



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000548

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:	RFV
Date of birth:	[REDACTED]
Date of death:	29 January 2021
Cause of death:	1(a) Complications of stab wound to the chest
Place of death:	Royal Melbourne Hospital 300 Grattan Street Parkville Victoria 3052
Keywords:	Homicide; family homicide; mental ill-health; culturally and linguistically diverse communities; access to services; Child Protection

INTRODUCTION

1. On 29 January 2021, RFV was 58 years old when she died from complications arising from a stab wound to the chest, inflicted by her daughter-in-law, MHU. At the time of her death, RFV lived in a suburb of Melbourne, Victoria, with her son, BLR, MHU and two of their children.

Background – RFV

2. RFV was born overseas as one of four siblings. She had eight children, two of whom died as babies. Her husband was killed in a civil war in 1997. RFV came to Australia as a refugee in about 2004 with two of her sons and two grandchildren. She became an Australian citizen in 2007.
3. RFV's health was described as 'frail' at the time of the fatal incident. She had a kidney condition requiring dialysis three times per week.
4. The available evidence suggests that RFV was experiencing financial difficulties in the year prior to the fatal incident. She told her general practitioner (**GP**) that she could not pay her bills and sought help from Cohealth to access the National Disability Insurance Scheme (**NDIS**). She expressed a desire to access alternative housing to live with her two grandchildren and her 20-year-old nephew.
5. RFV may have experienced depression but did not have any formal history of mental illness. Clinicians involved with RFV queried whether her cognitive functioning was impaired by trauma, however there are no further details about her cognitive functioning in the available evidence. Her GP records indicate that she was illiterate.

Background – MHU

6. MHU was born overseas, and was the fourth of seven children, She was 27 years old at the time of the fatal incident. She speaks a dialect from her country of origin, however, did not receive any formal education and therefore could not read in any language. MHU and her family lived through civil war and famine when she was young, and her father died of starvation.
7. MHU met her husband, BLR in 2010 and they married when she was 16 years old and he was 26 years old. The couple moved to Australia in 2015.
8. MHU and BLR shared four children, born between 2012-2018.

9. In October 2018, BLR sent the eldest two children overseas to live with their extended family, following Child Protection involvement in Australia. They did not return to Australia prior to the fatal incident.
10. The available evidence suggests that MHU felt isolated after moving to Australia and missed her family who were overseas. She only had limited contact with the local community and wanted to return to her country of origin prior to the fatal incident. When she felt low, she described searching songs on her computer to remind her of her culture.
11. MHU had a significant history of mental health issues starting from 2015 when she first arrived in Australia. Her history included visual and auditory hallucinations and four inpatient mental health admissions between 2015 and 2018. She was supported by Orygen mental health services from 2015 to 2017, followed by the North West Mental Health Service and Inner West Mental Health Service (namely, the Waratah Clinic) from 2017 onwards. Mental health assessments were challenging at times, as she spoke a dialect that was difficult to translate.
12. Following her fourth pregnancy, MHU experienced acute psychosis requiring hospital admission in late-2018. Clinicians noted at the time that she appeared vulnerable to psychotic episodes when under stress. BLR reportedly had limited insight into the significance of MHU's needs or her inability to care for an infant at the time.
13. Following the fatal incident, MHU was diagnosed with post-traumatic stress disorder (**PTSD**), stemming from the family violence perpetrated against her by her husband and other family members. She reportedly understood that she had a mental illness, however had limited insight into the nature of her symptoms.
14. The manager at the childcare centre that MHU's children attended queried her ability to "*absorb*" information, however her cognitive functioning was not assessed prior to the fatal incident. Following the fatal incident, MHU was assessed as meeting the criteria for an intellectual disability and functioning within the lowest 0.1% of the population. The assessing clinician noted, however, that "*the testing used is not culturally fair as it is affected by level of schooling, and does not take into account cultural differences*".

Relationship between RFV and MHU

15. MHU and BLR moved in with RFV several years prior to the fatal incident, to assist with her medical appointments and so that RFV could help look after her grandchildren. RFV received

the parenting payment for caring for her grandchildren and at one point had a significant role in caring for them. However, in the 18 months prior to the fatal incident, she had a much smaller role in caring for her grandchildren due to her own health issues.

16. MHU and RFV often argued about household issues such as bills and childcare and at one point, RFV asked BLR to move out of her home with MHU and the children. RFV reportedly told a relative that she was “*unhappy with the way [MHU] treated the kids and hit them*”, that she paid for everything in the house and that she was the only one who cleaned.
17. Following the fatal incident, MHU told mental health clinicians that RFV verbally abused her, including insulting her. MHU reported that RFV was critical and controlling. In one assessment, clinicians documented:

MHU described her relationship with RVF. She said ‘my mother-in-law was always in my face...she wants to be violent, always’. MHU said that RVF frequently aspersed her, ‘my son married a bad wife’. MHU said she would be told ‘you have a sickness that doesn’t go away.’ MHU recalled that RVF would on some occasions wrench her from the shower, slap her on the ear, and accuse her of using too much water.

Relationship between MHU and BLR

18. After the fatal incident, MHU reported that she did not want to marry BLR and that it was an arranged marriage. She reported that he had other wives. Service records from prior to the fatal incident suggest that MHU felt “*controlled and manipulated*” by BLR, and that he allegedly perpetrated family violence against her, including:
 - a) Hitting her if she did not do as he said.
 - b) Not purchasing enough food for MHU and the children.
 - c) Behaving in a coercive and “*extremely controlling*” way, including not allowing MHU to access supports such as childcare or family services, refusing to allow her to attend appointments on her own, and trying to scare her by telling her the “*white people*” at childcare would give the children drugs.
 - d) MHU repeatedly told professionals that she was unable to make decisions about her healthcare or social supports without permission from BLR. For example, she was not permitted to change her GP without his permission, was unable to make decisions about her dental care or attend appointments on her own.

- e) The available evidence suggests that MHU felt isolated and wanted support, however believed that BLR would be angry at her for accepting support from services.
 - f) BLR and RFV received all Centrelink payments for MHU's children. They also received a carer's payment for MHU, however, allegedly did not permit her access to any money and did not provide her with the necessary information to apply for a healthcare card or for her own income in the form of a disability support pension. MHU did not have a bank account and did not have enough money for the children or for transport so she could not go far from home.
 - g) Reproductive coercion, including refusing to allow MHU to commence contraception when she wanted to, as BLR reportedly wanted her to have a fifth child.
 - h) Making MHU feel afraid of him.
19. Evidence available to the Court suggests that the services engaged with MHU prior to the fatal incident often found BLR's behaviour to be challenging and a barrier to engagement, describing it as aggressive and overbearing.
20. Of note, several of the forensic mental health assessments completed with MHU after the fatal incident did not indicate that she was asked about family violence. In one assessment, MHU described her relationship with BLR and his family as "good" and denied a history of conflict while they lived with RFV. However, MHU also denied experiencing mental health complications during or after her pregnancies during this same assessment.
21. In one assessment, dated 27 May 2022, the clinician documented:
- MHU described life in this house [with BLR and RFV] as "no good". She said there were "arguments, fights, next minute happy...angry". She added, "they were all abusing me".*
- MHU gave an example, having recently just given birth to her third child, when her husband and brother-in-law assaulted her, "They beat me up, unprovoked...they beat me up bad, I don't know how to call police. I fell on the floor...this happened many, many times." MHU told me that she felt like a "prisoner" in her own home. "They go shopping, go out, I go to the park with the kids. No friends.*
22. MHU further described experiencing nightmares and flashbacks to the family violence allegedly perpetrated against her by BLR and other family members. In later assessments,

MHU reported that she was concerned that her brother-in-law would attack her if he saw her after release from prison. MHU:

...characterised her life with her husband and his family in a negative light, reporting exposure to verbal and physical abuse at the hands of all parties. MHU reported living a solitary life and did not have any form of social support outside of her abusive family. They [sic] stated that her husband and brother-in-law frequently abused her, in addition to being criticised on a frequent basis by her mother-in-law.

THE CORONIAL INVESTIGATION

23. 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.
24. 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.
25. 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.
26. Victoria Police assigned Detective Leading Senior Constable Mick Cashman to be the Coronal Investigator for the investigation of RFV'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.
27. 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.
28. 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

29. On 29 January 2021, RFV, born [REDACTED] was visually identified by her son, BLR.
30. Identity is not in dispute and requires no further investigation.

Medical cause of death

31. Professor Noel Woodford, Director of the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy on 31 January 2021 and provided a written report of his findings dated 28 May 2021.
32. Prof Woodford explained that the cause of death was related to complications of a single stab wound to the left side of the chest.
33. The stab wound penetrated into the pericardial sac and left ventricular cavity, causing significant haemopericardium and tamponade. Upon a review of the clinical records, it appears that accumulation of blood has resulted in cardiac arrest necessitating urgent cardiopulmonary bypass, thoracotomy and repair of the incised defect to the wall of the left ventricle.
34. Prof Woodford explained that assessment of the force required for the infliction of stab wounds is dependent upon a number of variables including the sharpness of the knife tip and blade, the relative kinetic energy of the blade and the resistive effect of clothing, skin and underlying structures such as bone. The presence of surgical intervention has made assessment of some of these criteria problematic, particularly since a large thoracotomy was performed. There were some findings to suggest that the stab wound was associated with the transection of the fourth rib, in which case an assessment of the force involved might be considered *at least* moderate on a three-point scale of mild, moderate and severe.

