however BRE was unable to get in touch with ZSQ via phone or text message. BRE was concerned that ZSQ's silence was unusual, particularly because ZSQ's son was due to have a medical procedure.

37. BRE called Triple Zero on 4 May 2020 and requested a welfare check. Police attended and gained access to ZSQ's home using keys from the landlord. Inside the house, police located ZSQ unresponsive on the floor of her bedroom and confirmed she was deceased.

38. After leaving ZSQ's property, MJD met with his father in a Melbourne suburb, then abandoned ZSQ's vehicle at an address in an outer Melbourne suburb. He hired a van and travelled to the Australian Capital Territory, arriving on 7 May 2020. The following day, he rented an apartment in New South Wales. He was arrested at this apartment on 14 May 2020.

39. MJD pleaded not guilty to ZSQ's murder. Following a trial in the Supreme Court of Victoria, he was found guilty by a jury of her murder. On 1 November 2024, MJD was sentenced to 28 years' imprisonment, with a minimum non-parole period of 22 years.

FURTHER INVESTIGATIONS AND CPU REVIEW

40. As ZSQ's death occurred in circumstances of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[3]

[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.

41. I make observations concerning service engagement with ZSQ as they arise from the coronial investigation into her death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and ZSQ's death.

42. 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 ZSQ to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Specialist family violence services

43. The evidence available to the Court suggests that ZSQ did engage with specialist family violence services with respect to abuse she experienced from previous partners, but not during her relationship with MJD. Usually, the services were unable to contact ZSQ after receiving the L17 referral. The available evidence suggests that MJD also did not engage with family violence services. Specialist family violence services were often either unable to contact MJD or did not attempt to do so as police had not spoken to him about the referral. It is clear that family violence services were unable to meaningfully engage ZSQ and MJD during their relationship.

44. I note that multiple coroners in Victoria have now made recommendations and comments in support of an expansion of co-responder models in Victoria.[5] A co-responder model involves the presence of a family violence specialist worker during police attendance at family violence incidents to provide a collaborative response. A co-responder program has the potential to increase engagement with specialist family violence services by both perpetrators and victims of family violence.

Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

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

[5] See, e.g., Finding into the passing of Noeline Dalzell with inquest – COR 2020 000670; Finding into the death of EDH without inquest – COR 2021 0204; Finding into the death of Carolyn James with inquest – COR 2023 1604; Finding into the death of CM without inquest – COR 2021 3935; Finding into the death of FCP without inquest – COR 2020 1981.

45. In Judge Cain's finding into the death of Jessica Geddes, his Honour made the following recommendation:

> *That the **Victorian Government** provide funding to implement Recommendation 5 in my Finding into the passing of Noeline Dalzell, as follows:*
>
> > *Victoria Police and The Orange Door in two regions as a pilot collaborate to embed advanced family violence practitioners within each FVIU to assess, jointly respond to and manage repeat and/or high-risk family violence matters and improve proactive victim/AFM engagement. I note the complexity of placing a Family Violence Practitioner within the structure of a statutory organisation such as Victoria Police and acknowledge that this will need to be a senior worker with extensive experience and provided with supervision by a specialist family violence service. An independent evaluation of the pilot program should be completed within two years of commencing operation in each of the two regions selected.*[6]

46. Victoria Police advised the Court, in response to a similar recommendation from Coroner McGregor, that funding external to Victoria Police would be required to implement the recommendation, and that implementation of the recommendation "*would require Victorian Government funding decisions*". The Department of Families, Fairness and Housing (**DFFH**) considered Coroner McGregor's recommendation in his finding into the passing of CM,[7] to resource an expansion of co-responder programs across Victoria. Coroner McGregor recommended:

> *That the Victorian Government resource an expansion of co-responder programs across Victoria.*[8]

47. In response, DFFH stated that the implementation of this recommendation was dependent upon appropriate resourcing.

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6 Finding into the death of Jessica Geddes without inquest – COR 2020 6055.
7 Finding into death without inquest – CM (COR 2021 3935).
8 Ibid, 16.

48. I therefore intend to recommend that the Victorian Government provide funding for the expansion of co-responder programs across Victoria, noting the numerous coronial recommendations and comments made about the benefits of co-responder models.

Relationships Australia

49. MJD contacted Relationships Australia Victoria (**RAV**) on several occasions between February and August 2019, requesting counselling and a MBCP. Based on the evidence available, it does not appear that MJD engaged with counselling or an MBCP beyond initial appointments. MJD completed a six-week parenting program between April and August 2019.

50. I have not identified any concerns with respect to MJD's contact with RAV. His inability to follow-through with voluntary behaviour change programs through RAV, and the potential limitations of the sector to intervene with high-risk perpetrators of family violence, is discussed further below.

Royal Melbourne Hospital

51. I have not identified any deficiencies with respect to ZSQ's admission to the RMH in February 2020.

Victoria Police

52. There were no issues identified with the Victoria Police contact until MJD's release from custody on 27 March 2020. Victoria Police completed a Family Violence Death Assessment (**FDA**) following ZSQ's passing, which is discussed in further detail below. I note that the FDA is a desktop review conducted by Victoria Police which occurs in a vacuum, absent of the time pressures and competing demands facing frontline members.

