



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006390

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	RFV
Date of birth:	[REDACTED]
Date of death:	24 November 2020
Cause of death:	1(a) Consequences of an assault with severe facial fractures
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052
Keywords:	Family violence; homicide; substance abuse; other familial relationship

INTRODUCTION

1. On 24 November 2020, RFV was 87 years old when he passed away at the Royal Melbourne Hospital (**RMH**) from injuries inflicted by his daughter-in-law, NJI.

Background

2. RFV was born in Greece where he married his first wife, DCQ, with whom he shared two children, BGV and a twin daughter, whose details are not known. RFV travelled to Australia to seek employment, leaving his wife and children behind. DCQ and her daughter remained in Greece, while RFV migrated permanently to Australia in about 1969 with BGV. RFV and DCQ later divorced.
3. While in Australia, RFV met his second wife, TNJ. RFV and TNJ married in 1982 in Melbourne. They lived in their family home in a suburb of Melbourne for more than 45 years.
4. RFV's son BGV was in a long-term on and off relationship with NJI for about 18 years. NJI shares two children with BGV, and three children from other relationships. NJI had a long history of substance misuse, in particular, heroin, and had a limited criminal history dating back to 2002. Most of her criminal convictions related to theft and property offences. There was a significant history of family violence allegedly perpetrated by BGV towards NJI.

THE CORONIAL INVESTIGATION

5. RFV's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned Detective Senior Constable Abbey Justin to be the Coronial Investigator for the investigation of RFV's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
9. This finding draws on the totality of the coronial investigation into the death of RFV 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

10. On 23 November 2020, RFV, born [REDACTED], was visually identified by his wife, TNJ.
11. Identity is not in dispute and requires no further investigation.

Medical cause of death

12. Senior Forensic Pathologist Dr Michael Burke, from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy on 24 November 2020 and provided a written report of his findings dated 24 August 2021.
13. The post-mortem examination revealed widespread healing scalp and facial lacerations. The clinical and post-mortem CT scans showed multiple facial fractures. There was a metacarpal fracture to the right hand.
14. Formal odontology examination showed two teeth recovered from the large bowel, and further teeth were presented for formal examination by police officers and recovered from various crime scene locations, were displaced from the deceased at the time of the injury.

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.

15. Neuropathological examination of the brain confirmed a large left middle cerebral artery territory cerebral infarction. In addition, the neuropathology examination showed a right thalamic infarct and haemorrhages in the cerebellum and cerebral contusion.
16. Toxicological analysis of ante-mortem samples (taken 19 November 2020) identified the presence of paracetamol and lignocaine.
17. Dr Burke provided an opinion that the medical cause of death was *1(a) consequences of an assault with severe facial fractures*.
18. I accept Dr Burke's opinion as to the medical cause of death.

Circumstances in which the death occurred

19. On 10 November 2020, TNJ suffered a fall and was transported to St Vincent's Hospital for treatment. RFV was therefore alone at the family home.
20. On the morning of 11 November 2020, BGV was with NJI at her home in a suburb of Melbourne. St Vincent's Hospital staff called NJI in relation to TNJ, who in turn, tried to contact RFV, however he did not answer. St Vincent's Hospital contacted NJI again at about 9.45am, and NJI returned their call a few minutes later. According to NJI's sentencing remarks, she used heroin that morning.
21. At about 10.30am, NJI and BGV left their address in NJI's car. They attended a local auto parts store and then travelled to another suburb. At about midday, St Vincent's Hospital staff contacted NJI again to advise that TNJ would not be returning home that day. NJI tried calling RFV several times to advise him of same, however was unable to reach him. BGV and NJI travelled to RFV's home and arrived at about 12.40pm, presumably to advise him that TNJ would not be returning home that day.
22. After leaving RFV's house, NJI and BGV attended various locations. NJI contacted her son's school to advise that she needed to collect her son earlier than usual. NJI and BGV collected their son at about 2.15pm, before the trio returned to NJI's home. NJI left the property alone at 2.42pm and advised BGV that she was going to move her horses which she agisted at a property in a neighbouring suburb. NJI did not attend the property and instead drove to RFV's house and arrived at about 3.35pm.

23. At some time after 3.35pm, NJI attacked RFV at his home. During the altercation, NJI struck RFV with an unknown weapon, damaging his watch and causing some of his teeth to become dislodged.
24. RFV's neighbours MJU and LKJ reported hearing thudding and groaning noises at about 4.30pm. MJU attended RFV's back door to investigate and called out, however did not receive a response. He attended the front door, heard someone groaning and called out "*Is everything OK?*". NJI responded to advise that BGV was upset.
25. The neighbours returned to their home. At about 4.45pm, MJU had a conversation with NJI over the back fence. He could hear her but was unable to see her. NJI asked MJU if LKJ received the text message she sent to her earlier about TNJ's hospitalisation.
26. NJI left RFV's house at 5.12pm and returned to her home at 6.42pm. Her hair was wet, and she was wearing different clothes.
27. NJI and BGV went out later that evening, travelled to a Melbourne suburb, followed by a property nearby. NJI and BGV left this address at about 10.30pm with the intention of driving back to their residence. On the way home, NJI suggested to BGV that they should check on RFV, as he was home alone.
28. When NJI and BGV drove past RFV's house, NJI commented that the house was in darkness, which was unusual as RFV ordinarily left a bedroom light switched on. BGV stopped the car, got out and thought he heard RFV calling out his name. When NJI and BGV entered the house, they observed RFV lying prone on the hallway floor, groaning. NJI called 000 while BGV asked who hurt him. BGV claimed that RFV said (in Greek) "*Afti Afti Afti*" which roughly translated to "*She did it, she did it, she did it*".
29. Paramedics and police attended and observed multiple injuries to RFV's face and head. Paramedics transported RFV via ambulance to the RMH in a critical condition. Police separated and arrested BGV and NJI at the scene.
30. On arrival at the RMH Emergency Department (**ED**), RFV experienced a cardiac arrest. He was resuscitated and clinicians were able to achieve haemodynamic stability. He was transferred to the Intensive Care Unit (**ICU**) for monitoring.
31. On 14 November 2020, Forensic Medical Officer, Dr Gary Huang, attended the RMH to conduct an examination of RFV. Dr Huang observed that the injuries RFV sustained were too