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.

35. The cardiac arrest with necessity for urgent chest surgery resulted in significant consequential complications in the form of ischaemic gut, and metabolic and vascular injury to the brain. The ultimate mechanism of death appeared likely to relate to sepsis and toxemia as a result of the significant intestinal injury.
36. Pre-existing natural disease was present in the form of end stage native kidneys and a renal transplant. This condition did not cause or contribute significantly to the mechanism of death.
37. In addition to the stab wound to the left side of the chest, there was an injury over the anterior aspect of the left lower leg which had the appearance of a shallow incised injury (superficially involving bone). There was a further injury showing healing changes in the region of the back of the right wrist which had minimal extension into the deeper skin structures (dermis). Neither of these injuries were associated with significant pathology.
38. Toxicological analysis of post-mortem blood samples identified the presence of morphine,² fentanyl,³ ketamine,⁴ metoprolol,⁵ lignocaine,⁶ paracetamol,⁷ loratadine,⁸ pheniramine⁹ and laudanosine.¹⁰
39. Toxicological analysis of post-mortem urine samples identified the presence of ketamine, metoprolol, lignocaine, paracetamol and amlodipine.¹¹
40. Toxicological analysis of post-mortem hair samples identified the presence of morphine, fentanyl and ketamine.
41. Prof Woodford provided an opinion that the medical cause of death was 1(a) Complications of stab wound to the chest.
42. I accept Prof Woodford's opinion as to the medical cause of death.

² Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.

³ Fentanyl is a synthetic opioid with 50-100 times the analgesic potency of morphine, rapid onset (2-3 min) and short duration of action. It is used in surgical anaesthesia, chronic pain and breakthrough cancer pain.

⁴ Ketamine is an anaesthetic normally used for short and medium duration operations as an induction agent.

⁵ Metoprolol tartrate is an anti-hypertensive drug.

⁶ Lignocaine (lidocaine) is an amide local anaesthetic and antiarrhythmic drug.

⁷ Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propo

⁸ Loratadine is indicated for seasonal and perennial allergic rhinitis, chronic urticaria in adults and children, and for the relief of symptoms and signs of allergic skin disease.

⁹ Pheniramine is an antihistamine used in combination with decongestants, antitussives, expectorants and analgesics.

¹⁰ Atracurium is a non-depolarising neuromuscular blocker indicated for general anaesthesia to aid tracheal intubation, muscle relaxation for surgery and mechanical ventilation. It undergoes enzymatic and spontaneous hydrolysis to a quaternary alcohol and acid, and spontaneous degradation to laudanosine and an acrylate moiety.

¹¹ Amlodipine is a dihydropyridine calcium channel blocker indicated for hypertension and angina.

Circumstances in which the death occurred

43. In the weeks prior to the fatal incident, MHU reportedly told a friend that she did not like her husband's family and wanted to kill her brother-in-law, or RFV. However, this information was reported second hand by her brother-in-law, and MHU reported that he was abusive towards her.
44. MHU and RFV's relationship also became increasingly tense in the lead-up to the fatal incident. They reportedly argued about the length of MHU's showers, household expenses and care of MHU's children. RFV reportedly asked BLR and MHU to leave her home and live elsewhere.
45. MHU's mental health reportedly deteriorated in the period prior to the fatal incident, as she ceased taking her medication. She reportedly heard voices, mixed up words and aimlessly moved around the house. After the fatal incident, MHU described experiencing paranoia and frightening hallucinations.
46. On 11 January 2021, MHU was sighted at a local library with blood on her clothing, however there were no further details available about this incident in the records available to the Court.
47. On the evening of 19 January 2021, RFV spent time at her friend's home nearby to avoid being at home with MHU. She arrived at her friend's home at about 9.00pm and was reportedly upset about BLR and MHU living at her home. RFV explained that she asked her son to leave and find another place to live. She stayed the night at her friend's home, as she did not want to be at home with her son or daughter-in-law.
48. On 20 January 2021, RFV attended her regular dialysis appointment then returned home. Her brother-in-law was also at the property and stayed overnight, in an attempt to mediate between RFV and MHU.
49. Between 3.00am and 3.15am on 21 January 2021, BLR and his brother awoke and got ready for work. BLR left the house at about 3.35am, while his brother spoke to RFV briefly, who was still in bed. BLR's brother recalled that he got dressed and wanted to wash his face and brush his teeth before leaving for work, however MHU was already in the bathroom. He recalled that he had to wait 15 minutes for her to leave. BLR's brother left the home for work at about 3.45am and recalled that MHU was still awake and was in the kitchen when he left.

50. Later that morning, RFV and MHU had an argument about the water bill and about MHU having a shower early that morning. MHU alleged that RFV slapped her twice and bit her during the argument and that she “*lost control*” and slapped RFV back. During the argument, MHU took a knife from the kitchen and stabbed RFV on the left side of the chest. She also used this knife to cause a laceration to RFV’s left shin. MHU later stated that she did not recall stabbing RFV, however acknowledged that this is what happened. It is not clear whether MHU’s children witnessed the fatal incident, however the available evidence suggests that they were in the house at the time and one of the children may have attempted to intervene.
51. At about 9.15am, after the fatal incident, MHU left the home with her two children, pulling a large blue suitcase. At 9.19am, she encountered two strangers near a BP Service Station nearby. One of the strangers, noted that she and MHU were both from the same country of origin, so she stopped to talk to her. MHU told the stranger that her mother-in-law kicked her out of the house, and she had nowhere to go. The stranger felt sorry for MHU and as it was her ‘pay day’, she gave MHU \$50 and suggested that she could get some help through a nearby housing support service. The stranger wrote down the name and number for the housing support service to assist MHU and explained she could catch the bus to the organisation.
52. MHU arrived near vicinity of the housing support service by about 10.00am. She approached a stranger and asked for help. The stranger stated that she did not know MHU but felt sorry for her and decided to drive her and her children to the housing support service. Unfortunately, when they arrived, they discovered it was closed due to COVID-19 related restrictions. The stranger called the contact number displayed on the front door and was advised to take MHU and her children to the nearby Police Station, who might be able to assist them. The stranger drove MHU and the children to the Police Station, accompanied her inside and advised police that MHU needed assistance with housing. MHU remained at the Police Station during the day and was taken into custody at 5.00pm that afternoon, once police became aware of the assault on RFV and detectives learned of her location.
53. Meanwhile, RFV’s neighbour, AIJ, was walking to the ground floor laundry room when she heard knocking on the security door of unit 4 (RFV’s unit). AIJ heard a female voice calling out from inside the unit saying, “*call I’m sick*”. AIJ looked through the security door and observed RFV lying on the floor. RFV pointed under her arm and said, “*call doctor*”. AIJ observed RFV’s clothes were soaked with blood and when she asked RFV what happened, RFV only moaned in pain. AIJ called Triple Zero and provided updates to the call-taker.

54. Paramedics arrived on scene quickly and treated RFV for a stab wound to the chest, then transported her to the Royal Melbourne Hospital (**RMH**). While enroute to the RMH, RFV told paramedics that ‘MHU’ was responsible for her injury. At the RMH Emergency Department (**ED**), clinicians inserted a left pleural drain, then urgently transferred her to the operating theatre (**OT**).
55. In the OT, RFV experienced a brief cardiac arrest. She was placed on cardiopulmonary bypass while surgeons attempted to repair the stab wound. After surgery, RFV was admitted to the Intensive Care Unit (**ICU**). She required respiratory and haemodynamic support and was placed on renal replacement therapy.
56. Clinicians transferred RFV back to the OT on 25 January 2021 for closure of the chest, which occurred without difficulty. From 26 to 28 January 2021, clinicians noted slow improvement in her physical medical condition and attempted to wean sedation to assess neurology. However, from 28 to 29 January 2021, RFV’s condition deteriorated, and a CT scan of her abdomen revealed an infarcted bowel with extensive mesenteric and portal venous gas. Clinicians determined that this was an unsurvivable condition and conferred with her family. RFV passed away on the morning of 29 January 2021.

Police investigation

57. After her arrest, MHU was assessed by a forensic medical officer who documented her injuries and deemed her fit for interview. Police formally interviewed MHU with the aid of an interpreter. She stated that she was involved in a fight with RFV, obtained a knife from the kitchen and cut RFV’s leg. She explained that she wiped the knife on a sheet/pillowcase and returned the knife to the kitchen cupboard where she obtained it. She denied causing the stab wound to the chest and stated that this occurred after she left by another unknown person(s).
58. Police originally charged MHU with intentionally causing serious injury, however this was upgraded to murder after RFV’s death. Once MHU was in custody, she underwent psychiatric assessments which demonstrated that she had a defence of mental impairment available to her. One psychiatric report suggested that MHU’s “*mental state was clearly acutely disturbed*” at the time of the fatal incident and that the “*ongoing difficulties with her mother in law may have been a factor, but it is unlikely she would have attacked the victim, if she was not acutely unwell*”.

59. MHU's legal team did not raise the defence of mental impairment. At a special hearing, defence did not challenge the prosecution's case. The jury returned a verdict of guilty, and MHU was sentenced to a custodial supervision order with a nominal term of 25 years.