53. At the time of MJD's release from custody, he was not flagged as a prisoner to follow-up with post-release, as his address in the police database was in Queensland. The Family Violence Investigation Unit (**FVIU**) with oversight of MJD closed their involvement with him. Police did not appear to take any steps to obtain an accurate address or other contact details following his release to assess or manage risk. Police also did not contact ZSQ regarding MJD's release. The FDA described these decisions

as "*questionable*", given the practice guidance on prison releases available to members. The FDA further noted that police Family Violence Intelligence Analysts must risk assess prison releases for potential reoffending and monitoring post-release once per week, and that this may not have been sufficient given the risk of immediate reoffending by high-risk offenders such as MJD.

54. The FDA made the following recommendations:

> *<u>Recommendation 1</u> – Review of the accountability process be undertaken by FV Command regarding monitoring of FV Incidents. Specifically, I refer to the response, investigation and subsequent completion of FV incidents in LEAP in accordance with the FV Code of Practice. Currently, there is rarely a notation on LEAP FV narratives beyond the rank of Sergeant.*
>
> *<u>Recommendation 2</u> – FV Intelligence Analysts – Core Duties and Principles…Monitoring of Prison Releases be reviewed as to its effectiveness. The current instruction of analysing prison releases once every 7 days, potentially places AFMs at risk if the release occurs within the 6 days preceding that analysis.*
>
> *<u>Recommendation 3</u> – VPID as it relates to Prison Releases as detailed in the Divisional Intelligence Practice Guide be reviewed regarding its effectiveness in preventing serious crime. Issue is similar to recommendation 2 except that the focus of prison release analysis is not limited to FV.*
>
> *<u>Recommendation 4</u> – Extraction of information from prison release data, as provided by the Department of Corrections, be reviewed regarding its effectiveness in identifying high risk FV perpetrators. Specifically, ire fer to the situation in the case of ZSQ, where the RESP MJD was not flagged as potentially requiring post release monitoring due to his address being recorded interstate.*

55. A further recommendation was made due to police non-compliance with respect to their management of family violence perpetrated against ZSQ, prior to her relationship with MJD. These instances of non-compliance involved decisions made outside of Victoria

Police family violence policy by members and sergeants which were not subject to oversight beyond the rank of sergeant. The FDA noted:

> *The culture of policing which leads to members making operational decisions in good faith, but outside the bounds of policy and procedures, will continue to be an issue in spheres of policing, not just FV. Unless there is greater accountability around such decisions, the above failings will continue to occur.*

Recommendation 1

56. With respect to Recommendation 1 and the additional recommendation regarding "*[t]h culture of policing*", I note that it does not specifically relate to police contact with ZSQ during her relationship with MJD. However, it *does* relate to prior contact which *may* have negatively impacted ZSQ's willingness to engage with police processes during her relationship with MJD.

57. In response, Victoria Police noted that any proposed comments about prior police responses to family violence experienced by ZSQ are not sufficiently proximate or causally connected to her death and therefore should be omitted from the finding.

58. Victoria Police also noted that it is committed to improving victim-centric policing responses to family violence. In response to Recommendation 1, the Family Violence Command (**FVC**) identified an opportunity to review the existing policy of the supervision of family violence matters to assess whether the level of oversight was sufficient and appropriate. This reviewed determined that supervisory oversight at the sergeant level was appropriate and consistent with other organisational accountability and processes.

59. Victoria Police further noted that supervising sergeants and Family Violence Liaison Officers (**FVLOs**) are afforded high level training to support analysis of emergent situations, assessing risk, and ensuring appropriate actions are taken. Involvement at the sergeant level already provides active supervision and intervention in other matters, such as bail decisions. Therefore, Victoria Police considered that it remained appropriate for sergeants to continue to oversee family violence matters. Victoria Police found that higher supervisory oversight was not warranted in terms of necessarily

delivering an enhanced response, nor was it practicable when considering the volume of family violence incidents reported.

60. Victoria Police explained that as part of their ongoing commitment to continuous improvement, it has uplifted family violence training and investigative practices to ensure police members, supervising sergeants and FVLOs are equipped with the skills to investigate and respond to family violence effectively and appropriately. Since 2020, the organisation has implemented enhancements including:

    a) Development and implementation of version 3 of the Case Prioritisation and Response Model (**CPRM**), which is the framework for FVIUs to identify and priories the highest risk cases and develop tailored risk management to prevent serious harm.

    b) Completion of a training needs analysis for the FVLO role in collaboration with Monash University, resulting in the development of a comprehensive FVLO Training Package.

    c) Delivering a significant program of work to improve the identification of the predominant aggressor.

Recommendations 2 and 4

61. Victoria Police explained that in 2022, the Family Violence Prison Release Tool (**FVPR Tool**) was developed by the FVC to better facilitate risk assessments on family violence perpetrators who are due to be released or planned to be released from prison in the near future.

62. Victoria Police noted that the FVPR Tool has provided FVIU analysts with the ability to commence a proactive offender management strategy in a timely manner. This has assisted by minimising the gaps in identifying family violence perpetrators who may be at high risk of committing further family violence post-release. It further allows members to compete a complete risk assessment. The tool also provides a standardised practice that strengthens FVIU offender management and consistency in the monitoring of prisoner releases.

