IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006564

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	PLM
Date of birth:	[redacted]
Date of death:	6 December 2021
Cause of death:	1(a) Stab wounds to the chest and abdomen
Place of death:	[redacted]
Keywords:	Family violence; homicide; homelessness

INTRODUCTION

1. On 6 December 2021, PLM was 40 years old when she died from stab wound inflicted by her former partner, CVB.

2. PLM and CVB commenced an intimate relationship in 2020, however at the time of PLM's passing, the couple had separated. They were both homeless and were seeking support from various services including housing services.

3. PLM and CVB both had a history of substance abuse and involvement with the criminal justice system. Both had children from other relationships, none of whom were in their care at the time of the fatal incident.

4. CVB had an extensive history of family violence offending and was noted as a respondent in multiple Victoria Police L17 reports with various affected family members (**AFMs**) from 2011 to 2021. At the time of the fatal incident, there were eight active intervention orders in place against CVB in Victoria, including one protecting PLM There was also one active intervention order in place in NSW against CVB. Three of the nine active intervention orders were in place to protect former intimate partners (including PLM). One of CVB's former partners and her four children received an intervention order to protect them against CVB in 2010. This was an indefinite intervention order. CVB had another indefinite intervention order against him, taken out in 1996. CVB's relationship with this person is not known.

5. CVB's relevant criminal history included threats to kill, threats to inflict serious injury, stalking and intimidating intending to cause fear and physical harm (NSW), using a carriage service to threaten (NSW), breaching family violence intervention orders (**FVIOs**), persistently contravening FVIOs, unlawful assault, intentionally or recklessly cause injury and intentionally threaten serious injury.

6. At the time of the fatal incident, CVB was on bail for multiple charges of recklessly causing injury, intentionally cause injury, contravene FVIO, unlawful assault, assault with weapon and persistently contravene FVIO in relation to PLM.

7. PLM also had a significant history of family violence, both as an AFM and as a respondent, however she was not recorded as a respondent in relation to CVB. In relation to incidents where PLM was recorded as the respondent, many incidents involved PLM self-harming, being intoxicated and/or causing property damage.

THE CORONIAL INVESTIGATION

8. PLM'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.

9. 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.

10. 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.

11. Victoria Police assigned Detective Senior Constable Alex Lewis to be the Coroner's Investigator for the investigation of PLM's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as friends, neighbours, paramedics, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of PLM 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

13. On 6 December 2021, PLM, born [redacted], was visually identified by Sergeant Brian McCormick, from the local Police Station.

[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.

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

Medical cause of death

15. Forensic Pathologist Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 8 December 2021 and provided a written report of her findings dated 1 April 2022.

16. The post-mortem examination revealed multiple sharp force injuries (that is, injuries inflicted by a blade or sharp implement, such as a knife). There were three stab wounds and three incised wounds. Stab wounds are a sharp force injury where the depth of penetration into the body is greater than the size of the wound on the skin. Incised wounds are commonly known as 'cuts', tend to be superficial and are longer on the skin than the dept of penetration.

    a) There were two stab wounds to the left side of the abdomen (left flan and left lateral abdomen) that formed a combined wound track directed from left to right, upwards and not discernibly towards the front or back. The wound tracks were associated with injury to the left side of the abdominal wall, the bony part of left rib 10, left retroperitoneal haemorrhage (bleeding at the back of the abdomen), incisions of the small and large bowel with bleeding in the bowel (100 mL), bleeding in the abdomen (at least 500 mL), haemorrhage around the pancreas, kidney and adrenal, transection of the inferior vena cava (the large vein in the abdomen that returns blood for the limbs and abdomen to the heart) and incision into the liver.

    b) There was a stab wound of the lower left chest directed downwards, from front to back and not to the left or right. This was associated with injury to the left chest wall including the bony part of left rib 6, collections of air and blood (500 mL) in the left chest cavity, perforation of the left lung, perforation of the left side of the diaphragm, and a cut of the front of the stomach.

    c) There were incised wounds of both thumbs and the right middle finger. Injuries such as these may be sustained in an attempt to ward off or grab a sharp weapon, hence they are sometimes referred to as "*defence type injuries*". The right middle finger injury was associated with incision of a tendon and the bone, whereas the thumb injuries were only associated with injury to the subcutis.

17. The skin injuries associated with the stab wounds had appearances best in keeping with the stab wound inflicted by a knife. Some (left lower chest and left flank) had a somewhat squared

off appearance at one end suggesting they may have been inflicted by a weapon with a single edged blade.

18. Estimation of the force required to inflict a wound is problematic as it is subjective and requires consideration of factors such as the protective effects of clothing and skin, the sharpness and taper of the blade, and the relative kinetic energy of the blade. The stab wound tracks of the left lower chest and left flank both caused injury to bone, and in Dr Glengarry's opinion, the force involved to cause these injuries was severe. For the remaining stab wound, only soft tissues were involved, and therefore she opined that the force involved with those injuries was at least moderate.