concentrated, too numerous and in too many different spatial locations to have been acquired in an accident alone.

32. Testing revealed multi-organ failure including acute on chronic kidney injury. A CT scan of the brain identified a large subacute left middle cerebral artery infarct. RFV underwent an MRI which confirmed a large middle cerebral artery infarct with intra-infarct petechial haemorrhage with further foci of infarct throughout both cerebral hemispheres and in cerebellum. Clinicians noted that the infarcts would likely result in a very poor neurological recovery. Following discussions between clinicians and RFV's family, RFV was transitioned to comfort care, and he passed away peacefully on 24 November 2020.
33. Following a comprehensive police investigation, NJI was arrested on 9 March 2021 and was charged with one count of murder. NJI pleaded not guilty to the charge and the matter proceeded to trial. A jury found NJI guilty of murder and on 4 April 2025, was sentenced to 27 years' imprisonment, with a non-parole period of 20 years.

FURTHER INVESTIGATIONS AND CPU REVIEW

34. As RFV's death occurred in circumstances of family violence, I requested that the Coroner's Prevention Unit (CPU)² examine the circumstances of Peter's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD)³.
35. I make observations concerning service engagement with RFV and his family as they arise from the coronial investigation into his 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 RFV's death.
36. 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

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.

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

with RFV and his family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Family violence history and contact with Victoria Police

37. Prior to the fatal incident, there were 15 reported instances of family violence allegedly perpetrated between BGV and NJI. BGV was nominated as the respondent for 11 of those incidents, with NJI nominated as the respondent in four incidents. There was only one incident of family violence recorded between NJI and RFV/TNJ, which is discussed below.
38. In the months prior to the fatal incident, TNJ reported to neighbours and friends that NJI attended their home and took items. TNJ observed missing money, jewellery and food from the refrigerator.
39. RFV attended a local Police Station on 14 September 2020 and reported to police that he was having difficulties with NJI as she attended his house unannounced and took items from the refrigerator. He also reported that NJI allegedly broke a door.
40. The same member attended RFV's home on 15 September 2020 in the company of another member, in an attempt to ascertain what had occurred. TNJ again reported the same concerns and that they did not want NJI to have a key to their house anymore. The members used an interpreter to speak to RFV and TNJ, and were unable to ascertain any 'story', other than that food had been taken from the fridge. The members did not observe any damaged doors and noted that RFV and TNJ were upset that NJI had not brought their grandson to visit for some time.
41. The members contacted BGV and NJI, who reported that NJI had not been at RFV/TNJ's address for several weeks due to the COVID-19 restrictions in place at the time. NJI noted that TNJ and RFV were upset that their grandson had not attended in some time and that TNJ and RFV did not understand the COVID-19 restrictions. Police documented that RFV suffered from partial dementia, and they were "*Unable to ascertain full story*".
42. Police prepared a family violence report and concluded that RFV and TNJ were "*upset due to not being able to see grandson*" and that RFV was "*possibly being taken advantage of by [NJI] however due to living distance and location of both parties no imminent danger disclosed*".

43. Police submitted a referral for RFV and did not apply for an intervention order against NJI. The incident was classified as low risk; however, the investigating member incorrectly noted it as ‘medium’ on LEAP. This did not have an impact on the investigation of the incident, as there was no follow-up required.
44. I have not identified any deficiencies in relation to Victoria Police’s contact with RFV, TNJ and NJI.

Elderly people experiencing family violence

45. This case highlights that elderly people are often more vulnerable to family violence and that current systems are not well-designed to support elderly people who experience family violence. Following the September 2020 family violence report, RFV was referred to the Victims Support Agency, when it might have been more appropriate to refer him to Seniors Rights Victoria. The Victims Support Agency did not appear to action the referral as they had ‘incomplete/missing information’. Therefore, it appears that RFV did not receive a service response. TNJ was not referred to any support services.
46. I note that Victoria Police is currently reviewing its family violence practice and policies, so I will direct that a copy of this finding is provided to Victoria Police, to consider as part of their review. I intend to make a recommendation that Victoria Police consider the importance of upskilling members in working with elderly people as part of their review.

FINDINGS AND CONCLUSION

47. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was RFV, born [REDACTED];
 - b) the death occurred on 24 November 2020 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052, from *1(a) consequences of an assault with severe facial fractures*; 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) That **Victoria Police** consider the importance of upskilling members in working with elderly people who experience family violence, as part of their review into family violence policies and procedures.

I convey my sincere condolences to RFV'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:

BGV, Senior Next of Kin

Victoria Police

Detective Senior Constable Abbey Justin, Coronial Investigator

Signature:



Judge John Cain
State Coroner
Date: 25 June 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.
