IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005579

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:	Narelle Catherine Simmons
Date of birth:	14 March 1979
Date of death:	Between 10 and 19 October 2021
Cause of death:	1(a) Haemothorax and pneumonia in the setting of acute and chronic chest injuries and consumption of multiple drugs Contributing factor(s) 2 Hepatic cirrhosis, chronic alcoholism
Place of death:	4/8 Lyall Street, Cranbourne, Victoria, 3977
Keywords:	Family violence; abandonment of victim in medical need; mental health conditions; substance use

INTRODUCTION

1. On 19 October 2021, Narelle Catherine Simmons was 42 years old when she was found deceased in her home by police. Narelle is survived by her adult daughter and adolescent son.

2. From late-2018, Narelle commenced a relationship with Craig Jennion. Their relationship was regularly marred by incidents of violence, with the first report to Victoria Police occurring on 26 November 2018, shortly after they commenced a relationship. At the time of the fatal incident, there was an unserved family violence intervention order (**FVIO**) against Craig, to protect Narelle. There was also an FVIO in place against Craig to protect his mother, who reportedly experienced family violence perpetrated by Craig.

THE CORONIAL INVESTIGATION

3. Narelle'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.

4. 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.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

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

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Narelle Catherine Simmons 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

9. On 25 October 2021, Coroner David Ryan made a formal determination identifying the deceased as Narelle Catherine Simmons, born 14 March 1979, via fingerprint identification.

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

Medical cause of death

11. Forensic Pathologist Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 21 October 2021. A second autopsy was performed on 26 October 2021, after further information became available. Dr Young provided a written report of his findings dated 28 September 2022.

12. The post-mortem examination revealed complications of acute and chronic chest injuries (in this case, rib fractures) which may have caused respiratory failure leading to death. These specific complications were a left haemothorax and pneumonia. A large volume of fluid was seen in the left pleural cavity, with a blood-stained appearance and associated chronic pleuritis raising the possibility of an organising haemothorax on a background of pre-existing pleural effusion (as previously seen on an ante-mortem scan dated 6 August 2021). Pneumonia was seen in the upper lobes of both lungs, which showed acute (new) and organising (old) changes.

13. Acute fractures of the right 3rd to 7th and left 5th to 9th ribs were of a nature that may have been sustained from cardiopulmonary resuscitation (**CPR**) attempts; however, acute fractures of the left 8th to 11th ribs may have been sustained from an injury at or around the time of death, given they were not in locations typically seen for resuscitation-related fractures. Fractures of the left 5th to 9th ribs had features in keeping with healing (chronic) injuries consistent with

[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.

the acute fractures identified on the 6 August 2021 ante-mortem scan. The mechanism of sustaining the non-CPR-related rib fracturs could not be unequivocally established from the autopsy, however, could have been related to falls or assaults.

14. Toxicological analysis of post-mortem samples identified the presence of ethanol, sertraline, methadone and its metabolite, methylamphetamine and its metabolite, diazepam and its metabolite, olanzapine and a cannabis metabolite. Dr Young opined that the presence of ethanol at a low level (0.01 g/100mL) was likely related to bacterial fermentation in the setting of decomposition, rather than actual alcohol use.

15. Dr Young explained that many of the drugs detected in the deceased's blood can cause depression of the central nervous system and, in combination, may contribute toward further respiratory failure in the setting of the known complications of the rib fractures.

16. Hepatic cirrhosis was seen at the autopsy, on a background of known chronic alcoholism and intravenous drug use. The deceased's history of alcohol-withdrawal seizures was noted, as were the post-mortem biochemistry results showing renal impairment (possibly due to hepatorenal syndrome). In this setting, Dr Young opined that a seizure or electrolyte disturbance could not be excluded as having contributed to the death.

17. The deceased was found with a pillow over her face. Whilst the autopsy did not show any unequivocal bruising around the mouth, the possibility of suffocation or airway obstruction, in the setting of other contributors toward respiratory depression, could not be excluded.

18. Within the limits of the examination, there was no evidence of any significant traumatic head or neck injuries contributing to the death. Bruises seen on the frontal scalp, torso and limbs were non-specific and, similar to the rib fractures, may have been caused by falls or assaults.

19. Dr Young provided an opinion that the medical cause of death was *1(a) haemothorax and pneumonia in the setting of acute and chronic chest injuries and consumption of multiple drugs*, with contributing factors of *hepatic cirrhosis and chronic alcoholism*.