63. Victoria Police noted that intelligence regarding released prisoners is limited to the information provided by Corrections Victoria. Corrections Victoria data is generally only available for update once per week, hence the potential delay in receiving updated information about released prisoners.

64. Given the potential safety implications where Victoria Police and victims are not promptly notified about an offender's release from prison, in my view it would be prudent to improve the regularity of information received from Corrections Victoria. I therefore intend to recommend that Corrections Victoria investigate and implement a system to create real-time (or near real-time) notifications when offenders are released from prison.

65. Victoria Police otherwise submitted that Recommendations 2 and 4 were addressed through the implementation of the FVPR Tool.

Recommendation 3

66. At the time of ZSQ's death, the Victoria Police Intelligence Doctrine (**VPID**) had been repositioned as a statement of Victoria Police intelligence, tasking, coordination philosophy and guiding principles. Policy was set out in the Victoria Police Manual (**VPM**) Intelligence and VPM Tasking and Coordination, with extensive practice guidance contained in 24 VPID Practice Guides (**PG**) including the VPID PG Person of Interest (**POI**) Management and Coordination, and the VPID PG Recidivist and Other High-Risk Offenders.

67. Since ZSQ's death and the FDA recommendations, Victoria Police submitted that there have been various updates to the documents that set out Victoria Police's intelligence, tasking and coordination and POI management, coordination philosophy, policy and practice guidance. It explained that the VPID continues to set out the Victoria Police intelligence, tasking and coordination philosophy and updated versions of the VPM Intelligence and VPM Tasking and Coordination remain in place. The majority of the relevant PGs have been consolidated into the Intelligence PG and the Tasking and Coordination PG. Additional practice guidance is provided in the Information Reports PG and the Offender Debrief PG.

68. In November 2023, the VPID PG POI Management & Coordination and the VPID PG Recidivist and Other High-Risk Offenders were withdrawn. The guidance in these documents have been substantially updated and reshaped into two new PGs which are framed around the key stages in the POI management and coordination process, including:

    a) The POI Identification and Prioritisation PG, which is aimed predominantly at Divisional Intelligence Units and Tasking and Coordination committees; and

    b) The POI Response PG, which is primarily aimed at Investigation and Response units, and other units who manage POIs.

69. Victoria Police submitted that its approach to identifying, prioritising and responding to high-risk POIs continues to evolve and provides advice on the use of prison release information to support POI identification and prioritisation decisions. The policy and practice guidance remains under constant review and is updated annually to ensure it remains contemporary.

Victoria Police conclusion

70. Victoria Police submitted that the intent of the recommendations contained within the FDA are considered addressed by the organisation and advises that it continued to build capacity and uplift member capability, supporting a process of continuous improvement in the police response to family violence.

71. In circumstances where significant changes have been implemented by Victoria Police in the years since ZSQ's passing, I am satisfied that I do not need to make any further recommendations.

Queensland Police Service

14 February 2020

72. As noted above, ZSQ and MJD went on a short trip to Cairns together in February 2020. ZSQ later reported that while she was there, MJD smashed her phone and assaulted her at least twice. She reported the assaults included kicking her in the legs and choking

her. ZSQ told her mother and professionals that she believed MJD was trying to kill her.

73. On 14 February 2020, staff at the hotel where the couple were staying called police and reported that MJD ejected ZSQ from their room, that they later argued by the pool and that a separate room had been arranged for ZSQ. Witnesses heard screaming from the balcony of ZSQ's new room. The Queensland Police Service (**QPS**) records indicate that they were aware of the Victorian FVIO in place for ZSQ's protection at the time, and that the National Domestic Violence Order Scheme was operating at the time.

74. Upon police arrival, the members spoke to MJD and recorded that he was "*cooperative*" and "*upfront*" as he advised police of his "*past and other orders related to another ex-partner in Western Australia*". MJD told police that ZSQ had been drinking and would be "*making up a lot of stuff*". QPS records noted that MJD was "*intoxicated yet coherent enough to give his account of what happened*". QPS also recorded that MJD told them he recently:

> *...sent her to see her son who was residing with her mother. He thought that this was important for her to do. When she returned she accused him of cheating on her while she was away. He alleges the aggrieved has a split personality, smokes bongs and when she drinks, gets aggressive*.

75. MJD further alleged that ZSQ "*smashed her room and threw her phone to make it look like he assaulted her*". QPS documented that the receptionist confirmed that ZSQ screamed "*Help me, help me, help me. He's bashing me!*" from her balcony while MJD was on another floor of the hotel. The receptionist reportedly stated that "*On one occasion the respondent was talking to reception when from the pool area the female was shouting 'Help, help…' in relation to being attacked by partner*".

76. QPS documented that "*aspects of the respondent's version was corroborated by the account from the receptionist*". I note that it is possible that ZSQ may not have been able to call for help until MJD left the room and her delay in calling for help does not invalidate her allegations against him.

77. QPS attended ZSQ's room and noted that it "*did not appear smashed*" which would contradict MJD's account. ZSQ reported that her mother paid for her to get her own

room after "*the first incident*" which occurred in the room she was previously sharing with MJD. ZSQ reported that she went for a swim and MJD came to the pool, grabbed her, threw her iPad in the pool and bit her ear. Police later located the iPad by the pool and noted that it "*had a cracked screen but was not wet*". ZSQ further reported that MJD then attended her room and strangled her.