19. There were blunt force injuries to the face, scalp torso and limbs. Blunt force injuries are those that result when the body is impacted by a blunt object or, the body impacts a flat surface. There was bruising and laceration of the lips. There were bruises of the left breast, abdomen, and limbs. There were abrasions of the chest, abdomen, neck and limbs.

20. Minor natural disease in the form of chronic pancreatitis, a focus of left kidney infection and smoking-related lung disease was present. These conditions did not contribute to the death.

21. There was microscopic scarring of both antecubital fossae and recent needle puncture sites in the right antecubital fossa. Microscopic assessment showed features in keeping with long-term injecting drug use.

22. Toxicological analysis of post-mortem samples identified the presence of alcohol (0.1 g/100mL), methylamphetamine and its metabolite, dimethyltryptamine,[2] diazepam and its metabolite, temazepam and its metabolite, pregabalin, olanzapine, quetiapine and a cannabis metabolite.

23. Sequelae of resuscitation including a right pneumothorax (due to pneumocath insertion) and rib fractures were present. The left pneumocath did not enter the left chest cavity. These findings did not cause or contribute to the death.

24. Dr Glengarry provided an opinion that the medical cause of death was *stab wounds to the chest and abdomen.*

25. I accept Dr Glengarry's opinion as to the medical cause of death.

[2] Dimethyltryptamine (**DMT**) is a short-acting hallucinogenic compound structurally related to serotonin.

Family violence history between CVB and PLM

26. In October 2020, CVB reportedly stabbed PLM in the torso with a kitchen knife, then drove her around a Victorian State Forest for an hour whilst she attempted to stem the bleeding from the wound. CVB eventually drove her home and assisted her to stop the bleeding, whilst also advising her that he had been thinking of killing her and leaving her in the forest. PLM did not report this incident to police until June 2021.

27. In January 2021, CVB reportedly drove PLM to a remote location again and assaulted her, including strangling her, and stated "*this is where you bring people to kill them*". A bystander intervened and reported the incident to police. The Family Violence Investigation Unit (**FVIU**) triaged this incident as high-risk. Police applied for an FVIO against CVB to protect PLM, and a full, no contact FVIO was granted by the Magistrates' Court on 27 January 2021. Police initially arrested and charged CVB, however the criminal brief against CVB was non-authorised on 2 June 2021.

28. In April 2021, PLM reported to the Centre Against Violence (**CAV**) that CVB had held her hostage for two weeks at his home. She further described CVB punching her and smashing her head into a shower screen after she refused sexual activity. He reportedly threatened to stab her and put her in the shower to "*bleed out*". She did not seek medical assistance, as she felt that she would be perceived as "*drug seeking*". She also did not report this incident to police.

29. In June 2021, PLM attended a Community Corrections Office as part of her Community Corrections Order (**CCO**). She reported that about 10 days earlier she had moved in with CVB and whilst staying at his home, had been subjected to multiple physical assaults. She explained to the Corrections officer that she and CVB disregarded the FVIO and continued to see and contact each other despite its existence. A major factor for these breaches was PLM's reliance on CVB due to her homelessness. Police arranged emergency accommodation through CAV and the FVIU again triaged this incident as high-risk.

30. On 5 July 2021, CVB was arrested, charged and bailed by Victoria Police to appear at the Magistrates' Court on 1 October 2021. He was charged with recklessly cause injury, intentionally cause injury, contravening FVIO, unlawful assault, assault with weapon and persistently contravene FVIO. CVB's bail conditions included for him to reside at an address in a regional Victorian town, not to contact any witnesses for the prosecution and to abide by the conditions of the FVIO protecting PLM.

31. In July 2021, CVB applied for an FVIO against PLM, however this order was never served and was withdrawn in August 2021.

Circumstances in which the death occurred

32. On 6 December 2021, CVB advised his Salvation Army housing support worker that "*on Monday the first person I see I am going to do whatever I have to do*". When the support worker queried what CVB meant by that comment, he refused to elaborate.

33. At some time that afternoon, PLM and her current partner, VGY, attended a support service to seek assistance with accommodation and food. They were provided with a swag to sleep in and food, however PLM reportedly did not want to sleep overnight in a swag.

34. At about 4.00pm, the Salvation Army (**TSA**) and a support service, who were both supporting CVB, individually contacted the Police Station and requested they perform a welfare check on him. Sometime between 4.00pm and 4.40pm, VGY attended the Police Station in person and advised them that PLM was missing and asked them to call her mobile. Police tried to call PLM; however, she did not answer. VGY told police that he believed PLM may have gone to see CVB and he was told that police "*would keep an eye out for her*". VGY's recollection was that Victoria Police advised him that they would perform a welfare check on her.

35. At about 4.40pm, PLM attended the caravan park where CVB was staying. CVB's evidence was that he and PLM took a nap and shower together and that she was drug affected when she arrived. At some between 4.40pm and 6.57pm, CVB took a large knife from the kitchen and stabbed PLM three times to the abdomen and chest.