20. I accept Dr Young's opinion as to the medical cause of death.

Circumstances in which the death occurred

21. On 18 October 2021, Narelle's daughter, Tayla, contacted the Cranbourne Police Station and requested police perform a welfare check on her mother. Tayla explained that she normally received a call from Narelle once per week, and she had not heard from her for about three

weeks. Tayla noted that her mother also experienced issues with substance use and family violence. A police unit attended Narelle's Cranbourne home; however, they were unable to raise anyone inside the property when they knocked on the door.

22. On 19 October 2021, Tayla called the Cranbourne Police Station again and requested another welfare check. She again noted concerns about her mother's substance use and family violence. Police attended Narelle's Cranbourne home and gained access via an unlocked back door. Police located Narelle deceased on a mattress which was placed on the floor of the lounge room. She was covered by a mink blanket and was heavily decomposed.

23. While processing the scene, police located Craig's wallet next to the mattress where Narelle was found. Police spoke to Narelle's neighbours, including her immediate neighbour, Tracey. Tracey advised police that she heard Narelle yelling "*get the fuck away from me*" and "*leave me alone*" at about midnight between 10 and 11 October 2021.

24. Detectives attended the scene and determined that the death was not suspicious, opining that it may have been a drug overdose, given Narelle's history of substance misuse.

25. On 25 October 2021, Craig attended the Cranbourne Police Station and confessed to assaulting Narelle and causing her death. He told police that between 10 and 11 October 2021, he was present at Narelle's unit where the couple were arguing. He admitted to punching her to the face twice and elbowing her once to the back of the head.

26. Craig was arrested on 4 October 2022 and was charged with common assault and failing to report a reportable death. He pleaded guilty to these charges on 10 February 2023 and was sentenced to five months' imprisonment and a 12-month community corrections order (**CCO**).

FURTHER INVESTIGATIONS AND CPU REVIEW

27. As Narelle's death occurred in circumstances where she was experiencing family violence in the lead-up to her passing, this case was referred to the Coroner's Prevention Unit (**CPU**)[2] to

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

examine the circumstances of Narelle's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3]

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

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

30. I note that while Craig was charged and convicted with offences in relation to Narelle's death, he has not been charged and/or convicted in relation to many of the alleged offences that occurred during his relationship with Narelle. The Court provided Craig an opportunity to respond to these concerns, however to date, he has not responded to same. I do not reference the history of alleged family violence in order to draw conclusions about Craig's criminal or civil liability, as it is not my role to do so. However, I have referenced the allegations in order to enable a broader discussion about family violence sector responses and to determine whether any prevention opportunities exist or recommendations could be made. I make no comment as to the veracity of the alleged offences.

Family violence history

31. Narelle and Craig were in an intimate relationship from late-2018, during which time police attended ten family violence incidents between the pair. Narelle was identified as the affected family member (**AFM**) in nine of the ten incidents.

32. Craig was also recorded on the Victoria Police LEAP database as the perpetrator on 18 other occasions with different AFMs from 2000 to 2021. He was also the respondent to a personal

[3] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

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

safety intervention order (**PSIO**) to protect Narelle's neighbour, following an incident in August 2021.

33. In addition to the above reported family violence, evidence available to the Court suggests there was substantial unreported family violence, including:

    a) Craig attended Narelle's home and taunted her multiple times per day by driving up and down her driveway, yelling abuse at her front door and/or going inside and yelling at her.

    b) Craig's use of 'foul' and abusive language towards Narelle.

    c) Narelle's neighbour reported hearing 'someone' being assaulted inside Narelle's home, sometimes several times per week.

    d) Narelle disclosed to her neighbour that she thought Craig was "*injecting something in her*".

    e) Visible injuries to Narelle including bumps, scratches and bruises.

    f) Narelle disclosed to her daughter that Craig had pulled a knife on her, strangled her, and that she had constant ulcers from being hit in the face.

    g) Craig controlling and isolating Narelle by damaging or stealing her phone.

34. In the 10 months prior to her passing, there were a significant number of notifications to Victoria Police alleging Craig was perpetrating family violence against Narelle, including:

    a) In December 2020, Narelle's father, Gary Simmons, called Triple Zero to report that Craig had assaulted Narelle, where he held her on the ground with a knife to her throat. Craig's mother told police that there had been no dispute, and they had been in bed together all night (in breach of the FVIO protecting Narelle). Police did not speak to Narelle or Craig, and did not take any further action in relation to the FVIO breach.

    b) In May 2021, Tayla and Gary both contacted police with concerns that Narelle was missing. Narelle was eventually located at Frankston Hospital, however Narelle declined to make a statement to police. It does not appear that any further action was taken.

c) In June 2021, a neighbour living next to Craig's mother called Triple Zero to report a woman being assaulted by a man. Craig advised police that Narelle had "*turned up uninvited*" and left. Victoria Police's calls to the neighbour were not answered.