78. Police recorded that ZSQ's account "*just didn't match with other witness accounts*" and that she did not have any injuries. It is not clear from the records which witness accounts the attending members assessed as contradicting ZSQ's version of events. Police recorded that a guest in the neighbouring room only heard a verbal argument and that witnesses in the pool area heard ZSQ scream shortly after she and MJD left the area. The witnesses approached the elevator and saw MJD exiting the elevator while ZSQ was still screaming.

79. Police transported ZSQ to the station to make a statement. Police recorded that during the drive to the police station "*In talking a little about her relationship with the respondent she indicated that she had contributed to the arguments as well*" and that MJD did not want her to work so he paid her instead.

80. At the police station, police administered a breathalyser which returned a result of 0.177 g/100mL. Police decided not to take a formal statement from ZSQ due to her level of intoxication. The QPS records state that they transported ZSQ back to the hotel "*where further arrangements were made to check out from the hotel and make new arrangements elsewhere*".

81. The QPS member who was assigned as the investigating officer entered the incident on the QPS computer system, QPRIME, for contravention of the interstate FVIO, listed MJD as a suspect and created a task to obtain a statement the following day. The member also conducted a protective needs assessment of the incident and identified some risk factors including previous incidents/breaches, alcohol/drug misuse, controlling behaviour and respondent's history of violence. The member noted the level of risk was "*unknown*", ZSQ's fear level was recorded as "*fearful*". Relevant risk factors of property damage and strangulation were both present, however were not identified or recorded during the risk assessment.

82. QPS advised that the investigating member was due to commence leave the next day and therefore entered a task in QPRIME to obtain a statement from ZSQ the next day. While the member was on leave, this task was unable to be actioned. Upon his return from leave, the member attempted to contact ZSQ, however, was unable to reach ZSQ on the phone numbers she provided at the time. The QPS member contacted the Victorian police officer who had originally assisted him regarding his enquiry about contact details, and the QPS member requested that Victoria Police attend ZSQ's address. Following up the email enquiry, the QPS member was advised that ZSQ had passed away.

16 February 2020

83. QPS recorded that at about 5.00pm on 16 February 2020, ZSQ was "*located by police*", having left her hotel on foot after being locked out of her room by MJD. Police recorded that they took ZSQ to the airport as she wanted to return home, and did not want to provide police with a statement. Police documented that MJD had breached the Victorian FVIO by "*not being of good character towards*" ZSQ. Police also documented that they attended the hotel the speak to MJD, however found that he had been "*kicked out*". QPS records do not indicate that any further actions were taken by police to investigate this incident or ensure ZSQ's safety.

84. QPS advised the Court that ZSQ briefly informed the attending members about what had occurred and stated that she did not want to provide a statement to police to support an investigation or prosecution, and "*just wanted to go home*", referring to Victoria. QPS also advised the Court that the members attempted to locate MJD, however he had left the hotel, and they were unable to find him.

85. Despite the flagging task to take a statement from ZSQ regarding the 14 February incident, it is unclear whether the attending QPS member attempted to take a statement regarding same. QPS submitted that they were unable to determine whether any attempts were made, without speaking to the member involved. QPS noted that as ZSQ did not want to provide a statement about the 16 February incident, she may have been unwilling to give a statement about the 14 February incident either.

86. QPS noted that police conducted a protective needs assessment of this incident and recorded risk factors of frequency of incidents and controlling behaviours. QPS

submitted to the Court that further risk factors may have been present including separation and strangulation. These risk factors may have provided a more detailed risk assessment of the situation.

87. The risk level was identified as medium, which equates to "*no significant/current indicators of risk of harm to the aggrieved. Changes in circumstance or DV may create risk for the aggrieved and any future incidents should be carefully assessed.*" QPS submitted that there may have been a missed opportunity regarding the identification of the level of risk, however the officer was still faced with the prospect of not having relevant evidence for this second matter. However, combined with the event two days prior, QPS submitted that this was sufficient to raise concerns regarding the level of risk to the aggrieved and the action required to be taken by the officer. The level of risk therefore should have been identified as high.

88. At the airport, Australian Federal Police (**AFP**) located ZSQ in a distressed state. She disclosed that MJD had assaulted her, smashed her phone, kicked her out of the hotel and kept all her belongings that day. ZSQ reportedly had no phone or money. The AFP members assisted ZSQ to contact XCV to arrange a flight back to Melbourne, however the available evidence suggests that ZSQ later decided to stay in Queensland for a further two days.

National Policing System

89. QPS noted that national policing agencies rely upon the National Criminal Intelligence System (**NCIS**) database to store and access information to support police decision-making, strategies and responses. Family violence applications or information relied upon that gives rise to an application for a court order (or issuing of a police order where relevant) is not stored within this database. This impacts the capability of any policing agency to operate with all information available to it at the time – that is, information relevant to the making of an application for a protection order (or variation of an interstate order) is invisible, impacting risk assessments and policing responses.

90. Noting MJD had an interstate history, QPS suggested that there is a strong case to ensure that Australia has an appropriate database that provides relevant information in a timely manner to enhance police risk assessment processes. Until system capabilities improve, police across Australia will continue to operate with the limited information

available to them at the time of crisis for the victim-survivor, perpetrator and children. I agree with this suggestion and note that it is not a matter for QPS or Victoria Police to implement individually, as it will require all States and Territories to work together, potentially with the assistance of the Commonwealth Government.