36. At 6.57pm, CVB called his NDIS-funded support worker and told him that he had stabbed PLM and asked the support worker to come and collect him so that he would have time to call his son. The support worker refused and told CVB to call an ambulance.

37. CVB alerted the caravan park managers who called for an ambulance shortly after 7.00pm. Paramedics arrived at 7.26pm and PLM was declared deceased shortly thereafter.

38. Following PLM's passing, CVB pleaded guilty to the murder of PLM and was sentenced to 24 years' imprisonment with a non-parole period of 18 years.

CPU REVIEW AND FURTHRE INVESTIGATIONS

39. As PLM's death occurred in circumstances where there was a reported history of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[3] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[4]. I specifically requested the CPU consider the various services involved with PLM and CVB, proximate to the fatal incident.

Victoria Police

40. Victoria Police were familiar with PLM and CVB prior to the fatal incident, with various criminal and family violence dealings with the pair, both individually and as a couple. Victoria Police completed a family violence related death assessment (**FDA**) following PLM's passing, which made 14 key findings and recommendations. These findings/recommendations largely focused on training and enhanced supervision needs. The FDA was comprehensive, so I have only referred to specific areas of interest from the FDA.

January 2021 family violence response

41. The brief of evidence against CVB in this matter was recommended for non-authorisation, citing no reasonable prospect of conviction and that PLM's evidence was "*questionable*". The brief also included a statement from the independent witness who intervened in the incident, and there was evidence that PLM had suffered a fracture to her vertebrae that was consistent with strangulation.

42. The FDA, which is only a desktop review, noted that evidence in the brief of evidence was indeed sufficient to support a reasonable prospect of conviction and that it was in the public interest to proceed with the prosecution.

43. Whilst it cannot be determined now whether proceeding with a criminal prosecution against CVB would have altered the final outcome or would have prevented PLM's death, I consider

[3] 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.

[4] 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.

the decision not to proceed with prosecution represents a missed opportunity for Victoria Police to hold CVB to account for his behaviour.

44. Through its legal representatives, Victoria Police was provided with an opportunity to respond to the above comments. Victoria Police agreed that it may have been a missed opportunity to hold CVB to account for his behaviour, however stressed the limitations of the FDA as a desktop review.

June 2021 family violence response

45. In relation to this incident, the FDA noted that PLM was subject to serious harm by CVB, was at risk of future serious harm, that PLM was homeless and dependent upon CVB for housing, she was a user of illicit substances and suffered from mental health issues. There was no evidence to suggest that police considered a referral to the Risk Assessment and Management Panel (**RAMP**), which is a formally convened meeting of key local agencies and organisations who conduct a multi-agency risk assessment of people who are at high risk of serious harm from family violence.

46. I note that if a RAMP referral was made for PLM and CVB, and RAMP accepted the referral, there would have been a coordinated effort by multiple agencies to support both parties and attempt to manage the risks posed by CVB. It is mere speculation now to say whether a RAMP referral would have prevented PLM's death, however I consider that given CVB's history, a RAMP referral would have been prudent in the circumstances.

47. The FDA further noted that despite PLM attempting to contact the FVIU on 29 June 2021 to report CVB had been contacting her friends in an attempt to try and locate her, the FVIU members did not complete a family violence or crime report. The FVIU instead referred PLM to the police station instead to make a report. For a victim-survivor who was as vulnerable as PLM, I consider this to be a suboptimal response. This is compounded by the fact that PLM was known to be generally unwilling to report family violence incidents to police. One of the benefits of management by the FVIU is to enable a more coordinated response with the victim-survivor and the perpetrator, however it appears that this did not occur on this occasion. It is not clear why FVIU did not accept the report, and it is unfortunate that this did not occur. For a victim-survivor like PLM, who was often reticent to engage with any services (especially police), this was a rare opportunity to engage with her whilst she was forthcoming and cooperative.

48. Notwithstanding this deficiency, I cannot determine now that if the FVIU accepted PLM's report on 29 June 2021 that PLM's death would have been prevented. However, it potentially represents a missed opportunity for police to hold CVB to account for his actions and to engage with PLM.

49. When offered an opportunity to respond to these above comments, Victoria Police did not seek to provide a response.

Reports to Victoria Police on 6 December 2021

50. Whilst VGY and two support services called Victoria Police on 6 December 2021 and reported their concerns about PLM's welfare, no welfare check was conducted by Victoria Police on PLM or CVB. This issue was not addressed in the FDA, however, was subject to an investigation by the Professional Standards Command (**PSC**). The PSC investigation has been completed and the allegations of duty of failure were deemed not substantiated.

51. VGY's evidence was that when he attended the Police Station, he spoke to a male police officer and advised him that he was worried, and that the last time PLM disappeared, she returned to CVB who held her hostage and took her phone from her. VGY alleged that the officer did not look interested in his concerns.