FURTHER INVESTIGATIONS AND CPU REVIEW

60. As RFV's death occurred in circumstances where the offender, MHU, was experiencing family violence in the lead-up to the fatal incident, this case was referred to the Coroner's Prevention Unit (CPU)¹² to examine the circumstances of RFV's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).¹³
61. I make observations concerning service engagement with RFV, MHU and BLR as they arise from the coronial investigation into RFV's 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.
62. 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*".¹⁴ I make observations about services that had contact with RFV, MHU and BLR to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.
63. In the years prior to the fatal incident, various services were involved with the family due to repeated concerns regarding family violence, mental health and the wellbeing of the children.

Child Protection

64. There were nine reports to Child Protection from March 2018 to January 2021 and two Section 38 consultations.¹⁵ Child Protection closed seven of the nine reports at the intake stage, with

¹² 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.

¹³ 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.

¹⁴ *Adamczak v AlSCO Pty Ltd (No 4)* [2019] FCCA 7, [80].

¹⁵ Child FIRST, The Orange Door and registered family services can consult with Child Protection at any time under section 38 of the *Children MHU and Families Act 2005* (CYFA). Community-based Child Protection practitioners

the ninth report progressed to investigation and assessment after the fatal incident. The reasons for the reports included:

- a) Concerns about the children not attending school/childcare or attending “*very hungry*”.
 - b) Concerns about the children’s development and behaviour.
 - c) The family’s financial issues.
 - d) Alleged family violence perpetrated by BLR to MHU. This included alleged coercive and controlling behaviour, financial abuse, and physical violence including hitting MHU if she did not do what he said.
 - e) MHU having no access to money and subsequently being unable to meet the children’s basic needs.
 - f) MHU’s poor/deteriorating mental health, and BLR’s limited insight into her condition.
 - g) Concerns about a lack of parental supervision.
 - h) Poor hygiene of MHU and the children.
65. At times, Child Protection communicated with the other support services involved with the family including the Maternal and Child Health Nurse (**MCHN**) service, Waratah Clinic (where MHU was receiving mental health treatment), a local Community Centre, and the children’s school/childcare. Child Protection made several referrals to Child FIRST prior to closing reports at the intake stage and consulted with Moonee Valley City Council (**MVCC**) Family Services in relation to a partner agency assessment they carried out on behalf of Child FIRST in late 2020.
66. I have considered three of the most pertinent service contacts with Child Protection below.

Report seven – 15 October 2020

67. The reporter raised concerns about MHU, and two of her children “*hanging out*” in front of their former childcare centre for three to four hours every day. The children’s former childcare

have a role in providing consultation under section 38 of the CYFA to community-based child and family services/agencies on matters including supporting the development of risk assessments, decision making and ongoing supports for infants, children and young people. <https://www.cpmanual.vic.gov.au/policies-and-procedures/phases/intake/section-38-consultations>

centre was next door to the family home. The children were reportedly observed to be hitting cars with sticks, playing on the road and eating food from a rubbish bin while MHU watched videos on her phone. Childcare staff reportedly tried to intervene, however MHU “*stares at them and doesn’t engage*”. The reporter noted that they had not seen RFV or BLR in a long time.

68. On 16 October 2020, Child Protection made a referral to Child FIRST to assist MHU with “*prioritising the children’s needs over her own and offering her additional parenting support*” and closed the report at the intake stage. Child Protection sent a letter in English to MHU about the referral. As this report was the third report within 12 months, a Practice Leader reviewed the decision to close the report without an investigation “*in regards to cumulative harm considerations*”. The Practice Leader endorsed this decision to close the report.

Second Section 38 consultation – 11 November 2020

69. MVCC conducted a Section 38 consultation with Community Based Child Protection (**CBCP**) on 11 November 2020. MVCC advised that the Child FIRST referral was allocated to them on 27 October 2020 to complete a partner agency initial assessment on behalf of Child FIRST, however the contact number provided was incorrect, so they sent a letter to the family. MVCC consulted with a local child care centre, the enhanced MCHN (**EMCHN**) and the Waratah Clinic about the family and advised that “*the parents*” declined a referral for Integrated Family Services and declined a home visit to discuss the referral.
70. MVCC advised Child Protection of “*suspected family violence concerns from the information gathered from services*” including “*extremely controlling*” behaviour by BLR and stated that they had been unable to speak to MHU independently as BLR reported that her phone was broken. MHU reportedly did not have access to money and reportedly told a childcare manager that she was afraid of BLR. BLR reportedly stated his belief that a Child Protection referral was made by a local Community Centre and that MHU might need to find another place to attend her English classes.
71. MVCC advised Child Protection that MHU’s engagement with the Waratah Clinic had declined and she had not been seen by them since July 2020 when they conducted a home visit. During the July 2020 home visit, Waratah Clinic staff observed the home was “*not children-friendly*” and was in a state of poor hygiene. MHU missed follow-up appointments and presented to the Waratah Clinic on 10 November 2020, but did not attend her scheduled

appointment, stating that she did not want to be there. The Waratah Clinic staff did not have an up-to-date assessment of MHU's mental health.

72. MVCC noted that the children could access free childcare through the Families where a Parent has a Mental Illness (**FAPMI**) program, and that MHU was reportedly keen for this support, however BLR declined. MVCC noted that both (E)MCHN and childcare had been trying to link MHU with supports, however BLR prevented this and declined assistance with kindergarten enrolment for one of her children. MVCC reported that MHU was very fearful of Child Protection as BLR had sent their two eldest children to live overseas so that Child Protection did not remove them.
73. MVCC further noted their ongoing concerns from the MCHN and the children's former childcare centre about the children's development and their inability to monitor their development since they stopped attending childcare. The children were still enrolled with the MCHN but had not been seen by the service since February 2020. The MCHN reportedly held concerns about the condition of the family home. MVCC stated that RFV was living at another address to the family at this time, however she continued to receive carers payments for the children. MHU reportedly commented that the children needed new shoes, but that she did not have any money to purchase them.
74. MHU continued to bring the children to the front of the childcare centre so that she could use their WiFi. While the children were at the front of the childcare centre, they were largely unsupervised by MHU.
75. On 17 November 2020, MVCC emailed Child Protection to advise that they had contacted Victoria Police (as agreed) to confirm that there had been no police contacts regarding family violence or the children being left unsupervised. MVCC stated that they would:
 - a) Contact the EMCHN and the Waratah Clinic and *"flag that they contact Child Protection for any concerns they may have"*.
 - b) *"Flag the family violence concerns to Waratah Clinic clinician for a risk assessment and family violence response as deemed appropriate"*.
 - c) Close the Child FIRST referral for family services support.

76. There were no further records in the Child Protection file with respect to this Section 38 consultation. The available records suggest that the family did not engage further with Child FIRST or MVCC after this time, and Waratah Clinic discharged MHU.

Report nine – 20 January 2021

77. This report was submitted the day prior to the fatal incident. The reporter raised concerns that MHU and the children were attending the local library every day from 12.00pm or 1.00pm until closing time where MHU would use the WiFi and the children made a “ruckus” and fell asleep on the floor.
78. On several occasions, after being asked to leave, MHU and the children stayed out the front of the library for several hours, including on a hot 37-degree day, apparently without anything to drink or eat, and without access to shade. The reporter also noted concerns about the personal hygiene of MHU and the children, and about the family “possibly not having electricity or a fridge”. The family had ceased engagement with the MCHN and MHU commented that the children had stopped attending childcare due to previous Child Protection involvement.
79. On the day of the report, an intake worker noted “[t]here does not appear to be supervision concerns as the children are with the mother, however concerns for their disengagement with child care and there does not appear to be current services involved” and that “[Child FIRST] appears appropriate for parenting support”.
80. In a statement provided to the Court, Child Protection noted:

At the time of RVF’s death, Intake had not made any decisions to close the report with another Child FIRST referral. The Team Manager consultation noted that an enhanced referral to Child FIRST may be appropriate, however follow up with Child FIRST was required to obtain a better understanding of the history of referrals and engagement. No decision regarding case direction had been made by Intake prior to learning of MHU’s arrest”.

81. On 22 January 2021, while this report was still open at the intake phase, Child Protection were notified of the stabbing incident, and the case was progressed from intake to investigation and assessment.

Analysis of Child Protection involvement

82. Upon a review of the Child Protection involvement with the family, I am of the view that there may have been missed opportunities to intervene with the family and enhance the safety and wellbeing of MHU and her children. I do not suggest that there is any direct causal connection between the Child Protection involvement and RFV's death.
83. Successful intervention would have required addressing the family violence allegedly perpetrated by BLR, particularly given his control over the family and limiting their access to support services. In my view, Child Protection could have worked more assertively alongside other services (MCHN, Waratah Clinic, Child FIRST, inTouch) to ensure that the family received the specialist support they required. This could have included meeting with MHU alone, coordinating multi-agency communication and support, and completing family violence risk assessment and management activities.
84. I note that since the fatal incident, practice and policy changes have been implemented to improve Child Protection's future response to families in similar situations. This includes implementation of the Multi-Agency Risk Assessment and Management (**MARAM**) practice guides and training, which is discussed in further detail below. However, I note that Child Protection practitioners continue to operate within challenging circumstances, including high workloads, staff turnover and insufficiently experienced practitioners. I make no explicit criticism of the individual staff members involved with the family, and my concerns are with the broader, systemic response that MHU and her family received, and how this might be improved in the future.