Missed opportunities

91. The review of the QPS interactions with ZSQ and MJD identified the following matters:

a) It appears that police inferred the plea for help by ZSQ was due to being "*bashed*" at that time, not realising this plea may have been related to conduct earlier than the request for urgent assistance. They inferred the comment to be implausible due to MJD not being in the vicinity of ZSQ. The nexus between the request for help and the incident occurring appears to have weighed on the officer's mind regarding an inconsistent statement.

b) ZSQ stated to police on several occasions that she was nearly killed but it does not appear that this was explored in detail at the time. ZSQ alleged that MJD strangled her and showed the action of putting her hand around her throat, however this was not explored in further detail.

c) There was ineffective investigation to identify further detail of the event from ZSQ or identification of witnesses to unearth or elicit potential corroborative evidence, including the witness to the incident at the pool area and the neighbours of the 'verbal argument'.

d) The exploration of the 'verbal argument' may demonstrate a lack of knowledge (at that time) of emotional abuse or other forms of family violence.

e) While ZSQ appeared to be content to stay at the hotel, it appears that this was paid for by her mother. It does not appear that crisis accommodation was explored fully, suggesting a lack of insight into the gravity of further family violence to ZSQ.

f) Knowledge and application of the Domestic Violence – Protective Assessment Framework (**DV-PAF**) appeared to be lacking with relevant risk factors not

identified in the protective assessment by both police officers, impacting an appropriate assessment of risk, protective need and resulting police action.

g) Obtaining a signed written statement from ZSQ was a critical evidential component to support a further investigation of the stand-alone criminal offences, including the breach of the Victorian FVIO. This inability to secure a written statement ultimately impacted the ability of police to commence a criminal prosecution. It does appear that that the investigating member made several attempts to contact ZSQ, however, was unsuccessful.

h) This case demonstrated perpetrator tactics and a motivation to avoid detection as the predominant aggressor. In this case, MJD was the first to engage with police, offering his version of events and attempting to bias the officers with his views and opinions, including his attempt to identify ZSQ as a prostitute whom he "*still loves*". He provided an impression that he was being open, honest and "*upfront*" with police to appeal to them, which was a clear demonstration of perpetrator tactics to bias the outcome in his favour. At the time of this incident, perpetrator tactics and motivations had not been extensively covered in the QPS training curriculum, however this was later introduced in 2022.

i) Police noted the "*erratic conversation*" with ZSQ, which may have not identified the impact of trauma, including cumulative trauma. QPS made significant investments in 2022 to upskill the entire organisation regarding family violence. This included training in perpetrator tactics, content regarding trauma, the presentation of the 'ideal victim' and officer bias. The training was designed to help members identify the presence of trauma and how this may impact their pre-conceived perceptions of the 'ideal victim'.

j) The QPS member noted that ZSQ's iPad screen was cracked but it was not wet. ZSQ mentioned her iPad was "*smashed in the pool*", however she may have been referring to the pool area, rather in the pool itself. It is not possible to determine now if the member incorrectly interpreted ZSQ's statement, however if they did, it may have been a missed opportunity to gather evidence to support a civil and/or criminal investigation.

k) The risk level was identified as "*Level of risk unable to be determined*". QPS identified that this was an inappropriate selection given the presence and identification of some "*Category 1 and 2 factors*" by the officer, and some other factors that were not identified, regardless of the parties' level of intoxication. This may have been a missed opportunity to assess the risk of further or future family violence to ZSQ and may have impacted the potential protection to ZSQ, including an ability to apply for a variation to the Victorian FVIO.

92. I acknowledge the deficiencies and potential missed opportunities identified by QPS and commend the organisation for completing a comprehensive and transparent review of their contact with ZSQ and MJD. Given the significant reforms and changes implemented by QPS (discussed below), I am satisfied that further recommendations are not required.

Recent reforms or changes implemented by QPS

93. Since ZSQ and MJD visited Queensland in February 2020, QPS submitted there have been a significant suite of reforms and changes to their policies, procedures and responses to family violence, as well as relevant legislative changes. Without listing every change that has occurred in the five years since ZSQ's death, QPS noted the following matters:

a) Establishment of the Domestic Family Violence and Vulnerable Persons Command (**DFVVPC**) in March 2021 as an expansion of the State Domestic and Family Violence and Vulnerable Persons Unit, originally established in 2015. The purpose of the Command is to develop, enhance and support QPS capability to prevent, disrupt, investigate and respond to family violence and harm to vulnerable persons. It also has responsibility for family violence and vulnerable persons capability for the organisation, including leading the broader strategic and policy direction and identifying opportunities for continuous improvement of the policing response and supporting district-led frontline operations.

b) In August 2021, the QPS Domestic and Family Violence Advisory Group was formed, with members from DVConnect, Women's Legal Service Queensland, Multicultural Australia, the Queensland Family and Child Commission and

from academia. It has subsequently broadened to include representatives for young people's issues.

c) In May 2022, the Queensland Government called an Independent Commission of Inquiry into QPS responses to domestic and family violence. In November 2022, Judge Deborah Richards provided a report, *A Call for Change*, which included 78 recommendations.

d) QPS developed its current domestic and family violence Doctrine and Strategy for 2023-2025.