52. A support worker from the a support service, was one of two support workers who contacted the Police Station. She claimed that the person she spoke with at the Police Station appeared to be familiar with CVB and was "*spectacularly disinterested*". This call was with Police Custody Officer (**PCO**), who advised he would advise his supervisors of the call. The PCO's evidence was that he was advised by a Senior Constable (**SC**) that based on the information he had, there was no need to put through the call to anyone and he recalled she made a comment about "*attention seeking*".

53. TSA records show that the information provided to police was about both self-harm and the comment CVB made about "*the first person he sees*". TSA records also noted that police advised the TSA case manager that they "*have tried sectioning him previously*" (i.e., apprehending him pursuant to section 351 of the *Mental Health Act 2014* (Vic)), and that this exacerbated the situation.

54. In her statement to the Court, the SC explained that she spoke with TSA case manager and noted that CVB spoke of suicidal ideation but did not have a plan and did not disclose any

other threats. The SC noted that she checked CVB's LEAP history, and that the Case Manager advised that CVB had agreed to stay safe until she called him the following morning.

55. In correspondence to the Court, Victoria Police submitted that it was not open to me to make a finding that the response to these calls was not in accordance with the *Victoria Police Code of Practice* and the *Victoria Police Manual (**VPM**) – Family Violence*. The *VPM – Family Violence* guidance states there is a positive obligation to take action when in receipt of a report of family violence. Victoria Police submitted that the calls from VGY and the support services did not pertain to a family violence report or an FVIO breach.

56. I accept Victoria Police's submission on this issue, and it is correct that VGY and the support workers did not *explicitly* make a family violence report. However, the reports included information that CVB was suicidal and wanted to harm the "*first person he sees*". In my view, this information warranted some level of response.

57. I note that there is no Victoria Police manual that specifically governs a member's responses to welfare checks, nor their requirement to record same. In the PSC report, it is noted that the Organisational Policy Unit (Capability Department) was consulted and has confirmed that a policy could not be developed that covered all possible 'welfare check' scenarios and associated variables, and this is more broadly covered by the *VPM Operational Duties and Responsibilities*. In my view, the response of police to a concern that CVB was suicidal and was potentially in contravention of an FVIO was suboptimal.

58. Given that the fatal incident occurred between 4.43pm and 6.57pm, it is possible that if Victoria Police performed a welfare check during that time, PLM may have still been alive when they arrived. However, I cannot determine now that this means that PLM's death was preventable, merely that this represented a missed opportunity for Victoria Police to attend CVB's address and conduct a welfare check on CVB (and/or PLM).

Victoria Police and bail decision-making

59. The Victoria Police FDA noted that if CVB was charged and bailed for the January 2021 incident, this would have seen him placed in the criminal justice stream earlier and held accountable for his actions. If this had occurred, the bail decision for CVB's offending in June 2021 may have differed.

60. Regarding the bail decision maker's (**BDM**) decision in July 2021, Victoria Police submitted that bail decisions are difficult. The BDM must balance a complex set of circumstances and

weigh up many competing considerations under the *Bail Act 1977* (Vic). Furthermore, the *Bail Act 1977* (Vic) recognises that a person may be released on bail despite there being some level of risk.

61. The BDM in this case considered a range of factors, including the following:

    a) The nature of the alleged offending was considered to be serious

    b) The strength of the prosecution case given that PLM refused to provide a medical release to the police regarding the injuries she received

    c) CVB's lengthy criminal history, although noted his most recent offending in Victoria was in 2013

    d) Relatively minor history of breaching bail

    e) A full and active FVIO in place protecting PLM

    f) CVB's vulnerability due to having an acquired brain injury (**ABI**) and learning challenges, and was an NDIS client

    g) CVB was engaged with the FVIU who would actively monitor and supervise CVB in the community

    h) CVB's stable accommodation in the regional Victorian town

    i) CVB's phone being seized, limiting communication with PLM

    j) PLM was engaged with the CAV

62. I note that the existence of a full, no contact FVIO against CVB was considered to be a relevant protective factor in this situation and is considered to be a relevant protective factor in bail decisions more broadly.

63. However, given that the FVIO was issued in January that year and CVB was arrested on this occasion for offences including breaching the FVIO, it appears that CVB was not concerned with compliance. PLM similarly told Corrections that she and CVB treated the FVIO with disregard. Therefore, there was no evidence to suggest that CVB would start complying with the FVIO when he was apprehended for the same offending. His history of breaching FVIOs in Victoria spanned from 1996 to 2014, again suggesting a disregard for court orders.

64. The BDM complied with their obligations on this occasion to consider the relevant protective and mitigating factors, and I make no criticism of the BDM. However, I am of the view that the mere existence of an FVIO should not automatically be considered a protective factor. In cases such as this one, the existence of the FVIO mean that the offender could be arrested if a breach occurred, however it does not mean that the offender is a lower risk to the general public or a specific AFM. I accept that in some cases, the FVIO will be a mitigating factor, however this case is a clear example of a scenario in which it was not a strong mitigating factor.

