IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000793

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:	HDS
Date of birth:	[redacted]
Date of death:	10 February 2022
Cause of death:	1(a) Multiple injuries
Place of death:	[redacted]
Keywords:	Family violence; homicide; parricide; victim with a disability; history of family violence; NDIS support

INTRODUCTION

1. On 10 February 2022, HDS was 41 years old when she died from multiple injuries inflicted by her adult son, THN. At the time of her death, HDS lived in a share-house in the outer suburbs of Melbourne, Victoria, with her youngest child, MJU, THN, THN's friend, REW and REW's father, IUY. REW's partner, also occasionally stayed at the house.

Background - HDS

2. HDS was born overseas. Her family and friends described her as a dedicated mother who loved her children. HDS was the eldest of seven children to her parents FRT and CDE, however, was raised by her grandmother and moved to Melbourne when she was about 15 or 16 years old. She moved to Australia with her aunt EDR after she was sexually assaulted by a person known to her family and her family "*were not dealing with it well*".

3. HDS was in a relationship with THN until about 2011 and he was the father of her first four children – THN (born 2001), ASD (born 2002), RDX (born 2006) and XCV (born 2007). Records available to the Court suggest that THN perpetrated family violence against HDS during their separation and the last recorded incident occurred in 2012. It is unclear from the records whether HDS's children witnessed these incidents. HDS's medical records also reference alleged violence perpetrated by THN; however, details of these incidents were not documented.

4. HDS's youngest child, MJU, was not fathered by THN and the evidence suggests that MJU's father was not involved in her life. HDS was therefore MJU's primary caregiver from birth.

5. After HDS and THN separated, THN became the primary carer of the children due to a deterioration in HDS's mental health. Nevertheless, HDS remained in regular contact with her children and her children occasionally stayed with her for prolonged periods of time.

6. HDS was diagnosed with schizophrenia, and experienced periods of inpatient mental health treatment in 2012 and 2013 due to cannabis and alcohol-induced psychosis. Two Child Protection reports were made in 2012 in relation to "*conflict around custody*" for HDS's older children, however this was settled within the family and did not proceed any further. From the available evidence, it appears that HDS's mental health was stable in the years prior to her death and it appears that she remained abstinent from drugs and other substances.

7. HDS suffered from a degenerative condition for more than 20 years which resulted in weakness and muscle wasting. This condition impacted her balance and mobility, for example, she struggled to stand up if she fell or if she was sitting in a low chair. There was conflicting evidence in HDS's medical records in relation to whether she also experienced a cognitive impairment. Some practitioners suspected foetal alcohol syndrome and fragile X as possible diagnoses, some records suggested there was no cognitive impairment, while other records indicated "*low-average*" cognitive function. In 2021, HDS consulted with the General Genetics Unit at Monash Health who suspected she had a mild intellectual disability. However, treating clinicians did not reach a consensus or definitive conclusion about HDS's condition.

8. Due to her physical and mental health conditions, HDS received twice-weekly NDIS-support worker visits. Her support worker helped her with various tasks around the house, and with accessing the community. HDS was unemployed and received a disability pension at the time of her passing. The available evidence suggests that HDS was experiencing financial hardship in the year prior to her death.

Background - THN

9. THN was 20 years old at the time of the fatal incident. As noted above, THN had three brothers, a half-sister from his mother and a half-sister from his father.

10. According to THN's sentencing remarks, he allegedly experienced neglect and family violence from his parents as a child, however the details of this abuse are not contained within the evidence available to the Court. THN left the family home at the age of 14 or 15 and stopped attending school in Year 10 due to "*poor behaviour*". THN lived with HDS occasionally (including at the time of the fatal incident), however also experienced periods of homelessness.

11. THN reportedly misused substances including alcohol, cannabis and methylamphetamine to self-manage his depression and anxiety. The available evidence suggests that THN started using cannabis daily when 16 years old and regularly consumed alcohol. One of THN's younger brothers reported that THN "*got really mad when he was drinking*". THN attended an Alcohol and Other Drug (**AOD**) assessment at the Youth Support and Advocacy Service (**YSAS**) in late-2019 when he was about 18 years old, however he did not follow-up with the recommended treatment.

12. THN's sentencing remarks noted that he attempted suicide once by walking in front of a moving vehicle, however it does not appear that he received any mental health treatment in response.