QPS domestic and family violence specialist resources

94. Family violence specialist resources are delivered at QPS through a partnership model between the strategy capability responsibility of the DFVVPC and operational capability undertaken within each of the police districts. Specialist DFV Coordinator (**DFVC**) positions, at the rank of sergeant, are in each of the districts. The DFVCs are responsible for co-ordinating and monitoring the policing response to family violence within their district in accordance with QPS strategy, plans, policy, legislation and procedures. Many of the DFVCs are assisted by full-time DFV Officers (**DFVOs**) at the rank of Senior Constable or Constable.

95. The DFVVPC has DFVC positions operating in the Brisbane Police Communications Centre to provide specialist knowledge and assistance of DFV to frontline staff. DFVCs and DFVOs are based in police districts and often operate within a designated specialist unit within their area. The size and structure of each unit is in response to demand, resourcing, operational nuances and community dynamics relevant to the district.

96. QPS also has High Risk Teams (**HRTs**) which coordinate high-risk family violence referrals into the multi-agency HRT, provide QPS-held information on non-QPS referrals and coordinate any QPS actions arising from developed safety plans.

Training and development of QPS members

97. In 2022, 2023 and 2024, new and approved online and in-person training modules have been launched to uplift QPS members' identification and responses to family violence.

This includes coercive control, identifying patterns of behaviour, prioritising victim-survivor safety and ensuring perpetrator accountability.

Systemic issues

Perpetrator interventions – high-risk offenders

98. In Victoria, perpetrator interventions consist of two key intervention types – behaviour change programs (mostly MBCPs), and legal and policing interventions.[9]

99. The available evidence to the Court suggests that MJD did not meaningfully engage in community-based behaviour change interventions. Prior to the fatal incident, MJD was listed as the respondent on eight L17s, however records indicate that he never engaged with family violence services as a result.

100. While in prison, MJD was noted to be "*eager to work and complete programs*", however the available records indicate that offence specific and/or related programs such as the 'Violence Intervention' program were only available to sentenced prisoners. As MJD was on remand and not sentenced (until his day of release), these programs were not available to him. Even if the programs *were* available to him, 27 days is insufficient to meaningfully engage with behaviour change work. As he was not placed on a CCO at the end of his sentence, MJD was not required to engage with any programs aimed at reducing his perpetration of family violence.

101. Victoria Police assessed that MJD was an "*extreme risk FV perpetrator*". Evidence available to the Court suggests that policing and justice responses did not deter him from perpetrating family violence, given his repeated and significant abuse of ZSQ. His lack of respect for such interventions was also evidenced when he was served a FVSN in protection of his former partner in January 2019 and he stated that the FVSN was "*only a piece of paper*", and that he would find her and his children, despite them fleeing to refuge accommodation. MJD allegedly breached the FVSN immediately and allegedly breached FVIOs. I note he has not been convicted of these breaches.

[9] Bell, C., & Coates, D., ANROWS, *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews* (2022) 4.

102. The Australian Law Reform Commission (**ALRC**) canvassed issues with short prison terms in their report *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples.*[10] The ALRC found that while short prison sentences can provide a brief period of safety for victims of family violence,[11] they do not deter offenders, and may increase the likelihood of recidivism. The ALRC commented that prisoners serving short sentences are less likely to be able to access programs which might assist them to desist from offending and are generally released into the community without supervision or supports.[12]

103. The ALRC did not recommend the abolition of short sentences given the dearth of community-based sentencing options, supports and programs available to replace them. It did, however, recommend expansion of community programs aimed at addressing the underlying causes of crime, and therefore of community-based sentencing options.[13]

104. In Judge Cain's finding into the passing of Noeline Dalzell, his Honour noted that although the homicide offender in that case was successfully prosecuted and served several short sentences for his family violence crimes, these criminal sanctions had no impact upon his recidivism.[14]

105. According to ANROWS, Australia is yet to adequately invest in behaviour change work with perpetrators of family violence.[15] Effective intervention with high-risk perpetrators of family violence is a particular challenge for the service sector,[16] and the Expert Advisory Committee on Perpetrator Interventions (the Committee) found that there is "*an urgent need for a more intensive intervention in the community to respond to higher risk perpetrators*", particularly those found unsuitable for a MBCP, and those recently released from prison whose sentence was too short to allow for participation in

[10] ALRC, *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report No 133, 2017).
[11] ALRC, *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report No 133, 2017) 271-2.
[12] ALRC, *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report No 133, 2017) 268.
[13] ALRC, *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report No 133, 2017) 271-2.
[14] CCOV, Finding into the Passing of Noelene Dalzell 2020 06770, 68.
[15] Helps, N., Bell, C., Schulze, C., Vlais, R., Clark, O., Seamer, J., & Buys, R. *The role of men's behaviour change programs in addressing men's use of domestic, family and sexual violence: An evidence brief* (February 2025). ANROWS 23
[16] State of Victoria, Expert Advisory Committee on Perpetrator Interventions, *Final Report* (2018) 67.