Child Protection alignment with MARAM

85. Child Protection was prescribed under the MARAM in September 2018 and therefore was required to align their policies, procedures, practice guidance and tools to the MARAM. MARAM prescription conferred responsibilities onto Child Protection to identify, assess and manage family violence risk, although I note that Child Protection's policies prior to MARAM prescription also guided practitioners to identify, assess and manage family violence risk.
86. Despite ongoing concerns with respect to alleged family violence perpetrated by BLR and possibly RFV against MHU, Child Protection did not perform any family violence risk assessment or management activities, and most reports did not progress beyond the intake stage.

87. In a statement to the Court dated 16 October 2025, Child Protection noted that their “*records indicate no concerns were raised for family violence between the parents until the Section 38 consultation in November 2020, therefore, Intake did not complete any family violence assessments prior to this*”. As outlined above, there were concerns about BLR perpetrating family violence recorded by Child Protection prior to November 2020. For example:

- a) The first report in March 2018 included information suggesting BLR was violent and controlling towards MHU and that she presented as “*scared*” of him.
- b) The first Section 38 consultation in April 2018 noted concerns that BLR and RFV were allegedly financially abusive towards MHU.
- c) Following the sixth Child Protection report on 7 April 2020, on 9 April 2020, the Child Protection Intake Worker contacted the Waratah Clinic. The Waratah Clinic confirmed that MHU was still engaged with their service. The intake worker sent an email to the Waratah Clinic’s Key Worker that same day, advising that Child Protection would close the report. The Intake Worker noted “*[i]f you can provide support and monitoring for MHU, particularly during this time when face to face contact is likely to have ceased, that would be fantastic*”. According to the Waratah Clinic records, the Key Clinician responded to the Intake Worker on 16 April 2020 and advised:

Despite all of these [efforts to support MHU], actually supporting MHU and her children just by our mental health clinic alone were [sic] quite hard. It was because her husband was not interested in MHU and the children’s welfare. Her husband refused all the services I suggested including family service, Centrelink, child care service, home help service, etc. And MHU did not consent with the referral without her husband’s consent. I have attempted to apply [sic] disability support pension for her with the support from our psychiatrist because she did not have money to spend for herself and the children. But MHU was not able to supply her husband’s details like TFN, income etc. The carers’ payment from Centrelink were all gone to the mother-in-law and the husband. There had been times that MHU did not have any money for the children and rely on her husband to buy food home [sic] which appeared to be minimal and poor in quality. MHU had tried her best to look

after her children on her own most of the time which was quite stressful to her. She was definitely in need of more support.

I am not sure if Child Protection is going to intervene to help improve this situation for MHU and the children. I know MHU and her husband had been very scary [sic] to involve Child Protection which will jeopardize MHU's engagement with our mental health service if it does. If you can give me some advice, that will be fantastic!

- d) Child Protection did not record asking for any information about why this referral was made and did not appear to take any further action to assess family violence risk such as contacting inTouch or speaking with MHU about the concerns.

- 88. In their October 2025 statement, Child Protection did not comment on whether they complied with their responsibilities under the MARAM. In their April 2026 statement to the Court, Child Protection conceded that prior to the systemic changes introduced in 2018, Child Protection stated that although they were prescribed under the MARAM in September 2018, MARAM was not implemented in Child Protection practice until February 2021, after RFV's death. Child Protection noted that their understanding of family violence was consistent with knowledge and practice standards at the time. Since then, Child Protection advised its practice has evolved with current knowledge, practice frameworks and implementation of the SAFER risk assessment and MARAM practice standards.
- 89. As a result of these changes, practitioners are now prompted to consider elements of the MARAM when entering information into the Client Relationship Information System (CRIS) and are automatically alerted when mandatory assessments are required. These changes also mean that some determinations made by practitioners must be endorsed by Practice Leaders before the matters can progress through the system. In their October 2025 statement, Child Protection stated with respect to their involvement with this family that "*Today, it would be expected that a MARAM assessment would be completed*". I am hopeful that the above outlined changes will improve Child Protection compliance with the MARAM.

Cumulative harm

- 90. I note that a more thorough consideration by Child Protection of the potential for cumulative harm to two of MHU's children may have been warranted, given the volume and duration of the concerns raised by various reporters. In my view, this may have led to a more proportionate

response by Child Protection, and a better understanding of the family's needs by Child Protection. I do not suggest that this would have necessarily prevented the fatal incident, however, may have improved the supports available to the family as a whole, including MHU.

91. Prior to the fatal incident, all but one of the Child Protection reports were closed at the intake phase, despite concerns with respect to the children's development, their basic needs going unmet (including for food and clothing), parenting capacity, parental mental health issues, alleged family violence by BLR and allegedly financially controlling behaviour by BLR and RFV, and denial of and aggression towards support services by BLR, amongst other issues.
92. Following the seventh report to Child Protection made on 15 October 2020, a Practice Leader reviewed and endorsed the decision to close without an investigation "*in regards to cumulative harm considerations*". In my view, given the numerous concerns with respect to two of MHU's children at this time, and the fatal outcome in this case, it may be appropriate for Child Protection to review their guidance on cumulative harm.
93. The Court indicated this above view to Child Protection, as part of a procedural fairness letter. In response, counsel for Child Protection advised that this observation (and those that followed in the draft finding extract provided) were not open on the evidence and arose from a fundamentally flawed premise. Counsel submitted that this premise appeared to be that because MHU ultimately killed RFV, the cumulative harm assessment performed by Child Protection in response to the seventh report was somehow inadequate. Counsel highlighted that the cumulative harm assessment was performed in relation to the harm suffered by the children as a result of parenting capacity. Counsel submitted that the tool could not have predicted whether one adult in a family might kill another.
94. There was no suggestion or inference that the cumulative harm assessment should have been used for that purpose (or that it is capable of doing so). However, the Best Interests Case Practice Model (**BICPM**) in place at the time of the reports (and currently available to guide Child Protection practice) indicates that Child Protection workers must "*critically reflect on indicators of cumulative harm in the case history*". The BICPM also states that practitioners must re-examine historical reports each time a new report is made. The BICPM notes that these steps are necessary to "*assess whether a number of low-level risk factors combined are placing the child at risk of significant cumulative harm*". The importance of this consideration is particularly highlighted at the intake phase, when critical decisions are made regarding the notification received.

95. Counsel for Child Protection further noted that the seventh “*report was escalated to a team manager, who carefully considered the cumulative concerns. The team manager noted that Child FIRST was planning to allocate a worker to MHU in the near future, and concluded that the current information did not suggest the children were at any immediate or significant risk of harm warranting further Child Protection involvement. That is a considered, documented, and appropriately escalated decision*”.
96. Upon a review of the available Child Protection records, I was unable to find any documentation relating to the process or further rationale. The case note available to me regarding the cumulative harm assessment stated, “*Intake PL [practice leader] reviewed the current report in regards to cumulative harm considerations in this case and endorsed closed*”.
97. Child Protection provided a case note dated 21 October 2020 to assist with my inquiry. In this case note, a Practice Leader noted “*I have reviewed this report for closure given it is the forth [sic] report to child protection in 12 months without investigation for these children.*” In the SAFER Statement below this note, the Practice Leader stated:

The reported concerns pertain to the mother not adequately supervising the children and watching videos on her mobile phone instead. The children play on the road, hit cars with sticks and have been seen eating food from a rubbish bin, without the mother intervening. Child Care staff have needed to intervene and the mother stares at them and doesn't engage. There have been historical concerns regarding the mother's mental health also. The most recent report to child protection outlined the same concerns and was closed at intake just days ago. It has been assessed that whilst the children are not currently deemed to be at significant risk of harm, the mother would benefit from additional supports to address the reported concerns. As such, a referral has been made and accepted by Western Melbourne Childfirst [sic]. Child protection has contacted Childfirst [sic] to inform of the most recent concerns who advised allocation to family services should be soon. In the meantime the child care centre will continue to support the family around these concerns and contact police if required. There is no further role for child protection at this time.

98. Given the additional contextual information provided, I make no adverse comment about this particular case closure.

99. Additionally, counsel for Child Protection objected to my inclusion of a recommendation by former State Coroner, Judge John Cain in his Honour's finding into the passings of four children known to Child Protection. His Honour recommended:

That Child Protection, as part of the work they are doing to reform and improve the Child Protection Manual, incorporate easy access to a singular policy and simple tool relevant to cumulative harm assessment being undertaken.¹⁶

100. In response, counsel for Child Protection submitted that this recommendation was not open on the evidence, and that it proceeded from a fundamentally flawed premise (as noted above). As I have outlined above, I do not intend to find that different Child Protection involvement may have prevented the fatal outcome, only that the involvement could have been more assertive and proactive, and more responsive to the needs of the family. I also do not intend to find that Child Protection could have (and should have) foreseen the fatal incident.

101. I therefore otherwise support his Honour's recommendation above.

Community referrals made by Child Protection

102. As noted above, prior to the fatal incident Child Protection closed several reports and Section 38 consults with referrals to Child FIRST. Additionally, the report made on 22 September 2018 was closed with a plan for Waratah Clinic mental health service to build rapport with MHU, before making a Child FIRST referral. Despite these repeated referrals, Child FIRST's attempts to engage with the family were unsuccessful, and it appears that the multiple concerns raised with Child Protection went largely unaddressed.
103. In their statement to the Court, Child Protection noted that at the time of RFV's death, Child FIRST was the only referral pathway available to Child Protection intake to access family support. Child Protection acknowledged:

...continuing to refer the family to Child FIRST when they had previously not engaged was insufficient and future referrals were unlikely to result in engagement. Intake should have attempted an enhanced Child FIRST referral to facilitate joint work with Child FIRST and Community Based Child Protection to support engaging the family. If this was unsuccessful in addressing concerns, further investigation by Child Protection should have been considered.