13. THN's criminal history included recklessly causing injury for which he received a good behaviour bond without conviction in September 2020. He was also convicted of robbery, attempted robbery, committing an indictable offence while on bail and failing to answer bail that same month and received an 18-month Community Corrections Order (**CCO**). The CCO required THN to complete community work, and alcohol and drug testing and treatment, however he breached the order.

14. THN had a history of perpetrating family violence against his former partner. There were four reported incidents of family violence between 14 April 2021 and 28 November 2021. Police applied for a Family Violence Safety Notice (**FVSN**) against THN in relation to the 14 April 2021 incident. An interim full Family Violence Intervention Order (**FVIO**) in full conditions was issued on 22 April 2021. Later in 2021, THN was convicted of breaching the FVSN and received a fine.

15. One of THN's brothers reported that he witnessed THN assaulting his dog on several occasions, however it does not appear that these incidents were formally reported to police.

16. Following the fatal incident, THN underwent forensic psychiatric assessments as part of the sentencing process. A forensic psychiatry report concluded that he had "*a persistent depressive disorder*" and experienced symptoms consistent with post-traumatic stress disorder (**PTSD**) "*stemming from considerable childhood trauma*". THN's symptoms included "*reliving experiences, nightmares, hypervigilance, combined with poorly formed self-concept, interpersonal changes and emotional dysregulation*". THN's other diagnoses differed between the various clinicians who reviewed him. A clinical psychology report concluded that THN had "*a psychotic disorder or schizophrenia*" and noted that he "*experienced unusual phenomena since childhood*" including hearing voices. The psychiatrist's report attributed the phenomena to childhood trauma, due to an absence of delusion in his thinking and no documented evidence of a thought disorder.

Relationship between HDS and THN

17. HDS and THN lived together in a share-house from May 2020 until the fatal incident. One of THN's brothers reported that after THN moved in with his mother, he often complained about HDS and "*talked about her as if she was a bad person*", which his brothers did not understand.

18. HDS's mother suspected that THN financially abused HDS by taking "*all of HDS's money*" so that she was unable to pay rent or bills. At the time of the fatal incident, THN was unemployed, however previously worked as a commercial cleaner.

19. Evidence available to the Court suggests that THN was regularly verbally and physically abusive towards HDS, including slapping her to the face, arms and legs, pinching her, grabbing her and sometimes hitting her with a closed fist. HDS's other children witnessed the alleged abuse and observed the resulting bruises she sustained.

20. HDS's other sons reported that when THN yelled at HDS, she remained quiet. One of her other sons stated that HDS was very protective of THN and "*[e]ven when [THN] said to call the police, [HDS] would be like 'No'. She didn't want to*".

21. HDS disclosed several of the assaults to her NDIS support worker and showed her the bruises to her arm and leg. THN's abuse often occurred in in circumstances where he admonished HDS's parenting of MJU, particularly when MJU entered THN's bedroom while HDS was busy with housework. THN also threatened to report HDS to Child Protection. The available evidence shows that THN's abuse of his mother escalated following the breakdown of his relationship with his former girlfriend in late-2021.

22. While pregnant with MJU, HDS's mobility declined further. The services she was engaged with noted that THN did not provide her with support when she requested it, despite HDS being "*very focused on THN and clearly identified him as the closest person to her*". One of THN's brothers stated that he believed THN took his anger out on HDS because she "*couldn't really do anything about it*" due to her vulnerability and disability.

23. HDS's support worker, THN's younger brothers and other family members who witnessed THN's abuse did not report the abuse to police as they were extremely fearful of him.

THE CORONIAL INVESTIGATION

24. HDS'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.

25. 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.

26. 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.

27. Victoria Police assigned Detective Acting Sergeant Leigh Smyth to be the Coronial Investigator for the investigation of HDS's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

28. 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.

29. This finding draws on the totality of the coronial investigation into the death of HDS 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

30. On 10 February 2022, HDS, born [redacted], was visually identified by her son's partner, HBG.

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

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Medical cause of death

32. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 11 February 2022 and provided a written report of her findings dated 2 June 2022.