65. To that end, I intend to make a recommendation that Victoria Police update its policies to note that the presence of an FVIO is not automatically considered a mitigating factor when considering whether to bail an offender, particularly where there is a history of breaching FVIOs, bail and/or court orders.

66. Ultimately, I cannot now determine that even if the BDM made a different decision on this occasion that the outcome would have changed. Even if bail was denied by the BDM, he may have been granted bail by a magistrate or his criminal matters may have been finalised, permitting his release back into the community.

CVB's engagement with disability services

67. CVB had approved funding for supports under the NDIS. CVB described having an ABI, however it is not clear if there was ever an official diagnosis of same. He was engaged with Support n Connect (who was his NDIS-funded support service), Top Gunn, Prime Support Services, My Care Provider, and a clinical and forensic psychologist.

Support n Connect

68. At the time of the fatal incident, Support n Connect was CVB's funded NDIS Support Coordinator and engaged with him in 2021. Upon a review of the records available to the Court, it does not appear that Support n Connect were sufficiently equipped to assess or manage the family violence risk that CVB posed, for example:

    a) In a support worker's statement to police, they indicated that they believed an FVIO had been issued in January 2021, however the risk assessment and plan for CVB completed in April 2021 did not make note of the family violence risk and family violence was not recorded until June 2021 where it was recorded that "*PLM faked own death – AVO taken out*".

b) The same statement indicated that the support worker may have reviewed PLM as the risk in the relationship with CVB following the reported issue in June 2021. The support worker noted the "*risk plan…was for CVB to contact police and not answer the door if PLM attended where he was residing*" and noted that CVB was in fear of PLM knowing where he was.

c) On 3 November 2021, CVB advised the support worker that he did not want to go to prison, had done nothing to PLM and had had "*enough*". On 23 November 2021, CVB told the support worker that it was "*prison or death next Wednesday*". Support n Connect recorded a plan to call the Police Station on 30 November 2021 to express their concern. Support n Connect did not appear to have identified this as a period of risk for PLM.

69. In response to the above comments, the Court contacted Support n Connect via their last known email address and postal address. Correspondence sent via registered post to their last known address was returned to sender marker "*not at this address*". The Court did not receive a response to email correspondence, either. According to information obtained by the Court, it would appear that Support n Connect ceased operations in 2022, hence why the Court did not receive a response.

70. Based on the records available to the Court, Support n Connect did not appear to have explored or implemented risk management strategies or sought specialist expertise. I cannot make an adverse comment against the service, as they are unable to provide a response and appear to have closed down. I also cannot determine now that a different level of engagement could have prevented the fatal incident, rather I can only find that this was a missed opportunity for Support n Connect to engage on a deeper level with CVB.

Top Gunn

71. Top Gunn was another NDIS-funded service working with CVB in 2021. Upon a review of the available records, I observed some concerns about Top Gunn's ability to assess and mitigate his risk. There was only one record that resembled a case note in which a Top Gunn employee emailed the owner of Top Gunn in September 2021 and noted:

> *CVB has been struggling with a traumatic series of events involving a woman CVB cared for manipulating him for money to buy drugs…During meeting with CVB we*

are constantly analysing that series of events through conversation, helping CVB to see the manipulation techniques used upon him.

72. In the absence of case/progress notes or any other documented assessment (risk or otherwise), it is not clear what led the Top Gunn employee to these conclusions. This appeared to be a missed opportunity to engage with CVB on a more comprehensive level.

73. In response to my proposed adverse comments, the owner of Top Gunn, Andrew Gunn, explained that the employee referenced above was predominantly liaising with CVB's NDIS Support Coordinator from Support n Connect. Mr Gunn forwarded the note above to the Support Coordinator, who replied "*Thanks Andrew. [Employee] appears to have a good understanding of CVB and supports him accordingly*". No further correspondence was received from the Support Coordinator.

74. Mr Gunn explained that this employee resigned less than a month later. Mr Gunn contacted the Support Coordinator and explained that Top Gunn was unable to support CVB anymore as they no longer had an appropriate person to work with CVB. Mr Gunn conceded that there was an error with case note reporting back in 2021 by this particular employee and while management spoke to him about it numerous times, they should have followed it up further. Mr Gunn submitted that despite this, Top Gunn did provide all the details as requested to the Support Coordinator and the Support Coordinator provided a "*glowing letter of support*" for CVB's court hearing on 1 October 2021. Top Gunn stopped working with CVB in early-October 2021.

75. Mr Gunn concluded that I should not find that this was a missed opportunity for Top Gunn to engage with CVB on a more comprehensive and meaningful level regarding his perpetration of family violence. He explained "*I feel that this was not the case from Top Gunn as we have passed on all information required and followed all directions from [the Support Coordinator]*." He further suggested that this was a missed opportunity by the Support Coordinator, and not Top Gunn, and that "*Top Gunn Support be cleared of any wrong doing in this matter*".