¹⁶ [Finding into death following inquest – Child 1, Child 2, Child 3, Child 4.](#)

104. Child Protection noted that current policy:

...provides advice that where a referral has been made to Child FIRST, a family service or service agency due to significant concern for the wellbeing of a child, Child Protection is not to close the case until the referral is accepted, or other action taken within the prescribed timelines. However if assessed that there is a lower level of presenting issues and involvement of community supports for the family would be helpful, a referral to Child FIRST/The Orange Door in this category is not contingent on allocation to a family service prior to closing.

105. I note that mere acceptance of a referral by services does not necessarily result in successful engagement with a family, and current Child Protection practice advice does not require Child Protection intake to hold reports open to confirm a family's engagement with support services.

106. I further note that the issue of repeat Child Protection referrals to community services which are intended to mitigate risk, but which do not result in substantive engagement with children at risk or their families, has arisen in several cases before this Court. As a result, former State Coroner Judge Cain recommended:

Recommendation 5 – Child Protection update current policy regarding consequences of non-engagement with voluntary services including consideration of re-report or not closing until engagement has been confirmed with Child Protection. In the event of non-engagement, focus on risk assessment and mitigation should be prioritised.¹⁷

107. In response, Child Protection advised:

The department has been advised that in November 2024 the CCYP [Commission for Children and Young People] established an inquiry in accordance with Part 5, section 39 of the Commission for Children and Young People Act 2012, to look at the effectiveness of referrals made by Child Protection to support services. The inquiry will focus on effectiveness of these referrals in managing risk to children. The terms of reference of the CCYP inquiry including examining the service response to children and young people whose circumstances are assessed as not meeting the threshold for statutory intervention, including:

- *The effectiveness of referrals to support services*

¹⁷ Ibid.

- *The number of referrals that are closed and result in re-reports, the reasons for closure, and the outcome, including whether there are further re-referrals to the same service.*

The department will work with the CCYP in respect of this inquiry and consider its recommendations in considering appropriate updates to current policy.

108. The CCYP's report is discussed in further detail below.

109. Child Protection further noted in their statement:

There is consideration currently being given to Child Protection practitioners attending home visits or meetings (and phone calls) with families in conjunction with community based child and family services or agencies when there is no open report (post Intake) to Child Protection, including in the context of community-based section 38 consultations. Presently, Child Protection practitioners engage directly with families only after receiving a Child Protection report.

110. Given that more assertive Child Protection intervention may have improved the services and supports available to the family, I support the above amendment to practice.

111. The CCYP report and its relevance to this case is discussed in further detail below.

Communication

112. As noted above, Child Protection sent a letter to MHU in English, when she required an interpreter and could not read in her native language or English. In their October 2025 letter to the Court, Child Protection “*acknowledged that best practice would be to provide written material translated in the person’s language of origin*”. I note that this would have been preferable, however MHU could not read in any language, therefore a letter in her dialect would not have been effective for her.

113. The Court communicated my intention to make the following recommendation:

That Child Protection amend their information systems to prompt practitioners to obtain information about parents/carers’ literacy, to ensure that all communication with parents/carers are effective and appropriate.

114. Child Protection provided a statement of Natasha Courtney; Manager of Child Protection Learning dated 20 April 2026. Ms Courtney's statement included information about updates/changes to CRIS, practice advice and training since RFV's death, particularly in relation to multicultural and multifaith children, young people and families.
115. Ms Courtney advised that in December 2021, Child Protection developed a data practice resource entitled *CALD Data Practice Resource: Newly arrived and culturally diverse children and families*. The purpose of this Data Practice Resource is to support and guide Practitioners in assessing and recording information for multicultural and multifaith children, families and communities. It includes guidance on CRIS demographic data, including questions on ethnicity, language spoken at home, and confidence speaking English. It was incorporated into the CRIS as a link to guide practitioners.
116. Ms Courtney also noted a raft of workforce training that has been implemented to Practitioners, which has been in place for over ten years (in various iterations). In May 2024, a dedicated training subject on engaging multicultural and multifaith children, families and communities commenced within the Child Protection Practice Induction Program for new Practitioners. This includes both face-to-face and online learning components and covers:
- a) Effectively engaging with children, young people and families from multicultural and multifaith backgrounds.
 - b) Recognising culture, ethnicity, language, faith and immigration status.
 - c) Recognising and understanding the importance of addressing one's own unconscious bias.
 - d) Collecting cultural demographic information and data and recording this in CRIS.
 - e) Recognising the impact of migration history on parenting and attachment.
 - f) Utilising interpreters to engage with children and parents.
117. Prior to May 2024, the Induction program included a different cultural training session. Both before and after May 2024, new staff are advised that they have access to the department's Cultural Engagement Team, which provides support to Practitioners, housing and other departmental programs working with children, young people and families from culturally diverse backgrounds.

118. Finally, Ms Courtney noted that the Child Protection Learning Hub (launched September 2022) is an online, dedicated platform of resources to support Child Protection practice. This includes a dedicated Cultural Diversity and Engagement practice page, that presents key information and resources. Additionally, there are online webinar discussions held monthly for the Child Protection workforce which cover various themes. For example, in August 2025, the topic was *Enhancing cultural connections for children in out of home care*.
119. This is a positive step, in my view, and partially addresses the proposed recommendation above. However, I note the new Data Practice Resource does not include guidance on what to do when the intended recipient of the written communication cannot read at all, or their reading ability is limited. MHU could not read in any language, so translating the documents into her dialect would not have been beneficial for her.
120. The Court communicated to DFFH that I intended to recommend that the DFFH amend the *CALD Data Practice Resource* to include guidance for Practitioners when the intended recipient of their correspondence cannot read in any language (or has limited reading abilities). DFFH advised that it is already in the process of amending the Resource for scenarios where the intended recipient cannot read in any language. Some of the changes include:
- a) Under the section labelled “*Interpreter Required*”, prompts will be included to ask “*can you read and write in any language, including your first language?*” and “*do you require an interpreter for all contact – both written and spoken?*”
 - b) Under the section labelled “*English Written*”, a further question will be included to prompt practitioners to ask, “*can you read and write in any language?*”
 - c) The CRIS will be reconfigured to include an additional drop-down option in the “*Interpreter Required*” section to allow further specificity about the required language and communication needs of the recipient.
121. I commend DFFH for proactively implementing these changes. For completeness, I still intend to make the recommendation, and note that DFFH may have already implemented the changes, prior to this decision being published.

Further actions by Child Protection

122. In their October 2025 statement, Child Protection advised the Court that they implemented a series of workshops for intake and after-hours Child Protection workers. Some of these workshops are relevant to the issues canvassed above, including:

- a) Identification of family violence risk factors
- b) Referral pathways from the intake phase
- c) Understanding cumulative harm and best practice at intake phase
- d) Intake case conferencing – enhancing collaboration for child safety.

123. Following receipt of submissions from DFFH’s counsel, the Court wrote to DFFH again and provided them with a further opportunity to respond. DFFH provided information about the changes to the *CALD Data Practice Resource* and provided additional contextual information about the report closure on 21 October 2020. DFFH did not otherwise make further submissions.

CCYP report – *Left behind: Systemic inquiry into responses to children and young people who are the subject to multiple reports to Child Protection*

124. The Commissioner for Children and Young People (CCYP) recently released their report *Left behind: Systemic inquiry into responses to children and young people who are the subject of multiple reports to Child Protection* (**‘Left Behind’**). The report outlines the CCYP’s inquiry into the experiences of children and young people who “*become caught between different parts of the system when concerns raised with Child Protection about their safety do not meet the threshold for legal (or statutory) intervention*”.¹⁸

125. Left Behind noted that re-reports to Child Protection are common, with 75% of all intake reports received in 2025 involving a child or young person had been the subject of a previous report. Over half of Child Protection cases closed in 2024 had a subsequent report within 12 months.¹⁹ The average number of lifetime reports for children reported to Child Protection in 2025 was five.²⁰ The report states that re-reports “*are one indicator that the child and family system is not successfully addressing the needs of children and young people*”.²¹

¹⁸ CCYP, [Left behind: Systemic inquiry into responses to children and young people who are the subject of multiple reports to Child Protection](#) (June 2026), 16.

¹⁹ Ibid, 46.

²⁰ Ibid, 47.

²¹ Ibid, 46.