33. The post-mortem examination revealed extensive rib fractures, with an injury to the left lung resulting in a pneumohaemothorax. There were also lacerations of the liver, and mesentery (fat between the intestinal loops), with some bleeding into the abdominal cavity, and further haemorrhage in the soft tissues around the abdominal cavity. The sternum was broken, and the left pubic symphysis (part of the pelvis) was also broken. Both eardrums were ruptured. There were a large number of bruises over the entire body, some of which showed inflammatory change under the microscope. There were also skin injuries to the scalp, nose, and underside of the chin. Finally, there was bruising into the muscles at the front and back of the neck.

34. Neuropathology investigations also confirmed significant injury to the brain, in the form of bleeding and bruising. Injury was caused by trauma to the head. There was a patchy subarachnoid haemorrhage over the surface of the brain. A subarachnoid haemorrhage is bleeding under one of the membranes covering the brain caused by rupture of the small vessels that run in the subarachnoid space (area under the arachnoid membrane). There was also a minor contusional injury (bruise) to the right temporal lobe. Overall, microscopic changes were of grade 2 diffuse traumatic axonal injury, which means that there was tearing of the brain's long nerve fibres (called axons), which was caused by the brain shifting inside the skull due to the forces imparted by trauma.

35. The proposed mechanism of death is a combination of the effects of the multiple injuries:

    a) A major compromising feature was the large number of rib fractures, which were seen on both sides of the chest, involving the front, sides and back of the rib cage. Many ribs on both sides of the chest had multiple fractures. This resulted in the formation of a flail chest on the left (segments of the chest were 'free-floating'). A flail segment is defined as fractures of three or more contiguous ribs in two or more places. This can lead to significant respiratory compromise due to paradoxical motion of the free-floating part of the chest wall (the flail segment moves differently to the rest of the chest wall, leading to impaired breathing). Flail chest is a serious condition that can result in death.

b) In addition, rib fractures resulted in puncture of the deceased's left lung, with subsequent collapse and accumulation of some blood in the chest cavity. This would have caused further respiratory compromise.

c) Additional factors that may have contributed to the death were blood loss due to the large number of bruises, and the injuries to the face and scalp (these injuries have the potential to bleed copiously).

d) There was also some bruising to the strap muscles at the front of the neck, as well as some muscles at the back of the neck. Neck compression could therefore not be entirely excluded. However, there were no fractures to the hyoid bone, or laryngeal cartilages. There were also no petechial haemorrhages over the face. Petechiae and ecchymoses were seen in the eyes but may have been due to localised bruising (the deceased had bilateral 'black eyes').

e) The brain injuries were significant, although the clinical outcome was not predictable solely by examination of the brain of the deceased. Nevertheless, these types of brain injuries can be associated with consequences such as concussion and unconsciousness. Long-term brain damage can also be seen in survivors.

36. There were a large number of external injuries present:

a) The pattern of bruising and other soft tissue injuries over the head, torso, upper and lower limbs, was in a mixture of protected and unprotected areas. There was also a clustering of injuries about the head. The pattern is most indicative of assault, rather than collisions with solid objects or falls (where mainly bony prominences are usually affected). The colouration of the bruising indicated a mixture of ages.

b) Some of the injuries to the scalp, nose, forehead and underside of the chin had an unclear aetiology. The injuries had some features of laceration (blunt force) and some features suggestive of sharp force. It is not clear how these injuries occurred, but they may have involved a sharp implement.

37. There were numerous internal injuries including rib fractures, brain injury, liver lacerations, laceration to the abdominal mesentery, the pelvic fracture and haemorrhage into the soft tissues surrounding the abdominal cavity were most in keeping with blunt force trauma. Postulated mechanisms may include punching, kicking, blows with a blunt instrument, falls or stomping.

38. Cardiopulmonary resuscitation (**CPR**) was reportedly attempted. Injuries to the ribs, sternum, and even abdominal viscera can result from CPR. However, the majority of the deceased's injuries, including the most serious ones, were not characteristic of CPR. Moreover, there was early inflammatory change of the liver injury, which would not be expected with CPR.

39. There was no natural disease that could have contributed significantly to the death. The deceased had a known disorder that caused disability and weakness, but there was no definitive diagnosis. This disorder was not considered to be a contributing factor to the death in the setting of such severe injuries (particularly those to the chest).

40. Information received from the Department of Health indicated that the deceased completed a COVID-19 PCR test on 26 January 2022 (14 days prior to death). Histology confirmed that there was no COVID-19 pneumonia, and there were no other known medical complications of COVID-19 found at autopsy.

41. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

42. Dr Archer provided an opinion that the medical cause of death was 1(a) Multiple injuries.

43. I accept Dr Archer's opinion as to the medical cause of death.

Circumstances in which the death occurred

44. In late-2021, HDS, THN and MJU moved into the outer suburban share-house with THN's friend, REW, and her father, IUY. As noted above, REW's partner also often stayed at the house. THN, REW and IUY all slept in their own bedrooms, however HDS and MJU slept in the living room. HDS told her support worker that she decided to sleep in the living room after THN assaulted her in her bedroom of a previous house and she felt trapped "*with no way to escape*".

45. As noted above, HDS's support worker and family advised that THN's behaviour escalated in the months prior to her passing and he became increasingly abusive towards her.

46. In the weeks prior to the fatal incident, HDS told her support worker about two recent assaults by THN. On one occasion, THN allegedly held her head under water while she was in a blow-up child's pool with MJU. On another occasion, THN allegedly held a fork to her throat and very close to her eye. HDS showed her support worker new bruises to her legs and arms and told the worker that she also had bruises on her back and stomach where THN pinched her.

47. In late-January, HDS completed one week at home in quarantine due to contracting COVID-19. She told her support worker that during this time, THN had been very violent towards her. HDS also noted that THN had been using more cannabis during this time, and that when he combined cannabis with alcohol, "*his moods were more aggressive*".

48. THN's younger brothers stayed at the home from the evening of Friday 4 February 2022 to Sunday 6 February 2022. Over the weekend, THN's brothers (and others) witnessed THN being physically and verbally abusive towards HDS. This occurred in the context of historical issues and THN's views about HDS's parenting of MJU. THN's brothers also witnessed him assault his dog by hitting and biting him while he was intoxicated.

49. On the evening of 6 February 2022, one of THN's cousins (aged 15 years old) was present at the home. The cousin sent a text message to a group chat containing THN's brothers and alleged that THN was yelling at and assaulting HDS by "*slapping and gripping*" her, and that THN had taken her phone. One of THN's brothers suggested that the cousin should contact the police, however it appears she was too frightened of THN to do so. THN was reportedly aware of THN's abuse and spoke to him via phone to confront him about it.

50. On the afternoon of 9 February 2022, HDS's support worker visited her and noted that HDS appeared happy as THN reportedly sent her a text message apologising for "*his recent behaviour*". One of THN's brothers reported also seeing this text message.

51. On the evening of 9 February 2022, THN was at his home and consumed alcohol with a friend. He attended a local pool hall with REW and her partner, and another friend. At the pool hall, THN was reportedly "*acting strange*" and shouted, "*Where is he?*" and "*Why do people always do this to me?*". When a friend tried to subdue him, THN allegedly physically assaulted the friend.

52. THN returned home at about 11.00pm. When REW and her partner returned home 15 minutes later, they observed THN standing over HDS and yelling at her. HDS was on the floor, bleeding from the nose and forehead while MJU was on the couch. THN accused HDS of allowing MJU to climb onto a dirty table outside and eat cigarette butts. REW and her partner removed MJU and placed her in their bedroom. THN allegedly threatened to kill REW's partner when he tried to obtain a blanket for MJU. He also reportedly threatened to hit REW when she exited her bedroom to try and calm THN down. REW explained that she was too fearful to call police at the time.

53. REW reported that she then walked into her father's room and told him that THN was assaulting HDS. REW explained that she was too afraid to call police and asked her father to call on her behalf, however he refused. REW and her partner reported hearing THN yelling at HDS for up to two hours. They heard him yell "*get the fuck up*" and "*get the fuck out*" during this time. At an unknown time that evening, THN moved HDS into the garage and continued his assault. Eventually, THN placed HDS in bed and made basic attempts to render first aid, however this was unsuccessful. THN did not call an ambulance.

54. Beginning at 12.52am on 10 February 2022, THN sent a series of text messages to his on/off girlfriend, HBG. Amongst other messages, THN sent "*I think I might of [sic] went too far*", "*she seems okay but not okay*" and "*Like she doesn't breathe but every time I try to move her she breathes*".

55. HBG attended the home early that morning. She was not able to provide a consistent account of what occurred that morning, however other witnesses were able to provide an account.

56. IUY awoke to his alarm at 4.00am and did not observe anything unusual in the house. The house was dark, so he used his phone to navigate through the house, before leaving for work shortly thereafter.