76. As noted above, the coronial investigation and this jurisdiction is not about apportioning blame but determining the facts and identifying if there are any prevention opportunities. In this case, whilst the Support Coordinator from Support n Connect appeared to be the 'lead' agency, there was nothing preventing Top Gunn from conducting their own risk assessments regarding CVB's level of risk to himself or others.

77. NDIS service providers in Victoria are not currently prescribed entities under the Multi-Agency Risk Assessment and Management Framework (**MARAM**). In my finding into the death of Samantha Fraser[5], I explored the issue of private psychologists not being prescribed under the MARAM. I noted:

> *The psychologist's inability to identify multiple indicators that Adrian was perpetrating family violence and continued to present a risk to Samantha may relate to the absence of mandatory family violence training for private psychologists, and the fact that private psychologists are not prescribed under the MARAM framework, including under the perpetrated-focused MARAM guides.*

78. In response, the Department of Families, Fairness & Housing (**DFFH**) explained:

> *The Victorian Government is committed to ensuring that all individuals and bodies that have a role in family violence risk identification, assessment and management are supported with a consistent, evidence-informed framework. The Department will examine options for prescribing classes of individuals, such as psychologists, as framework organisations under MARAM to the extent that it is applicable to them in their professional capacity. The Department will consult across the Victorian Government and seek advice on the possible policy implications of this change with relevant sectors. This will include consideration of the implications for individuals, if able to be prescribed, in relation to MARAM alignment.*

79. As with private psychologists, I am of the view that case highlights an opportunity to expand the MARAM Framework to include NDIS service providers in Victoria. Given that people interacting with NDIS service providers may also experience or perpetrate family violence, it seems appropriate that those service providers should be prescribed under the MARAM, and I therefore intend to make that recommendation.

80. Requiring Top Gunn, Support n Connect and similar providers to be aligned with the MARAM would not have necessarily prevented PLM's death, however, would have provided another opportunity for CVB's support workers to identify and manage the risk he posed.

My Care Provider

[5] Finding into death without inquest – Samantha Fraser (COR 2018 3600).

81. My Care Provider (**MCP**) is a psychosocial occupational therapy service that worked with CVB from October 2020 and was funded by the NDIS. Upon a review of the available records, I note that MCP did not complete a risk assessment throughout their engagement with CVB, despite their knowledge that CVB had been charged with breaching an FVIO, and that he had an extensive criminal history. Whilst private occupational therapists are not prescribed under MARAM, it appears reasonable that occupational therapists working in such an environment would be competent in risk assessment and management to self and others.

82. The Court wrote to MCP and advised of my proposed adverse comments that it did not complete a risk assessment during their engagement with CVB. MCP responded that during their engagement with CVB, they were "*informally monitoring risks, though not conducting formal risk assessments or recommendations for CVB*". MCP noted that if it became aware of CVB making threats against PLM, it would have immediately escalated the issue to CVB's coordinator, the NDIS and the police. MCP stated that they did not feel that PLM, CVB or any other member of the public was in danger and hence why no formal incident report was made. MCP also stated that it was unaware that CVB had breached the FVIO.

83. Ultimately, occupational therapists are not prescribed under the MARAM and therefore there was no positive obligation on them to perform a risk assessment, however I am still of the view that it would have been prudent to complete same. Whether a risk assessment was performed or not would not have changed the final outcome and may have only offered a marginal opportunity to engage with CVB about his behaviour.

The Salvation Army

84. TSA had a long history of attempting to secure housing for CVB and were engaged with him throughout 2021. The agency had information about CVB's extensive use of violence and offending, breaches of the FVIO against PLM, court attendance for breaches of FVIOs and threats to kill PLM. In CVB's records, there was no mention of a family violence risk assessment or management, despite TSA being MARAM prescribed during the relevant time. The risk assessments of CVB only appeared to consider his risk of suicide and outreach risk to workers.

85. In response to correspondence from the Court, TSA noted that its Homelessness Program forms part of its Outreach Connections Program. The Homelessness Promotion of Client Safety and Duty of Care Procedure (**Client Safety Procedure**) and the Homelessness Client Risk Assessment and Safety Planning Procedure (**Risk Assessment Procedure**) provide

specific guidance to practitioners working within the Homelessness Program, including in relation to family violence matters. TSA developed these procedures throughout 2022 and 2023, and they were implemented in February 2024.

86. Pursuant to the Client Safety Procedure, where family violence is reasonably suspected while providing homelessness services, practitioners must:

    a) Complete a risk assessment (in the absence of a mandated risk assessment tool, TSA recommends using the MARAM Intermediate Risk Assessment Tool)

    b) Complete safety planning to identify protective measures and mitigate risk

    c) Educating clients and making a referral to a specialised family and domestic violence service

    d) Comply with any incident or mandated reporting requirements that apply

    e) Complete any resource allocation and service delivery with a high awareness of safety concerns

87. TSA explained that the Homelessness Program has already taken steps to incorporate the MARAM into the provision of its services. TSA also noted that it is continually seeking to further integrate other MARAM tools (such as those related to screening and management of family violence) as part of its alignment activities.