d) In August 2021, Gary called Triple Zero for a welfare check. A final FVIO was in place to protect Narelle from Craig which was due to expire on 29 August 2021. When police attended, Craig's mother's car was in Narelle's driveway, however Narelle reported no issues, so no further action was taken.

e) Three days later, the same member attended Narelle's home due to a dispute between Narelle's neighbour and Craig. Narelle was present at the neighbour's home and declined to make a statement about breaches of the FVIO. It does not appear that consideration was given to an extension of the final FVIO.

f) On 17 September 2021, Corrections Victoria submitted an Information Report (**IR**) to Victoria Police indicating Craig's escalating anger issues, recent drug use, homelessness, history of violence towards Narelle and their assessment that his risk of offending had increased. The IR was reviewed by a member of the Family Violence Investigation Unit (**FVIU**) and was filed for intelligence.

g) On 19 September 2021, Tracey called Triple Zero noting that the "*screaming was worse than usual*". No statement was sought from Tracey in relation to this incident.

h) On 27 September 2021, Craig's Corrections Case Manager called Triple Zero to report Craig was suicidal and was making threats to kill Narelle. The next day, Corrections Victoria submitted an IR with the same information and Victoria Police advised Corrections that Craig was not on a family violence management plan.

i) Also on 27 September 2021, Craig was arrested by police for breaching the FVIO against his mother. He was also arrested and bailed for an incident on 26 September 2021 where he broke Narelle's window. It does not appear that a remand application was sought.

j) On 29 September 2021, an interim FVIO was issued protecting Narelle from Craig. Neither party attended court on that day, and the matter was adjourned to 9 December 2021. The FVIO remained unserved at the time of the fatal incident.

k) On 5 October 2021, Corrections Victoria placed a Triple Zero call alleging that Craig was breaching the FVIO against his mother. Police advised Corrections they would not be charging Craig with a breach offence as a variation to the FVIO was being processed. Police also told Corrections that if they spoke to Craig, they should advise him there was paperwork waiting for him at Cranbourne Police Station (the unserved FVIO to protect Narelle).

Risk and contributory factors

35. The Family Violence Multi-Agency Risk Assessment and Management Framework (**MARAM**) details several "*evidence-based risk factors associated with greater likelihood and/or severity of family violence*" and factors which "*may indicate an increased risk of the victim being killed or almost killed*".

36. These risk factors are divided into three categories: those which are specific to adult victim-survivors, those which are caused by perpetrators' behaviours towards an adult or child victim-survivor and those which are caused by perpetrators which are specific to children. The MARAM also identifies a number of people who can experience "*particular risks, forms of family violence and barriers to accessing support*" which can impact on the options and outcomes available to them. The risk factors documented in the evidence reviewed include:

a) Previous physical harm and history of violence against others

b) Current unemployment

c) Threats to suicide

d) Misuse or alcohol or drugs

e) Threats to kill

f) Prior reports of family violence

g) Breached FVIOs

h) Use of weapons

i) Non-fatal strangulation

j) Coercive control

Corrections Victoria

37. In November 2019, Corrections Victoria recorded that Craig was not a suitable candidate for a CCO, due to previous non-compliance and offending against the same victim (Narelle) while under a CCO. Craig had a CCO breach hearing in April 2021, due to an FVIO breach against Narelle in June 2020. Craig was fined $400 and Community Correctional Services agreed to administratively manage the matter given the offence was committed in the "*infancy of the order*", he otherwise had "*positive compliance*", and he participated in treatment.

38. As part of Craig's CCO, he was engaged in one-on-one Men's Behavioural Change Counselling with a clinician. The clinician notified Corrections Victoria that Narelle and Craig were in contact, that his personality could easily trigger aggression, and that he was "*abusive*" in the way he spoke about Narelle.

39. I have not identified any deficiencies or prevention opportunities with respect to Craig's contact with Corrections Victoria. However, I note the limited efficacy of Men's Behavioural Change Counselling. In a recent publication by Australia's National Research Organisations for Women's Safety (**ANROWS**), it was noted:

> *Men's Behaviour Change Program's need to be embedded within the broader domestic, family and sexual violence ecosystem so they can work together with other services towards improved outcomes for victims and survivors including children, as well as improved outcomes for meaningful behaviour change, accountability, increased visibility and risk management.*

40. It appears in this matter, there were other parts of the ecosystem that were lacking in holding Craig to account and managing the risk he posed, which is explored in further detail below.