57. REW and her partner awoke at about 6.30am. They observed blood on the floor in the kitchen and thought it was likely from HDS's blood nose the night before, so they cleaned it. When they were cleaning the kitchen, they realised that HBG was also present in the house. REW and her partner did not see THN, although noted his bedroom door was closed.

58. Throughout the morning, THN and HBG exchanged text messages. In some of those messages, THN asked HBG "*[w]hy are they [REW and her partner] taking so long to leave*?" REW and her partner left the house at about 11.30am, leaving MJU in the care of HBG At 12.01pm, THN sent a message to HBG advising that he was unable to leave via the front door and that he intended to jump the back fence.

59. HBG called Triple Zero at 12.12pm to request an ambulance for HDS. She told the operator that she had just arrived at the house to check on the baby. She stated that upon her arrival, she located HDS unconscious and that it appeared she had been assaulted. HBG followed the call-taker's instructions to remove HDS from the bed and commence CPR. HBG continued CPR until paramedics and police arrived on scene.

60. When paramedics arrived on scene, they observed HDS was naked and had significant bruising to her upper torso, arms, legs, face and around her eyes. She had lacerations to her chin and the bridge of her nose, both of which were covered by a bandage. There was also a laceration to the edge of her left eye which was covered with tissue paper that was heavily bloodstained and secured in place with a headband. Paramedics opined that HDS had likely been deceased for some time.

61. When initially speaking to police, HBG advised that she arrived at the house about 20 minutes before she called Triple Zero. She alleged the front and rear doors were open, which was unusual, however all the internal doors were closed. She gave a similar (incorrect) version of events in her signed statement to police.

62. Police located THN on 14 February 2022 at Southern Cross Railway Station. At the time, he was on a Waurn Ponds-bound train, waiting to depart the station and he gave officers a false name. Police arrested THN and conveyed him to the Melbourne West Police Station where he participated in a formal interview. In his interview, THN told police that he was aware that his mother was deceased however claimed not to know how she died. He claimed that other people told him that the police were trying to blame him for her death.

63. Police formally interviewed HBG on 15 February 2022. During her interview, she admitted to speaking to THN via text messages in the early hours of 10 February 2022. She admitted being aware of THN being involved in an incident with HDS and that he told her that HDS might have internal injuries. She also admitted to attending the home in response to a request from THN.

64. HBG was originally charged with being an accessory to a serious indictable offence, however this charge was later withdrawn, and she pleaded guilty to a charge of perjury (due to her false statement to police).

65. THN pleaded guilty to HDS's murder on 30 October 2023. On 11 December 2023, THN was sentenced to 21 years' imprisonment with a non-parole period of 15 years.

FURTHER INVESTIGATIONS AND CPU REVIEW

66. As HDS'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]. The

[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

CPU were asked to examine the circumstances of HDS's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[3]

67. I make observations concerning service engagement with HDS and THN 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 HDS's death.

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

Child Protection

69. The available records suggest that Child Protection was not involved with HDS's four eldest children in relation to protective concerns. A Child Protection report was made during HDS's pregnancy with MJU due to concerns about HDS's ability to care for MJU in the context of her limited mobility and suspected cognitive impairment. This report was closed shortly after MJU was born as HDS was coping well and was supported by her family. There were no concerns in this report in relation to family violence.

Victoria Police

Incident on 24 November 2021

70. On 24 November 2021, police were responding to an unrelated incident near THN and HDS's home and overheard an argument from the rear patio area of their home. Police heard THN threaten to "*smash a bong*" over HDS's head while she was holding MJU. Police entered the home and located THN sitting with a bong, cannabis and a large knife. He was initially hostile towards police, however later settled and admitted to threatening HDS. He asked police for

prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

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

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

help to access "*anger management*". Police advised THN that they would submit a referral for YSAS Dandenong and would call him in two days' time to discuss the referral. They also advised that they would return to see THN and provide him with further information in the coming weeks.

71. Police issued a limited FVSN against THN to protect HDS. The conditions prevented THN from perpetrating family violence against HDS, however, did not prevent him from having contact with her. Police completed a field interview with THN in relation to unlawful assault, then seized the cannabis and issued a caution for same. HDS provided a statement of no complaint in relation to the incident and stated that she was not fearful of THN when police completed their family violence risk assessment (**FVR L17**). THN was later charged on summons in relation to the unlawful assault, and this matter was pending at the time of the fatal incident.