126. The Left Behind report also noted that of the children and families referred to The Orange Door in 2025, following a report to Child Protection which was closed without investigation (during the intake phase), 58% could not be reached or declined a service. Only 12% of these clients were allocated or referred to a service by The Orange Door.²² The report identified longstanding concerns about gaps in intake phase risk assessments, including inadequate consideration of cumulative harm, inadequate information gathering, inaccurate reflections of severity of harm, and “a lack of consideration of the outcome of previous referrals when considering further referrals and case closure”.²³ Of note, DFFH notified the CCYP during the course of this inquiry that The Orange Door and Child Protection are developing a feedback loop to ensure that outcomes of referrals from Child Protection to The Orange Door are shared.²⁴ This is a positive step in my view, and I note that former State Coroner, Judge Cain, made a similar recommendation:

*Child Protection update current policy regarding consequences of non-engagement with voluntary services including consideration of re-report or not closing until engagement has been confirmed with Child Protection. In the event of non-engagement, focus on risk assessment and mitigation should be prioritised.*²⁵

127. The Left Behind report further noted that the children who are not provided with a service after closure and referral by Child Protection “are often reported to Child Protection again, and the cycle continues”.²⁶ The report referred to this as the ‘refer and close’ cycle.²⁷ The Left Behind report found:

*Repeated reports to Child Protection and repeated referrals to services are not affecting lasting – or sometimes any – change for many children and young people. As a result, many remain in circumstances that threaten their safety and wellbeing.*²⁸

128. The Left Behind report noted that 86% of children/families who are referred to The Orange Door by Child Protection *after* intake (meaning their report progressed past the intake phase) were either allocated to a core The Orange Door service or referred to a broader service. Only 1% of these children/families declined a service. This means that clients referred to The

²² Ibid, 45.

²³ Ibid, 93-94.

²⁴ Ibid, 101.

²⁵ [Finding into death following inquest – Child 1, Child 2, Child 3, Child 4.](#)

²⁶ CCYP, [Left behind: Systemic inquiry into responses to children and young people who are the subject of multiple reports to Child Protection](#) (June 2026), 4.

²⁷ Ibid, 16, 30.

²⁸ Ibid, 18.

Orange Door by Child Protection after intake were seven times more likely to be allocated to a core The Orange Door service than clients who are referred during the intake phase.²⁹ The Left Behind report considered that this difference may be due to “*the additional involvement of Child Protection with the family post intake, a more intentional referral process in the investigation and protective intervention phases, and prioritisation of these referrals by The Orange Door*”.³⁰

129. The Left Behind report otherwise noted CCYP’s longstanding concerns regarding “*Child Protection prematurely closing reports at intake when there is evidence of ongoing and/or escalating risks to children and young people, and where there is a lack of effective service engagement, either voluntarily or through statutory practice*”.³¹

130. In my view, many of the CCYP’s recommendations are relevant to this case, particularly the following:

Recommendation 7 – Enhance assessments of cumulative harm

That the Department of Families, Fairness and Housing:

- *Evaluate the extent to which SAFER is supporting Child Protection practitioners to effectively assess cumulative harm, with a view to making any necessary changes to strengthen policy and practice*
- *Develop an approach to the ongoing monitoring of practice and decision-making in relation to cumulative harm.*³²

Recommendation 8 – Communicate a clear threshold for statutory intervention

That the Department of Families, Fairness and Housing communicate the threshold for statutory intervention in a way that ensures a shared understanding of risk, and associated roles and responsibilities, among Child Protection, The Orange Door, child and family services and family violence services.

Recommendation 11 - Strengthen The Orange Door’s engagement methods

²⁹ Ibid, 45-46.

³⁰ Ibid, 45.

³¹ Ibid, 51.

³² Noting that DFFH have conceded that an enhanced referral should have been made for the family in this case, but that the CCYP report outlines an ongoing lack of clarity regarding the process for handling enhanced referrals, including when engagement with the family does not occur.

That the Department of Families, Fairness and Housing strengthen The Orange Door's approach to attempting engagement with families, to include more flexible and assertive methods.

Recommendation 12 - Improve guidance for responding to enhanced referrals in The Orange Door

That the Department of Families, Fairness and Housing strengthen the enhanced referral process to include clear guidance for The Orange Door on the process of responding to enhanced referrals, including the importance of making every reasonable effort to allocate them to a service, and the role of Community-based Child Protection in joint work.

Recommendation 13 - Increase investment in child and family services and family violence services

That the Victorian Government increase the availability of child and family services and family violence services to support timely access, reduce waitlists and work towards meeting demand, including ensuring age-appropriate, flexible service provision for children, young people and families.³³

131. I strongly support and endorse the CCYP's recommendations and intend to provide a copy of this finding to the CCYP for their information and consideration.

Western Melbourne Child FIRST and MVCC family services

132. As noted above, Child Protection made several referrals to Child FIRST. On 27 October 2020, Child Protection allocated one of these referrals to MVCC for a partner agency assessment. Child FIRST were unable to substantively engage the family, including via MVCC, and conducted two Section 38 consultations with Child Protection as a result.
133. I have not identified any significant concerns with respect to Child FIRST or MVCC's service contact with the family, noting they were voluntary services and could not compel the family to engage. These services appear to have appropriately shared all family violence concerns identified with Child Protection.

Melbourne Health – Waratah Clinic

³³ Noting that recommendation 13's relevance to this case is particularly evident when considering the challenges with respect to service provision by inTouch in their statement, which is outlined below

Background

134. From October 2018 to June 2020, MHU voluntarily engaged with the Waratah Clinic (part of Melbourne Health). In June 2020, MHU did not present with any psychotic symptoms and was compliant with her treatment. However, staff recorded concerns about controlling behaviours perpetrated by BLR at this time. For example, MHU stated that she needed her husband's permission to change GP clinics and that he did not give her enough money for the children. BLR also refused to provide MHU with his tax/income details for her DSP application, so the Waratah Clinic was unable to assist her to access her own income. Waratah Clinic staff shared these concerns with Child Protection on 16 April 2020, noting that BLR's behaviour made it very difficult for them to support MHU.
135. Waratah Clinic records demonstrate that staff attempted to support MHU and her family to improve their circumstances, including by attempting to facilitate access to free childcare for the children, however BLR was not receptive to this support. The Waratah Clinic also attempted to assist MHU to apply for the DSP, however BLR refused to provide his date of birth or other details required for the application, leading MHU to feel *"hopeless with her situation"*.
136. The Waratah Clinic were concerned about BLR's alleged perpetration of family violence against MHU and attempted to link her with family violence services including by referring her to inTouch for support in February 2020 and facilitating an intake assessment in March 2020. The Waratah Clinic also appropriately shared information with Child Protection and Child FIRST about concerns for the family (including family violence concerns). The Clinic advised Child Protection that BLR's behaviour made it challenging for them to support MHU.
137. The Waratah Clinic last reviewed MHU on 7 July 2020, when two clinicians performed a home visit. The clinicians described the environment as *"not children-friendly without toys or anything stimulating to children. Home hygiene was poor with dirty carpet"*. The clinicians noted that MHU cooked on a small portable gas stove in the kitchen and recorded concerns that *"gas supply in the kitchen appeared to be an issue"*. After this visit, MHU disengaged from her treating team. Despite making attempts to see her, Waratah Clinic staff were unable to review MHU again prior to the fatal incident.
138. MHU attended the Waratah Clinic on 10 November 2020; however, she left before she was reviewed by a clinician. BLR attended the Waratah Clinic on 17 November 2020, and

requested a medication script for MHU, however staff refused to provide the script to BLR and scheduled a medical review for MHU.

139. On 17 November 2020, MVCC contacted the Waratah Clinic and advised that they “*suspect[ed] family violence [was] occurring*”. MVCC suggested that the Waratah Clinic complete a family violence risk assessment alone with MHU, if she engaged with them, and that they report any disclosures to Child Protection. MVCC advised of various concerns about BLR’s alleged behaviour, including ceasing the children’s childcare attendance, declining all support services offered, and generally controlling behaviour. MVCC also explained that MHU did not have any access to money, expressed being fearful of BLR to a childcare staff member and appeared open to engaging with support, however BLR refused to allow this engagement. MVCC advised that they would be closing their referral as their service had been declined.
140. The Waratah Clinic recorded that a family violence risk assessment should be completed if MHU attended the clinic, however she did not attend her scheduled appointment on 26 November 2020. Waratah Clinic staff attempted to visit MHU at home with MVCC on 1 December 2020, however this was unsuccessful as she refused to come out of her room when they called her. Waratah staff attended the local community centre and spoke to a program officer, who advised MHU and the children had stopped attending the centre “*since the Child Protection notification*”, however did attend the day prior to obtain nappies. The program officer reported that MHU’s “*mental health has been stable without any obvious deterioration*”. Following this attempted visit, staff held a clinical review meeting and documented “*Ongoing concerns about family violence within the home – financial and emotional abuse from husband.*”
141. MHU did not attend her next scheduled appointment on 13 January 2021. On 18 January 2021, a psychiatry registrar noted that MHU had disengaged from the service, that the service was unaware of any risks (“*nil risks evident or raised by childcare*”) and that the service would discharge her.

Analysis

142. I note that prior to the fatal incident, the Waratah Clinic was planning to close MHU’s case and recorded that there were no risks, despite recent concerns about family violence and knowledge that MHU had disengaged herself (or had been disengaged) from other services including MVCC and Child Protection.

143. In my view, best practice would have included attempts to complete an updated family violence risk assessment and management plan with MHU or refer her back to Child Protection given this unaddressed risk. However, given the various other concerns with respect to other services involved in this case, I am not satisfied that this approach would have necessarily resulted in a preventative impact.
144. I also note that at the relevant time, the MARAM framework was in place, but associated practice guides and training for professionals were still being rolled out. It is likely that implementation of MARAM practice guides may have improved the responses of public mental health services to family violence since the fatal incident.