88. TSA explained that "*historically, there have been some challenges with conducting family violence risk assessments within the Homelessness Program*". The reasons for this are multifactorial and include the inherent vulnerability of the clients, and the lack of housing resources, the latter may lead to clients being reluctant to provide fulsome disclosure for fear of not being eligible for resources.

89. TSA noted that it has implemented various steps to address and action these challenges. It implemented a Family Violence and Child Information Sharing Procedure (**FVIS Procedure**) in August 2021 to assist practitioners with accessing up to date information from other agencies. The Client Safety Procedure and the Risk Assessment Procedure, both implemented in February 2024, directs practitioners to specialist tools and resources provided as part of the MARAM. Whilst the FVIS Procedure was in place at the time of PLM's passing, TSA noted the organisation was in a transitional period and staff were still being trained on the process.

90. TSA stated to the Court that they believed their management of CVB was undertaken in accordance with the relevant policies and the training available to practitioners at the time. However, with the benefit of hindsight, a more wholistic assessment of the circumstances, beyond CVB's immediate housing and mental health needs, may have prompted a greater focus on family violence factors in this case, although it may not have resulted in a different outcome.

91. I agree with TSA's assessment. I echo their conclusion that a more wholistic assessment may not have changed the final outcome or prevented PLM's death, however it represents a missed opportunity to engage more deeply with CVB's family violence related issues, prior to the fatal incident.

Gateway Health

92. Gateway Health (**GH**) received several L17 referrals for CVB, including in January and June 2021. Upon contact with GH, CVB became "*aggressive and suspicious and told them to f*** off*". GH advised police via email that they attempted to engage with CVB, however he did not acknowledge his violence and disregarded his actions.

93. In response to the June 2021 L17 referral, GH advised Victoria Police to advise that the referral would not be accepted for the following reasons:

    a) CVB's history and level of offending would be better suited to a forensic response

    b) No contact details were provided

    c) Police had not spoken to CVB and GH had concerns about safety risks in making contact.

94. I note the current pilot program underway in the Bayside Peninsula and Barwon areas for adults perpetrating family violence who pose a serious risk to victim-survivors, potentially addressing the gap in the service system for serious perpetrators who are unsuitable for current family violence programs such as Men's Behavioural Change Programs (**MBCP**), or those who decline case management. The Expert Advisory Committee on Perpetrator Interventions Final Report in 2018 outlined that existing interventions in Victoria were not designed for higher risk perpetrators, and draws on the programs such as the Colorado Domestic Violence Offender model, Corrections Victoria Offender Management Framework, and Forensicare's Problem Behaviour Program to demonstrate the value of providing high risk/need offenders

with more intensive management than lower risk/need offenders in order to reduce reoffending.[6] They recommended that intervention for higher risk perpetrators should seek to address intersecting risk factors and offending patterns, including violence perpetrated against people other than family members, and complex needs that may contribute to the perpetration of family and non-family violence.[7]

95. As discussed in my recent finding into the passing of Noeline Dalzell (**Dalzell**), the recent Changing Ways pilot program, includes "*better coordinating across the service system so that serious-risk adults using family violence become and remain in view of services, tailoring an intensive response for victim-survivors, tailoring interventions that directly or indirectly engage the adult using family violence who poses a serious risk, and using multiple approaches to support them to take responsibility for stopping their family violence*".[8]

96. As highlighted in Dalzell, I am of the view that it is important for the Victorian Government to continue to develop and fund alternatives to MBCPs for higher-risk offenders. I look forward to seeing the outcome of this trial and an evaluation of its success.

Corrections Victoria

97. PLM had an extensive history with Corrections Victoria. A 'Manager's Review' of PLM's file was completed on 31 December 2022.

98. PLM noted in her case plan dated 11 June 2021 that "*secure accommodation to be safe on [her] own*" was of importance to her. There was also limited reference to family violence in PLM's file, despite police being called to a Corrections appointment in June 2021 so that she could report an assault and breach of the FVIO by CVB.

99. It is not clear what actions were taken by Community Correctional Services (**CCS**) to assist her with this goal, despite PLM clearly stating that she was reliant upon CVB for accommodation and therefore disregarded the FVIO as a result. The Manager's Review also noted that secure accommodation was PLM's most important priority in June 2021 and that the case plan was "*comprehensive however not appropriate to the offender's presentation/current needs*" and "*requires further breakdown to be realistic and achievable*". Family violence was not referenced in the Manager's Review.

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[6] State Government of Victoria, Expert Advisory Committee on Perpetrator Interventions Final Report, 68-75.
[7] Ibid.
[8] Finding following an inquest into the passing of Noeline Dalzell (COR 2020 0670), 68.