L17 referrals

41. When Victoria Police submit a family violence report (**FVR L17**), referrals are automatically generated to specialist family violence (and other) support services. In this case, most of the L17 referrals did not convert into active support for Narelle or Craig, either due to not answering calls or text messages or incomplete information provided by Victoria Police (either contact details not provided or respondent not spoken to).

42. This aligns with available data on service responses to L17 referrals more broadly. In 2022/2023, The Orange Door (as the statewide response to L17 referrals) closed 57% of

referrals due to clients declining services or being uncontactable.[5] Only 28% either had their needs met by The Orange Door or engaged with the service system.[6] These statistics highlight the need for a different mechanism to engage with victim-survivors and perpetrators of family violence. One such possibility is the implementation of co-responder programs to increase engagement with both victim-survivors and perpetrators.

43. Research has identified key benefits to co-responder programs, where a family violence specialist worker is present during police attendance at family violence incidents to provide a collaborative response. Research has also suggested that a co-responder model improves victim satisfaction with police, increases willingness of victims to contact police in future, encourages more information sharing and coordination of services for victims, improves understanding of family violence by police, and results in a perceived increase in the accountability taken by police in responding to family violence.

44. Former State Coroner, Judge Cain, noted in his Honour's finding into the death of Carolyn James[7] that co-responder programs may have been of benefit to Carolyn's mother, Jasmine Thomas. A co-responder program, if available to Ms Thomas, may have been able to engage with her more comprehensively than the traditional support options available. Judge Cain made a similar recommendation in his Honour's finding into the passing of Noelene Dalzell.[8] Coroner Ingrid Giles similarly recommended:

> *That the Department of Families, Fairness and Housing resource an expansion of co-responder programs, such as the Alexis Family Violence Response Model, across Victoria.*[9]

45. Similarly, it is clear that Narelle did not engage well with referrals to The Orange Door. I cannot determine that she would have engaged differently if a co-responder program was available to her, however the research into these programs demonstrates their key benefits. In circumstances where the mainstream/existing service responses are not meeting the needs of victim-survivors and perpetrators, I am of the view that more can and should be done to address this gap in the sector. I endorse Coroner Giles' recent recommendation and will direct

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[5] Victorian Government, Case closure results: The Orange Door Annual Service Delivery Report 2022-23, <https://www.vic.gov.au/orange-door-annual-service-delivery-report-2022-23/case-closure-results>.
[6] Ibid.
[7] Finding with inquest into the death - Carolyn James (COR 2023 1604).
[8] Finding with inquest into the passing - Noelene Dalzell (COR 2020 0670) – Recommendation 5.
[9] Finding without inquest into death – Ms KSQ (COR 2023 2596).

a copy of this finding be provided to the Department of Families, Fairness and Housing, to consider as part of their response to Coroner Giles' finding.

Review of Victoria Police involvement

46. Two Professional Standards Command (**PSC**) investigations have been conducted since Narelle's passing, in relation to:

    a) Allegations of duty failure (inadequate investigation) by police attending at Narelle's home on 19 October 2021. These were ultimately substantiated.

    b) Allegations of duty failures from numerous family violence incidents across Southern Metro Region Division 3.

47. A Family Violence Service Death Review (**FV-SDR**) was also undertaken, and it identified several deficiencies in Victoria Police's response to Narelle and Craig.

Victoria Police FV-SDR

48. The FV-SDR made five recommendations related to training/education, as follows:

    a) Body Worn Camera (**BWC**) activation

    b) Fast-track initiatives in relation to summons for family violence offences

    c) Family Violence Liaison Officer (**FVLO**) training for better oversight of family violence matters

    d) Further emphasis on 'initial action principles' for family violence incidents where offences may have been committed

    e) Accuracy in completing family violence reports

49. I note an incident between Craig and Narelle on 10 September 2019 where Craig physically assaulted Narelle on a V-Line train and Victoria Police proactively proceeded with charges against Craig, despite Narelle's unwillingness to assist. In the preliminary brief prepared by police for Craig's remand application, police noted:

    The accused is at risk of causing further physical and mental harm to the victim…while the victim in the past has reported breaches of the Intervention Order or Family Violence Incident of her own accord, it is evident that he is subjecting the victim to a

level of fear in which she no longer reports, as she did not on this occasion. Even when presented with evidence that other witnesses observed what happened, the victim refused to provide details to police and was visibly shaken. Police believe that the victim is now unlikely to report any future Family Violence Incidents or Contraventions between herself and the accused as he now has a concrete level of control over her. This is shown not only by the accused assaulting the victim in public, but by the victim hiding in the toilet from the accused and members of the public.