perpetrator intervention.[17] The Royal Commission into Family Violence (**RCFV**) made a similar finding.[18] The Committee therefore recommended the development of "*a family violence intervention in the community for high risk perpetrators who are unsuitable for participation in an MBCP*".[19]

106. ANROWS also noted that although fiscal pressure creates pressure to fund cheap interventions,[20] short-term perpetrator interventions "*do not seem effective and should be replaced or augmented with programs that include wraparound and holistic supports*."[21]

107. Subsequently, in March 2024, Family Safety Victoria finalised the program requirements for a pilot program entitled '*Changing Ways: Intensive interventions for serious-risk adults using family violence'* (**'Changing Ways'**). The pilot will run for two years and target serious-risk adults using family violence with an intensive, co-ordinated response based on their level of risk. The service model includes leading and coordinating multi-agency risk assessment and management, advocacy for victim survivors,[22] and, where appropriate, responsive, individual readiness for change and behaviour change work.[23] It aims to increase safety for victim survivors, reduce or stop the substantial harm caused by serious-risk adults using family violence, and build evidence of what works. [24] The pilot will be independently evaluated.[25]

108. Evidence suggests that individualised, tailored programs such as Changing Ways contribute to more positive outcomes for people who use violence than "*one-size-fits-*

[17] State of Victoria, Expert Advisory Committee on Perpetrator Interventions, *Final Report* (2018) 70.
[18] Family Safety Victoria, Changing Ways: Intensive interventions for serious-risk adults using family violence – Program requirements (March 2024) 6.
[19] State of Victoria, Expert Advisory Committee on Perpetrator Interventions, *Final Report* (2018) 7-.
[20] Helps, N., Bell, C., Schulze, C., Vlais, R., Clark, O., Seamer, J., & Buys, R. *The role of men's behaviour change programs in addressing men's use of domestic, family and sexual violence: An evidence brief* (February 2025). ANROWS. 26
[21] Bell, C., & Coates, D., ANROWS, *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews* (2022) 3.
[22] Family Safety Victoria, Changing Ways: Intensive interventions for serious-risk adults using family violence – Program requirements (March 2024) 16.
[23] Family Safety Victoria, Changing Ways: Intensive interventions for serious-risk adults using family violence – Program requirements (March 2024) 28.
[24] Family Safety Victoria, Changing Ways: Intensive interventions for serious-risk adults using family violence – Program requirements (March 2024) 6.
[25] Family Safety Victoria, Changing Ways: Intensive interventions for serious-risk adults using family violence – Program requirements (March 2024) 40.

all" approaches.[26] A tailored approach may have benefited MJD, whose specific background of trauma may have impacted the nature and intensity of his use of violence,[27] and required tailored case management and therapeutic interventions. An intensive perpetrator intervention may have also promoted ZSQ's safety, for example, by keeping MJD in view of the police after his release from prison. I note that this program's effectiveness in responding to high-risk perpetrators is yet to be evaluated and I therefore look forward to seeing these results in due course.

109. I support programs such as the Changing Ways pilot and will direct a copy of this finding be provided to Family Safety Victoria, so that the learnings from ZSQ's passing can be incorporated into their work in the Changing Ways pilot. In particular, I encourage Family Safety Victoria consider how they work with Victoria Police in circumstances of high-risk family violence perpetrators.

Gendered violence and primary prevention

110. In Australia, violence against women is 'staggeringly common', and is overwhelmingly perpetrated by men.[28] Although attitudes regarding violence against women are slowly improving, problematic attitudes in relation to gender equality and violence against women, including attitudes which reinforce rigid gender roles, persist for a concerning minority of Australians.[29] To address gender-based violence, more must be done to challenge dominant forms of masculinity, and the harm they do to people of all genders at an individual, group and society level.[30]

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[26] Helps, N., Bell, C., Schulze, C., Vlais, R., Clark, O., Seamer, J., & Buys, R. *The role of men's behaviour change programs in addressing men's use of domestic, family and sexual violence: An evidence brief* (February 2025). ANROWS 14; Fitz-Gibbon, K., McGowan, J., Helps, N. & Ralph, B. (2024) Engaging in Change: A Victorian study of perpetrator program attrition and participant engagement in men's behaviour change programs. Monash University, Victoria, Australia, 7, 82.

[27] R Vlais, *Working with adult users of domestic and family violence who have a trauma background* (April 2025) 3.

[28] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 12; Australian Bureau of Statistics, Personal Safety Survey – Physical Violence (2023) < Physical violence, 2021-22 financial year | Australian Bureau of Statistics (abs.gov.au)>; Australian Bureau of Statistics, Personal Safety Survey – Partner Violence (2023) <Partner violence, 2021-22 financial year | Australian Bureau of Statistics (abs.gov.au).>.

[29] Christine Coumarelos et al, ANROWS, *Attitudes Matter: The 2021 National Community Attitudes Towards Violence against Women Survey (NCAS) Findings for Australia* (Report, 2023) 22-4.

[30] Respect Victoria, *Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament* (Report, September 2022) 113 <Three-Yearly Report - Respect Victoria - 2022.PDF>.