100. Although it is not the sole or dominant purpose of CCS to assist with an offender's housing or family violence needs, it is often uniquely placed to assist an offender with referrals to appropriate agencies, given the frequency of appointments and engagement. Such referrals would not have necessarily prevented PLM's death; however, this appears to be a missed opportunity for corrections staff to provide her with referrals that may have allowed her to live independently from CVB.

Centre Against Violence (CAV)

101. PLM had engagement with CAV dating back to 2013, however for the purposes of this case, only records in the 12 months prior to her passing were considered.

102. In 2021, CAV interacted with PLM in January, April, June, and July. Their support was often limited by PLM's engagement, and it appears that PLM was not always easy to engage with. There were case notes referring to a case worker needing to end a call due to verbal abuse by PLM and multiple incidents of non-attendance. I note that the support needs of criminalised women are interrelated and complex (e.g., homelessness, mental health, family violence, substance abuse), and for most criminalised women, these needs are the result of experiences of multiple forms of trauma.

103. Upon a review of PLM's engagement with CAV, some concerns were identified:

    a) In April 2021, PLM disclosed being held hostage by CVB and that he had made threats to kill her. It was not clear from the records provided to the Court whether this risk information was shared with Victoria Police pursuant to the Family Violence Information Sharing Scheme (**FVISS**). In response, CAV explained that at the time, PLM was not an active client, and she had not signed a consent form, nor undertook an assessment with CAV. In those circumstances, they did not (and could not) share information with Victoria Police. I note that the CAV did not require PLM's consent to disclose information under the FVISS where the disclosure was necessary to lessen or prevent a serious threat to an individual's life, health, safety or welfare, however, I accept their reasoning for their decision-making at the relevant time.

    b) The risk assessment from July 2021 was incomplete and there was no reference to a referral to RAMP, despite CAV previously assessing PLM as being at serious risk and requiring immediate protection. In CAV's response to the Court, it did not articulate why a RAMP referral was not considered or made. CAV explained the steps it took to

manage PLM's risk, which included emergency accommodation, a safe phone, liaison with police and corrections, commencement of Case Formulation, and assistance to secure Centrelink crisis payments.

c) Despite PLM's risk level and the various brokerage schemes available at the time, CAV provided a total of $400 brokerage to support PLM in 2021, which included payment for two hotels and one meal. The average spend on a Family Violence Flexible Support Package (**FSP**) at the time was $3,400.[9] One of the key purposes of the FSP is to access suitable and stable housing.

104. CAV noted in response to the Court's query about FSPs, PLM had a network of friends with whom she could stay, she wanted to leave the local area so a priority housing application would not have been completed due to the plan to exit the area, and PLM's level of engagement was often crisis driven. Post-crisis support involved longer-term goal setting, including safe and stable accommodation, which PLM did not regularly engage with.

105. The CAV further noted that prior to closing its client files, CAV practitioners now make targeted attempts to ensure that victim survivors are safe and end their contact with CAV willingly, regardless of their level or history of engagement. This includes:

a) Securing details for a safe person in the victim-survivor's life so that CAV can contact the safe person if the victim-survivor is unable to be contacted.

b) Agreement with the client that if CAV are unable to contact them, they will contact their safe person and potentially Victoria Police to ensure their whereabouts and safety.

c) Requesting welfare checks via Victoria Police

d) Contacting other service providers involved

e) If children are with the victim-survivor, contacting daycares or schools to ensure the family are presenting at the daycare/school with minimal concerns.

[9] Family Safety Victoria, Family Violence Flexible Support Packages (FSPs) Program guidelines (July 2021) 21.

106. I cannot now determine that a different level of support or engagement between PLM and CAV would have prevented her death. I note the changes implemented by CAV to ensure the safety of victim-survivors and commend CAV for implementing same.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was PLM, born [redacted];

b) the death occurred on 6 December 2021 at [redacted] from *stab wounds to the chest and abdomen*; 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 the **Victorian Government** work with the **Commonwealth Government** to expand the MARAM framework to include NDIS service providers in Victoria and make them MARAM-prescribed entities.

(ii) That **Victoria Police** update its bail decision making policies/guidelines to note that the presence of an intervention order is not automatically considered a mitigating factor when deciding whether to bail an offender, particularly where there is a history of breaching intervention orders, bail and/or court orders. The decision-maker should consider the party's history of compliance with the order and/or bail as part of the decision-making process.

I convey my sincere condolences to PLM'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:

[redacted], Senior Next of Kin

Centre Against Violence

Department of Justice & Community Safety

My Care Provider

The Salvation Army (C/- Minter Ellison)

Top Gunn

Victorian Government

Commonwealth Government

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

Detective Senior Constable Alex Lewis, Coroner's Investigator

Signature:

Judge John Cain
State Coroner
Date: 9 May 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.