50. Despite the proactive approach taken by Victoria Police on this occasion, I note that there were other instances (including after this incident) where Victoria Police did not take a proactive approach or did not investigate reports of family violence thoroughly. For example:

    a) Gary reported that his daughter was assaulted with a weapon in December 2020.

    b) Alleged breach of FVIO reported by Craig's mother.

    c) Instances where police did not follow-up with witnesses to obtain statements, when Narelle declined to make a statement.

    d) Inadequate risk assessment and management of Craig, following information from Corrections Victoria in September 2021 in relation to threats to kill, no apparent application for remand, and no proactive attempts to serve the FVIO protecting Narelle.

First PSC investigation

51. The first PSC report made the following concerning comment:

    It is noted that Cranbourne Police have one of the highest rates of Family Violence within the state and attending Family Violence incidents equate to a significant proportion of jobs members attend on the road. This can lead to a complacency when attending jobs where AFMs are not cooperative or have significant other risk identifiers such as mental health, alcohol and drug abuse.

52. It is well established that victims of crime are often measured against an idealised standard of victim response, typically to the detriment of those who are seen to depart in significant ways

from notions of the 'ideal'.[10] Women who are victims of family violence often 'encounter conditional help'[11] which disadvantages many women, especially those who fight back, have a criminal history, abuse alcohol or other drugs or are seen as less than ideal parents.[12]

53. There is recent research that considered intimate partner femicides across Australia (by examining sentencing remarks) and noted that 25% of intimate partner femicide victims had a history of alcohol or other drug issues.[13] Further, 71% of offenders had prior engagement with a combination of police, a legal setting and/or child protection services. The circumstances of Narelle and Craig's relationship are therefore not unique, and Victoria Police need to respond well to individuals with such circumstances, given the potential link to risk of femicide as outlined.

54. It is concerning that some of the responses to Narelle may have been impacted by complacency, particularly regarding her substance use. In fact, Victoria Police acknowledged that her death was not initially considered suspicious until Craig handed himself into police, due to the combination of a mess in her property, Narelle's history of drug use and prescription medication on view. This is despite the fact that there was a broken window, an external door was open and ajar, Craig's wallet was located at the scene and the neighbour's reported hearing screaming from Narelle's property. It appears that attending members initially did not consider any of these factors, nor that Narelle had an unserved FVIO protecting her from the person whose wallet was found at the scene, in addition to the lengthy history of violence perpetrated by Craig against Narelle and others.

55. In response to the above identified concerns, Victoria Police provided the following response:

> *Victoria Police is grateful for the Coroner's work on this investigation and thank the Court for the opportunity to contribute. Victoria Police has undertaken numerous detailed internal investigations and reviews in relation to the circumstances of Ms Simmons' death in order to understand the circumstances of her death and to identify prevention and improvement opportunities. The investigations scrutinised the*

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[10] Julie Stubbs and Jane Wangmann, 'Competing conceptions of victims of domestic violence within legal processes' in D Wilson and S Ross (eds) *Crime, victims and policy* (Palgrave Macmillan, 2015).

[11] Sally Merry, 'Rights Talk and the Experience of Law: Implementing Women's Human Rights to Protection from Violence' (2003) 25(2) *Human Rights Quarterly*, 353.

[12] Ibid.

[13] Professor Kate Fitz-Gibbon, Professor Sandra Walklate, Dr Jasmine McGowan, Professor Jane Maree Maher, Emeritus Professor Jude McCulloch, Securing Women's Lives: Examining system interactions and perpetrator risk in intimate femicide sentencing judgments over a decade in Australia (2024) Monash University and University of Liverpool

actions of thirty members to identify any deficiencies in the police response and identified a number of breaches of discipline. As a result of those investigations, Victoria Police is committed to continuous improvement in relation to family violence responses and ensuring that members are supported to comply with family violence policies and procedures, including through further training to members. Victoria Police extends its sincere sympathy to Ms Simmons' family.

Second PSC investigation

56. As noted above, the second PSC investigation related to allegations of duty failure from thirteen family violence incidents across Southern Metro Region Division 3 (**SD3**). Detective Senior Constable Thomas Asciak of the Homicide Squad submitted the first 12 reports while the 13th report was made by Acting Senior Sergeant Stuart Dawson, the SD3 Divisional Family Violence Coordinator.

57. The initial 12 duty failures were assigned to an Inspector to complete a preliminary investigation. He authored a report on 4 November 2021 and requested a one-month extension, however no further reports were located, and he has since retired from Victoria Police.