Procedural fairness response

145. As a matter of procedural fairness, the Court wrote to Melbourne Health and provided them with my draft proposed comments and invited their response. In relation to MHU's discharge on 18 January 2021, Melbourne Health noted that the brevity of the clinical documentation on this occasion was likely because MHU had not been able to be seen and assessed by clinicians since at least July 2020. Melbourne Health submitted that there was a consideration of risk at each attempted encounter with MHU and at the multidisciplinary team (**MDT**) meetings. However, Melbourne Health noted that this appeared to be related to the children's welfare and the risk posed by family violence perpetrated against MHU.
146. Having reviewed the records, Melbourne Health advised that they were unable to find any reference to, or consideration of, whether MHU was at risk of perpetrating family violence to other family members. The prevailing concern appeared to be that she and the children were at risk of being subjected to family violence.
147. Melbourne Health acknowledged that changes have occurred since the introduction of the MARAM framework, which has improved the organisation's responses to family violence since RFV's death. In early-2021, NorthWestern Mental Health (**NWMH**)³⁴ supported a Specialist Family Violence Advisor (**SFVA**) capacity building program. This included two full-time SFVAs and senior supervision across NWMH's clinical streams. Supervision and support for the SFVAs included a Social Work Advisor, Chief Social Workers at each service/program and a Safety and Inclusion lead. There was also a network Family Violence

³⁴ A clinical division of Melbourne Health which included the Waratah Clinic. Following changes to the participation and organization of NWMH, the service is now called the Royal Melbourne Hospital Mental Health Services (RMH-MHS). RMH-MHS includes the Waratah Clinic.

Advocates embedded in teams, supported by SFVA and Social Work leads, through 6-8 weekly education and reflective practice sessions.

148. The now-named Royal Melbourne Hospital Mental Health Services (**RMH-MHS**), of which the Waratah Clinic is a part, uploaded new MARAM training modules to the hospital's online learning management system. The RMH-MHS offers:
- a) Information Sharing Scheme and MARAM Victim Survivor Screening and Identification courses which are highly recommended for all specialist mental health clinical staff to complete.
 - b) A Foundational Knowledge course for anyone who may have limited family violence knowledge, or who may be new to working with people experiencing family violence. It is also designed to help non-clinical staff understand the MARAM framework and is recommended for staff working in consumer or carer lived experience roles.
 - c) The MARAM Victim Survivor Brief and Intermediate courses, which are required for mental health professionals with Family Violence Advocate responsibilities.
149. Melbourne Health noted as part of their ongoing focus and support for family violence and trauma-informed care, they have developed numerous procedures and guidelines to assist staff. This includes guidance on the MARAM, information sharing, identification and response to patients experiencing family violence, working with families and carers, amongst others. Most recently, in 2025, the service developed the MHS Clinician Guideline, *Responding to Family Violence Information Sharing Scheme (FVISS) and the Child Information Sharing Scheme (CISS) requests*.
150. I am satisfied that significant changes have been implemented by Melbourne Health in relation to understanding, identifying and responding to family violence, and therefore do not intend to make any recommendations.

inTouch

Background

151. On 20 February 2020, MHU's Key Worker at the Waratah Clinic referred her to inTouch for support due to concerns about BLR's alleged perpetration of family violence. The referral outlined the alleged abuse perpetrated against MHU including significant financial abuse, blocking of support services for MHU and the children, and other controlling behaviour which

inhibited MHU's ability to meet the basic needs of herself and the children. The referral noted that MHU was the carer for her two youngest children, but that BLR and RFV received the carers payment for them, despite RFV being unable to care for the children due to her own ill-health. The referral also noted that MHU was scared of BLR.

152. The referral noted that the family had been referred to Child Protection recently, but that they had closed the case and that as a mental health service, the Waratah Clinic were struggling to *"provide support and change the aversive conditions of the clients"*.

153. On 12 March 2020, the Waratah Clinic called inTouch and they performed intake with MHU over the phone using an interpreter. According to the Waratah Clinic records, the inTouch worker explained to MHU that she was *"in a family violence situation in terms of emotional, psychological and financial abuse as well as experiencing control and isolation"* and spoke to her about her right to make decisions for herself and her children.

154. The inTouch records reflect that MHU did not understand that she had been referred to a family violence service and she denied experiencing family violence and did not believe that she was in danger. MHU:

...denied she was in a family violence situation, denied she was feeling unsafe, denied she wanted to leave the relationship, and said she did not want services to go to her home, afraid of her children being removed, even with Child First, she worried that if Child First looked at small issues, they will report to Child Protection.

155. MHU denied that she only received two-minute noodles from BLR to feed the children and explained *"it is just that the money provided by the husband is not enough"*.

156. The inTouch records reflect that the intake worker provided information about family violence and the services available to MHU, however closed the referral at the intake stage because:

- a) MHU was *"not willing to leave the relationship"*
- b) MHU said that family violence was not occurring
- c) A referral to family services would be more beneficial to MHU, despite noting that BLR had previously declined Child FIRST support.

157. The intake worker also noted that it would be difficult to provide MHU with a service, as she did not have a *"workable phone"*.

158. The intake worker documented risks to MHU including “controlling behaviours”, “unemployed [sic]” and “other” but concluded that “woman is not at risk or in danger”, marked her risk level as “not applicable” and closed the referral at the intake stage. The Waratah Clinic records reflect that the inTouch intake worker stated that MHU did not need a safety plan because she was not in danger.
159. The inTouch intake worker directed the Waratah Clinic to the Centrelink social worker when they asked for assistance with MHU’s DSP application, given BLR refused to provide the necessary information. They also advised that they could not provide MHU with any financial support, and even if she did meet their criteria, they could only provide about \$200.

Analysis – risk assessment and non-disclosure of family violence

160. In a statement provided to the Court by inTouch dated 29 August 2025, inTouch acknowledged that “MHU’s case illustrates the complexity of applying MARAM where cultural, linguistic, and literacy barriers intersect with non-disclosure, and where child wellbeing concerns are present despite denial by the primary caregiver”. With respect to whether inTouch met their MARAM obligations in the course of their contact with MHU, inTouch stated that “The primary gap was in the depth of formal risk assessment and the use of secondary consultation given the risk indicators present however a more detailed assessment was not possible due to the clients’ denial of any family violence or associated risks”.
161. inTouch noted that while they recorded MHU’s risk as “not applicable” based on her “denial of violence”, “the professional observations suggested significant unacknowledged risk”. inTouch, however, noted:

Under the MARAM framework, client self-assessment is a critical data point but must be considered alongside professional judgment and observed indicators. In this case, the refusal to identify her experiences as violence limited the scope for consent based interventions and made it difficult to activate more intensive case management.

162. I note that while a victim-survivor’s self-assessment is relevant to overall risk assessment, denial of fear should be considered in the context of other evidence-based risk factors, particularly given the many barriers to victim-survivors openly disclosing their level of fear, especially in their first contact with a family violence service. I further note other cases before this Court where professional responses to family violence relied solely or disproportionately

on victim-survivor's stated low level of fear and ultimately undermined the victim-survivor's access to support or intervention.³⁵

163. This raises an important question about how family violence services can and should respond when evidence suggests that a client is experiencing family violence, but the client does not conceptualise it as such, possibly based on a limited or different understanding of family violence when compared with official definitions provided, for example, within the MARAM or the *Family Violence Protection Act 2008*. inTouch similarly noted in their August 2025 statement:

Cultural stigma, community expectations, and gendered norms may have influenced MHU's refusal to acknowledge family violence. In many CALD [culturally and linguistically diverse] communities, separation is viewed as shameful or dishonourable, and women may feel pressure to prioritise family unity over personal safety. These dynamics can prevent disclosure and contribute to minimisation of abuse. Without a tailored, culturally safe engagement strategy, these dynamics may reinforce silence.

164. Despite MHU's non-disclosure, in my view, inTouch had adequate information to conclude that MHU's experience met the definition of family violence. The available records also reflect that inTouch concurred with this view, given their provision of information to her as to why "*she was in a family violence situation*". In their August 2025 statement to the Court, inTouch appeared to conflate MHU's statement that she was not experiencing family violence with a denial of consent to proceed beyond the intake phase. However, the available records do not reflect that MHU actually declined support from inTouch.
165. In such cases, consideration should be given as to whether inTouch can provide further support on the basis that they have assessed that a woman is experiencing family violence and is willing to accept support, despite not openly identifying her experience as family violence at that point. This approach may benefit many victim-survivors of family violence, given that some groups (including older people and people from culturally, linguistically and faith-diverse communities) may face particular barriers to disclosing family violence or identifying that they are experiencing family violence as per the definitions in Victorian legislation and policy.

³⁵ See for example, [Finding into passing without inquest – Helena Broadbent](#); [Finding into passing following inquest – Noeline Dalzell](#); [Finding into death without inquest – Michelle Darragh](#).