111. Primary prevention aims "*to change the underlying social conditions that produce and drive violence against women*" to prevent it from occurring in the first place. This includes addressing the gendered drivers of men's violence against women, such as the condoning of violence against women, and reinforcing factors which play a role in influencing the occurrence or dynamics of violence against women, such as prior experience of violence.[31]

112. As outlined above, the available evidence suggests that ZSQ experienced family violence perpetrated by MJD and at least two other previous partners. The evidence also suggests that MJD allegedly perpetrated family violence against at least two other female ex-partners and lacked insight into the impacts of his behaviour. His children reportedly witnessed the family violence perpetrated against their mother.

113. MJD experienced, and was exposed to violence throughout his life, and the available evidence suggests that violence was normalised in his family. Not only was MJD's experience of trauma and violence consistent with the above factors which reinforce men's violence against women, it may have led to an ABI. Available evidence indicates that 'rates of ABI are disproportionately high among perpetrators of family violence'.[32] MJD's longstanding substance misuse issues are also consistent with factors reinforcing men's violence against women.

114. In Judge Cain's finding into the death of Thi Minh Phuong Nyugen, his Honour made the following recommendations:

> *The Victorian Government urgently increase the total quantum of primary prevention funding, and prioritise longer term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria.*[33]

[31] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021).

[32] State of Victoria – Family Safety Victoria, *MARAM Foundation Guide* (February 2021) 105.

[33] Similar recommendations are made by the FVRIM and Respect Victoria in the following reports - FVRIM, *Monitoring Victoria's family violence reforms Primary prevention system architecture* (Report, 2022) 38-40; Respect Victoria, *Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament* (Report, September 2022) 11-16.

The Federal Government commit to long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch[34] in Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia. These include:

i. *Our Watch (to provide independent national leadership on primary prevention)*

ii. *Australia's National Research Organisation for Women's Safety (**ANROWS**) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)*

iii. *Australian Bureau of Statistics (to deliver the Personal Safety Survey)*

iv. *Workplace Gender Equality Agency.*[35]

115. In March 2025, the Department of Families, Fairness and Housing and the Department of the Prime Minister and Cabinet responded to these recommendations with outlines of State and Federal government investment into primary prevention.

116. Given the importance of primary prevention, I reiterate my support for primary prevention programs at both a State and Federal level.

FINDINGS AND CONCLUSION

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

b) the identity of the deceased was ZSQ, born 5 July 1993;

[34] Our Watch is the national leader in the primary prevention of violence against women and their children in Australia.

[35] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 100-110.

c) the death occurred between 29 April and 4 May 2020 at 360a Park Street, South Melbourne, Victoria, 3205, from *1(a) multiple stab wounds*; and

d) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

(i) That the **Department of Families, Fairness and Housing** and **The Hon. Natalie Hutchins, Minister for the Prevention of Family Violence** provide funding for the expansion of co-responder programs across Victoria, noting the numerous coronial recommendations and comments made about the benefits of co-responder models.

(ii) That **Corrections Victoria** and investigate and implement a system to create real-time (or near real-time) notifications to Victoria Police when offenders are released from prison, to improve risk assessment and management strategies.

COMMENTS

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

1. I support programs such as the Changing Ways pilot and encourage the program to consider this finding, so that the learnings from ZSQ's passing can be incorporated into their work in the Changing Ways pilot. In particular, I encourage Family Safety Victoria consider how they work with Victoria Police in circumstances of high-risk family violence perpetrators.

2. I note my support and endorse the recommendations made in Judge Cain's finding into the death of Thi Minh Phuong Nguyen:

> *The Victorian Government urgently increase the total quantum of primary prevention funding, and prioritise longer term funding across the primary*

prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria.[36]

The Federal Government commit to long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch[37] *in Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia. These include:*

i. *Our Watch (to provide independent national leadership on primary prevention)*

ii. *Australia's National Research Organisation for Women's Safety (**ANROWS**) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)*

iii. *Australian Bureau of Statistics (to deliver the Personal Safety Survey)*

iv. *Workplace Gender Equality Agency.*[38]

3. This case demonstrates the difficulties faced by the various police forces across Australia, when a victim-survivor experiences family violence in another Australian jurisdiction. Although the existence of intervention orders is available to all State and Territories police forces under the National Domestic Violence Order Scheme, critical information about the incident(s) leading to those orders are not available for interstate police agencies. As noted by QPS, until system capabilities improve, police across Australia will continue to operate with the limited information available to them at the

[36] Similar recommendations are made by the FVRIM and Respect Victoria in the following reports - FVRIM, *Monitoring Victoria's family violence reforms Primary prevention system architecture* (Report, 2022) 38-40; Respect Victoria, *Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament* (Report, September 2022) 11-16.

[37] Our Watch is the national leader in the primary prevention of violence against women and their children in Australia.

[38] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 100-110.

time of the crisis for the victim-survivor, perpetrator and children. While it may be beyond the scope of this investigation to suggest a national database for information about family violence offending, this case demonstrates the need for same.

I convey my sincere condolences to ZSQ'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:

BRE, Senior Next of Kin

ARE, Senior Next of Kin

Corrections Victoria

Department of Families, Fairness and Housing

Family Safety Victoria

The Hon. Natalie Hutchins, Minister for the Prevention of Family Violence

Queensland Police Service

Victoria Police

Windermere Child and Family Services

Detective Senior Constable Mathew Evans, Coronial Investigator

Signature:

Judge Liberty Sanger OAM
State Coroner
Date: 11 September 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.