58. Another investigation commenced in May 2023, after follow-up by the Homicide Squad. Detective Senior Constable Tuica had carriage of the investigation from May to October 2023, when it was reassigned for regional investigation. This report was eventually completed with 75 recommendations about how each allegation ought to be resolved or finalised.

59. The impact of delayed investigations was noted several times during the second PSC report. This is an issue Judge Cain noted in his Honour's recent finding into the passing of Helena Broadbent.[14] In the second PSC report, the impact of the delay was prominent, for example, some members had difficulty recalling details to assist the investigation, evidence (including day books) had been lost, many members had been promoted, some members had retired or been reassigned to other units and the report noted that different (i.e., more serious) outcomes would have been recommended, but for the delayed investigation.

60. Some of the established allegations in the second PSC report relate to:

    a) Failure to use body worn cameras/accurately classify footage

[14] Finding into passing without inquest - Helena Broadbent (COR 2019 5285).

b) Negligence or carelessness in investigating contraventions of FVIOs and allegations of assault

61. Of note, the investigating officer commented:

a) Training overall for members is considered appropriate for all ranks. Compliance for family violence incidents in SD3 is considered high.

b) While Narelle was often uncooperative with police, in most cases, there was sufficient evidence or enquiries to take further action.

c) There were multiple instances where police could have intervened and held the perpetrator to account but did not.

62. In the 22 months prior to Narelle's passing, the following duty failures were identified and established following investigation. There were additional duty failures that were not substantiated, or the member was exonerated, however for brevity I have not listed those allegations.

a) 15 January 2020 – members did not make inquiries about Narelle's phone being found in Craig's possession when attending a welfare check.

b) 5 and 6 May 2020 – members did not investigate a criminal damage report at Narelle's home.

c) 29 May 2020 – members did not investigate an allegation of an assault on Narelle by a third-party.

d) 31 August 2020 – members did not investigate a possible FVIO breach (Craig being at Narelle's home).

e) 22 December 2020 – members did not investigate a possible FVIO breach and an allegation that Craig assaulted Narelle. Members also did not accurately classify their body worn camera footage.

f) 8 to 10 May 2021 – members did not investigate a possible FVIO breach and Craig's alleged assaults on Narelle.

g) 4 June 2021 – members did not investigate a possible FVIO breach and an alleged assault by Craig on Narelle.

h) 20 August 2021 – a member did not investigate a possible FVIO breach and an alleged assault by Craig on Narelle.

i) 23 August 2021 – members did not investigate a possible FVIO breach and alleged assaults by Craig on Narelle. Members also did not accurately classify their body worn camera footage.

j) 19 September 2021 – members did not investigate a possible FVIO breach and alleged assault by Craig on Narelle.

k) 26 September 2021 – members did not accurately classify their body worn camera footage.

l) Between 24 September and 18 October 2021 – a member did not investigate a possible family violence incident and alleged assault by Craig on Narelle.

63. I accept that significant time has elapsed since Narelle's passing, and that Victoria Police have undertaken significant work in this space, including the two PSC investigations. Actions have been taken by Victoria Police against the members involved with these incidents. I am satisfied that I do not need to make any further recommendations. However, I note that in light of the second PSC investigation, the duty failures identified should not be considered on an individual/separate basis, but rather as a pattern of behaviour, much like family violence.

64. I am concerned by the number of members who were found to have not investigated allegations of family violence, FVIO breaches and/or assaults by Craig. Moreover, I am concerned about the lack of assistance that Narelle may have received and the lack of accountability for Craig's actions. Given that the second PSC report commented that a lack of training or inadequate training was not the issue, I remain concerned that other victims like Narelle may experience a similar response from Victoria Police and that perpetrators like Craig may not be held accountable for their behaviour.

Policy, training and education updates at Victoria Police

65. In response to correspondence from the Court indicating an intention to reference the second PSC report, Victoria Police advised that since 2021, the organisation has continued to strengthen family violence policy and practice. This includes significant updates to policy, including the review, streamlining, clarification and consolidation of policy into the Victoria Police Manual (**VPM**) Family Violence, and the extensive revision of the *Code of Practice*

for the Investigation of Family Violence. Further policy updates were published in July 2025 primarily regarding improving responses to identification of the predominant aggressor.

66. Victoria Police explained that in December 2024, it launched its *Safe from Harm: Victoria Police Strategy for Family Violence, Sexual Offences and Child Abuse 2024-2029* (**'the Strategy'**). The Strategy outlines Victoria Police's goal to consistently deliver high quality responses to family violence, sexual offences, and child abuse, within a sector-wide approach, to enhance community safety across four domains: victim-survivors, perpetrators, children and young people, and Victoria Police members.