166. inTouch further noted in their statement “*A scheduled follow up may have provided additional opportunities for engagement and trust building. Yet any ongoing contact beyond the intake appointment would have required client agreement to re engagement, which was not granted*”. I again note that while MHU denied experiencing family violence, records do not reflect that she declined input from inTouch, nor that they offered her any further support, including a follow-up appointment.
167. In their statement, inTouch acknowledged that the implementation of further strategies aligned with culturally responsive practice may have created culturally safe entry points for engagement with MHU. These could have included “*framing the discussion around children’s wellbeing, fairness, or financial independence*”.
168. In response to a question about what support inTouch currently provides to women who are experiencing family violence but are unable to identify this, including in cases where they may not feel safe enough to do so, or where they may need further education about family violence and what it is, inTouch identified several options for support. These include:
- a) Incremental education – this includes providing information over time about different types of family violence, including non-physical forms such as financial abuse and controlling behaviours. Since the fatal incident, inTouch have implemented a one day ‘support package’ which focuses on information provision for clients who may not be ready to engage fully in their support services. This is offered to all women referred to inTouch regardless of whether they meet the service’s eligibility criteria.
 - b) Building trust for future disclosure – establishing non-judgmental contact and rapport focusing initially on the client’s stated needs.
 - c) Engaging in a culturally safe manner – this means tailoring the way they explain family violence, rights, and available supports, so that they are meaningful, accessible, and respectful within the client’s cultural worldview. This also involves using familiar concepts and examples rather than abstract or legalistic language. For example, instead of starting with the term ‘family violence’, which may be stigmatised or misunderstood, a worker might describe specific behaviours (such as controlling access to money, isolating someone from friends, or making all household decisions) and invite the client to reflect on whether these occur in her situation.

- d) Framing rights and safety in culturally resonant ways – for example, linking them to values the client already holds (e.g., the wellbeing of children, equity in relationships, community connection), so the message is more likely to be received without defensiveness.

169. inTouch further identified the following resources which could improve their capacity to support women in a similar position to MHU, including:

- a) Extended intake capacity – flexible intake processes that allow multiple sessions before case closure, so workers can build rapport and revisit risk conversations over time. This is particularly critical for CALD women who may not disclose family violence at the first contact.
- b) Specialist workforce development – ongoing training in non-disclosure practice, covert risk assessment, cultural humility, and trauma informed care to strengthen practitioner ability to identify and respond to hidden risks in CALD communities.
- c) Dedicated outreach resources – capacity to provide in person, community-based engagement for women without safe communication channels, such as home visits coordinated with trusted health or community providers.
- d) Interpreter and bilingual workforce investment – access to highly trained interpreters with family violence expertise and expansion of bilingual caseworker roles to bridge language and cultural barriers more effectively.
- e) Flexible and generous funding models – funding arrangements that recognise the intensive, prolonged and iterative nature of engagement required in CALD family violence work. Current program-based models are often too rigid and short term, limiting the ability to deliver culturally safe, trust-based interventions.

170. I note that the above resources would likely improve the ability of inTouch and other specialist CALD family violence services to provide best practice support to victim-survivors, which in turn, may prevent future deaths. I therefore intend to recommend that the Department of Families, Fairness and Housing (**DDFH**) review this finding and consult with inTouch and other CALD family violence services about the additional funding and support they require to implement the above initiatives. I also intend to recommend that the Victorian Government commit to funding and otherwise supporting the implementation of the above initiatives.

Analysis – support for women who do not want to leave their relationship

171. The ability for victim-survivors to access family violence services is crucial for victim-survivors who do not wish to leave their relationship, as is the case for many women whose partners are perpetrating family violence against them. In their statement to the Court, inTouch noted that *“separation is not always a safe or desired option”* and outlined various support options they provide to women in this situation. These supports include safety planning, linking clients with health, financial and legal supports, and *“[a]ddressing cultural and religious pressures that may discourage separation”*. inTouch noted, however, that some support is not available to women who do not want to leave their partners, namely DFFH-funded Flexible Support Packages (FSPs).
172. FSP funding can be used for a range of expenses that assist a victim-survivor to *“transition from crisis, and establish long-term sustainable arrangements to improve their safety, wellbeing and independence in recovery from family violence”*. This may include funding a private rental (paying bond), relocation costs and other basic material needs, purchasing security cameras or personal security devices, funding therapeutic intervention or participation in learning and education.
173. The FSP Program Guidelines state that in order to access an FSP, victim-survivors must be *“planning to leave an abusive situation or have the perpetrator removed from the home”*. I note that many women experiencing intimate partner violence do not wish to leave the relationship, and the MARAM Foundational Knowledge Guide notes this as a practice consideration for responding to women experiencing family violence. Access to an FSP may have improved MHU’s safety and wellbeing, despite her stated intention to remain in a relationship with BLR. An FSP could have been used to purchase a phone for MHU, which may have improved her ability to access crisis and support services, and connect with her family and culture, noting that she was significantly isolated from most supports at the time. inTouch similarly noted that MHU not having a phone was a barrier to providing her with support both at the time of their meeting with her, and in their statement to the Court.

Procedural fairness response

174. As a matter of procedural fairness, the Court wrote to inTouch to provide them with an opportunity to consider an extract of the draft finding and a proposed recommendation. The proposed recommendation was in relation to expanding the FSP criteria. inTouch advised that

it did not have any further comment with respect to the analysis or proposed findings. However, it did wish to make a suggestion in relation to the FSP recommendation.

175. inTouch noted that there has been some discussion within the sector about the FSP being expanded to include victim-survivors who do not wish to leave their relationship. inTouch did not suggest that my proposed recommendation should change, however sought to highlight the concern that if the FSP is expanded to include victim-survivors who do not wish to leave a violent relationship, those victim-survivors may be at increased risk of experiencing further family violence, especially if/when the perpetrator becomes aware of the support that the victim has received. inTouch suggested that I might like to amend the recommendation to include crisis brokerage funding, not only FSPs, as the former is used more immediately to support survivors (e.g. to provide a phone). I agree with this suggestion and will make a recommendation accordingly.
176. inTouch otherwise noted that it continues to develop its intake and case management guidelines to ensure all elements identified in these findings are taken into consideration when responding to clients in complex situations, particularly those that face structural and systemic barriers, such as women from migrant and refugee backgrounds.

Maternal and Child Health service

177. The MVCC MCHN service was engaged with the family for several years and appropriately shared information about concerns for the family with Child FIRST and Child Protection. I have not identified any significant concerns with this service.

A local child care centre

178. This service was aware of the family for four years prior to the fatal incident. The children last attended the centre in July 2020, and the manager told MVCC on 2 November 2020 that MHU was ‘*in need of desperate support*’. This service repeatedly attempted to obtain support for MHU and her children via Child Protection. I have not identified any concerns with respect to this service.

Systemic issues and other concerns

Children bereaved by family violence homicide

179. The available evidence suggests that MHU’s children were victims of family violence in their own right, likely experiencing the negative impacts of their fathers’ refusal to allow them

access to support services. Ultimately, two of MHU's children were in the home when their mother killed their grandmother whilst unwell, and some records suggest that they witnessed the incident, with one of the children attempting to intervene. Following the fatal incident, records suggest that both children were non-verbal, behind on their immunisations and "*suffering from the impacts of significant trauma*" including nightmares. Records further suggest that the distant relative who cared for the two children, may have struggled following the fatal incident as the children may not have been linked with all appropriate and necessary services in a timely manner.

180. In recent cases before this Court, former State Coroner, Judge Cain, noted the lack of specialised services to support children bereaved by homicide. In Judge Cain's finding into the death of Monique Lezsak, his Honour recommended:

*That the Minister for Prevention of Family Violence provide funding for a service designed to provide support to children and young people (and their carers) bereaved by homicide.*³⁶

181. His Honour endorsed this recommendation in his finding into the death of GVV.³⁷ I also strongly support such a recommendation and note that this case is yet another tragic example of the need for specialised support services for children and young people bereaved by family violence homicides.

182. DFFH has since responded. They advised that the recommendation had been taken under consideration and noted that DFFH had funded the University of Melbourne to complete a project mapping current services in Victoria that support children, young people and families bereaved by family homicide as "*a precursor to any potential implementation of the recommendation*".

183. In circumstances where the University of Melbourne project is underway, I will direct a copy of this finding be provided to the team completing the project at the Centre for Health Equity at the University of Melbourne, and to the Minister for the Prevention of Family Violence.

FINDINGS AND CONCLUSION

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

³⁶ [Finding into death without inquest – Monique Lezsak.](#)

³⁷ [Finding into death without inquest – GVV.](#)

- a) the identity of the deceased was RFV, born [REDACTED]
- b) the death occurred on 29 January 2021 at Royal Melbourne Hospital, 300 Grattan Street,
Parkville Victoria 3052, from complications of stab wound to the chest; 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 **Child Protection** amend their information systems to amend their *CALD Data Practice Resource* to include guidance for Child Protection Practitioners when the intended recipient of their correspondence cannot read in any language (or has limited reading abilities in any language).
- (ii) That the **Department of Families, Fairness and Housing** review this finding and consult with inTouch and other CALD family violence services about the additional funding and support they require to implement the initiatives described at paragraph 167 (above).
- (iii) That the **Victorian Government** commit to funding and otherwise supporting the implementation of the above initiatives (at paragraph 167 above).
- (iv) That the **Victorian Government**, in consultation with **Family Safety Victoria**, fund an expansion of the crisis brokerage funding and FSP eligibility criteria to include victim-survivors who are not currently planning to leave an abusive situation or have the perpetrator removed from the home.

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:

BLR, Senior Next of Kin

Children and Young People Bereaved by Domestic Homicide Project Leader, Centre for Health Equity, University of Melbourne

Commission for Children and Young People

Department of Families, Fairness and Housing

Department of Premier and Cabinet

Family Safety Victoria

MHU's Psychiatrists, Forensicare

inTouch

Melbourne Health

[REDACTED]

The Hon. Ingrid Stitt MP, Minister for Prevention of Family Violence

Detective Leading Senior Constable Mick Cashman, Coronial Investigator

Signature:



Judge Liberty Sanger, State Coroner

Date: 02 October 2026

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.