67. In 2021, the following requirement was inserted into the VPM Family Violence:

> *The presence of family violence should be considered at all incidents attended by police, even where family violence was not the initiating report. For example, family violence is commonly seen in mental health, property damage and animal abuse incidents, and should be considered during welfare checks.*

68. Since this requirement was inserted into the policy, it has also been incorporated into family violence education and training courses.

69. Additionally, Victoria Police has undertaken a body of work to improve the accurate identification of the predominant aggressor and to ensure appropriate rectification action is taken if it is determined that parties have been misidentified.

70. Victoria Police released a new Predominant Aggressor Practice Guide (**'the Practice Guide'**) which draws heavily from the MARAM framework and supporting practice guides. The Practice Guide provides guidance to members on the actions they can take when reviewing the identification of parties to a family violence incident. It also provides steps to rectify misidentification such as withdrawing FVIO applications and applying appropriate risk management strategies.

71. Victoria Police submitted that it continues to prioritise family violence education and training. As at May 2024, the Centre for Family Violence (**CFV**) had provided training and delivered nearly 88,000 qualifications in family violence training to Victoria Police staff. The CFV also commenced formal training for Family Violence Liaisons Officers (**FVLOs**) which commenced in late-2023. In alignment with the new Practice Guide, the CFV has also recently developed a new three-hour training package, *Identification of the Predominant Aggressor*. This new package focuses on ensuring that supervisors are equipped to support frontline

police responding to incidents, and that they understand their role in reviewing frontline decision-making, as well as appropriate action to take if misidentification has occurred.

72. In relation to the Southern Metropolitan Region, which had primary involvement with Narelle, further work has undertaken. In January 2023, a Family Violence Training Officer (**FVTO**; a Senior Sergeant) was requested to work directly from Cranbourne Police Station, as this location was identified as one of the busiest areas for family violence. The FVTO has worked closely with the Cranbourne FVLOs and officers in charge to provide daily monitoring, to speak to members about family violence responses and to uplift a cultural change at Cranbourne. The FVTO also conducts regular family violence training in the region on various topics including identification of the predominant aggressor, non-fatal strangulation and employee-related family violence.

Abandoning a victim in need as an act of family violence

73. Narelle's case is one of several cases currently before the Court where a previously identified perpetrator of family violence has failed to act to assist an identified victim of family violence in need of urgent medical assistance. This has occurred in circumstances where a duty of care exists in the familial relationship and a reasonable person would be expected to seek medical assistance. All these cases involve current or former intimate partners.

74. In the cases identified, there was a significant delay in calling Triple Zero when an overdose was likely to have occurred, or there was a failure to call Triple Zero after the identified perpetrator of family violence took actions that injured the victim, who subsequently passed away. In the cases identified, the perpetrator of family violence faced either no criminal charges or were charged with summary offences only.

75. In the present case, Narelle's death could not be medically attributed to the assault by Craig, despite his admissions that after assaulting her she "*hit the ground*" and he was unable to revive her. The pathologist was unable to separate the possible contributions of hepatic cirrhosis, chronic alcoholism and consumption of multiple drugs from the injuries Narelle sustained, hence the cause of death provided contained all these conditions. The BWC footage of Craig's interview indicates that he hit Narelle with such force that he "*dislocated his knuckle*". Craig's account of the incident changed, in particular the nature and location of the assault, and whether they were lying down or standing up when she was assaulted. Upon a review of the evidence, it is only Craig's version of events that supports the theory that Narelle was deceased when he left. There is no independent evidence to confirm Narelle's condition

at the time when Craig left and therefore it is not clear whether Narelle may have survived if she received prompt medical attention. I cannot now determine whether Narelle died immediately after being assaulted, or whether she was assaulted and died some hours or days later.

76. There is established case law to confirm that a married or de facto couple owe each other a duty of care in circumstances where one needs medical attention, and they rely on the other to contact emergency services. These cases are summarised below:

    a) In *R v Naddaf*[15], a verdict of manslaughter by criminal negligence was delivered where a man found his wife in their garage with significant injuries from an assault and attempted to provide some care for her but did not call emergency services or an ambulance. She ultimately passed from complications arising from her injuries as a direct consequence of failure to obtain medical assistance. In the unsuccessful appeal, it was noted that the duty of care owed was particularly high, given the victim was in a severely debilitated state, and was vulnerable in a home she shared with the offender, who was also her husband. It was also noted that she was totally dependent on him for her well-being, care and survival, and the only action required to discharge his duty of care was to phone emergency services. On appeal, the original judgement of a "*very serious example of manslaughter by negligence*" was affirmed, and the sentence appeal of 11 years imprisonment with a non-parole period of 8 years was unsuccessful.

    b) In *Reid v R*[16], the offender assaulted his wife during an argument, then when they awoke the next morning, made no attempt to render or seek assistance despite her clear injuries and bleeding. She ultimately passed away from a combination of blood loss from the head wound and pre-existing conditions (enlarged heart, alcohol-related liver disease).

    c) In *R v Jagroop*[17], the offender pushed his wife, causing her to fall onto a concrete footpath and hit her head, rendering her unconscious. Instead of assisting her, he dragged her onto the other side of the road and down a slope, where he left her and told lies about her whereabouts. She ultimately passed away from an upper airway obstruction in association with the head injury. The sentencing judge noted that the offender knew the victim was in obvious need of urgent medical attention but chose

[15] [2018] VSC 429.
[16] [2010] VSCA 234.
[17] [2009] VSCA 46.

not to seek assistance for a prolonged period and left her in a position of greater danger while she was unconscious.

77. I am not suggesting that Craig's conduct was such that he should have been charged with manslaughter due to criminal negligence. Nor is it my role to assign blame or determine civil or criminal liability. However, I highlight the cases above to point to the established duty of care and the seriousness with which inaction is viewed by the courts.

78. It is concerning that Narelle's case is not the only case before the Court where a victim of family violence has passed away after a perpetrator of family violence has not sought medical assistance for that person, in a final act of control, and likely fear for a powerless victim.

79. There appears to be a gap in the current legislative framework that prevents the justice system from holding these perpetrators to account for their behaviour, where a charge of negligent manslaughter is not appropriate. It may be appropriate to consider amendments to the *Family Violence Protection Act 2008* (Vic) (**FVPA**) to include abandonment of a victim in need as a recognised form of family violence. This would align with the definition of family violence in section 5 of the FVPA as the inaction instils fear in a victim and affirms the perpetrator's control of the victim. However, this is not the only way in which these perpetrators could be held accountable.

80. It is not my role to determine if or how Parliament should consider amending the legislation, and I acknowledge that various stakeholders may have differing views about any potential legislative amendments. Therefore, I intend to recommend that the Attorney-General refer this matter to the Victorian Law Reform Commission, to undertake a comprehensive consultation and review of the FVPA and whether legislative change is required, in light of this and other similar matters currently being considered by the Court.

FINDINGS AND CONCLUSION

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

d) the identity of the deceased was Narelle Catherine Simmons, born 14 March 1979;

e) the death occurred between 10 and 19 October 2021 at 4/8 Lyall Street, Cranbourne, Victoria, 3977, from *1(a) haemothorax and pneumonia in the setting of acute and chronic chest injuries and consumption of multiple drugs* with contributing factors of *hepatic cirrhosis and chronic alcoholism*; and

f) the death occurred in the circumstances described above.

72. I note that sadly, Narelle did not always receive the support or assistance she required. This case demonstrates the critical need for all victims of family violence, regardless of their presentation, to receive a tailored, trauma-informed and comprehensive response to support their ability to engage with services. It appears that despite Craig being very 'visible' to the system as there were numerous reported instances of family violence, the system struggled to hold him accountable for his behaviour.

COMMENTS

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

(i) I strongly endorse Recommendation 5 of Judge Cain's finding into the passing of Noeline Dalzell[18], namely, which was reiterated in his Honour's recent finding into the death of Jessica Geddes[19]:

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

(ii) I strongly endorse Recommendation 1 of Coroner Giles' finding into the death of Ms KSQ:

> *That the Department of Families, Fairness and Housing resource an expansion of co-responder programs, such as the Alexis Family Violence Response Model, across Victoria.*

[18] Finding into passing with inquest – Noeline Dalzell (COR 2020 0670).
[19] Finding into death without inquest – Jessica Geddes (COR 2020 6055).

RECOMMENDATIONS

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

(i) That the **Attorney-General** consider making a referral to the Victorian Law Reform Commission to:

a. consider the creation of a new offence (abandoning a victim in medical need); and/or

b. amending the *Family Violence Protect Act 2008* (Vic) to include abandonment of a victim in medical need as an example of family violence; and

c. to consider how family violence perpetrators can be held to account in circumstances where a charge of criminal negligence is not available.

I convey my sincere condolences to Narelle'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:

Tayla Richardson, Senior Next of Kin

Chief Commissioner, Victoria Police (C/- MinterEllison)

Department of Families, Fairness & Housing

Sergeant Stuart Dawson, PSC Oversight Investigator

The Hon. Sonya Kilkenny, Attorney-General of Victoria

Detective Senior Constable Thomas Asciak, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 09 October 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.