72. A supervisor committed the FVR L17 to LEAP and noted that the report stated that there were children present, however their details were not included in the report. The supervisor recorded an instruction for members to contact Child Protection and notify them of the incident. The LEAP narrative indicates that police contacted Child Protection on 26 November 2021 and were awaiting a return call to report the matter. There are no further records to indicate that police followed up with Child Protection. The Child Protection records confirm that no report was ever made.

73. One of the members who attended the original incident returned on 25 November 2021 to field interview THN about breaching an FVIO against his ex-girlfriend (the breach occurred on 28 July 2021). The member did not discuss THN's request for a referral for anger management support or any of the other matters that were discussed one day earlier.

74. Police obtained a final FVIO against THN, in protection of HDS on 7 December 2021. The FVIO was limited and prevented THN from perpetrating family violence against HDS, however it did not include MJU as an affected family member (**AFM**). The FVIO was served on THN the following day and was active at the time of the fatal incident.

Analysis

75. Following HDS's death, Victoria Police completed a Family Violence-Related Death Assessment (**FDA**) and identified several issues with the police contact on 24 November 2021. I note that the FDA is a desktop review that is completed without the time pressures and

competing demands facing frontline members attending family violence incidents. The FDA identified the following issues:

a) MJU was not identified as being present, which was in breach of sections 3.2 and 5.2 of the Victoria Police Manual – Family Violence (**VPM FV**). Although police recorded leaving a message for Child Protection to make a report (at the direction of their supervisor), the report did not actually occur. None of the members involved appeared to be aware that they could have amended the FVR L17 to include MJU's details for up to 14 days after it was committed to LEAP. If an amendment was submitted it would have automatically transferred to the L17 portal, which would have informed relevant support services of MJU's exposure to family violence. The FDA concluded that this represented a missed opportunity to alert specialist family violence services that MJU was exposed to family violence and to trigger a Child Protection report. At the time, Child Protection were prescribed under the Multi-Agency Risk Assessment and Management Framework (**MARAM**) and were obliged to assess and manage family violence risk (if they were notified).

b) MJU was not listed on the FVSN or FVIO in protection of HDS. The VPM FV in place at the time required police to consider including children exposed to family violence on any FVIO application. Given MJU was present when the incident occurred, I am of the view that it would have been appropriate for MJU to be included on the FVSN and subsequent FVIO.

c) There was no evidence to suggest that the members conducted safety planning with HDS at the time they completed the FVR L17.

d) Despite being aware that THN was on bail for breaching the FVIO in protection of THN's ex-girlfriend, and on a CCO for robbery and attempted robbery, police did not appropriately separate all parties at the scene and obtain their details. Police also did not identify that the ex-girlfriend was present, and therefore that THN was in breach of the FVIO against him. The ex-girlfriend initially told members that she was a relative, however HDS later confirmed with police that this woman was THN's girlfriend. This may represent a missed opportunity to hold THN accountable for his use of violence against his ex-girlfriend.

e) Police did not arrest and process THN for an outstanding whereabouts for contravening an interim FVIO. This may also represent another missed opportunity to hold THN to account for his use of violence.

f) Police did not comply with the Family Violence Fast Track Initiative (**FTI**) timelines, which require family violence-related criminal offending be heard in court within four weeks from the date of offender processing.

g) Police did not offer HDS an opportunity to participate in a case conference, which breached section 29 of the VPM FV.

h) The FDA criticised the members' decision to field interview THN on 25 November 2021. The FDA stated "*[t]he choice to field interview offenders for contraventions of IVO presents a risk that the FV is minimised and the cycle of violence is not disrupted. This is also a risk that opportunities to charge (and remand) are not available when an offender is not processed at a police station*".

76. The FDA noted other issues with respect to the police management of THN's family violence offending against his ex-girlfriend, including with respect to repeated non-alignment with the FTI.

77. The FDA made three recommendations as follows:

a) That the report is submitted to the Divisional Commander (SD3) for a response to the findings made with consideration of appropriate performance and training interventions for the gaps identified in frontline service delivery.

b) That the report is submitted to Intelligence, Data and Insights at Family Violence Command (**FVC**) for consideration of a review of the frequency of use of field interviews and associated risks where a FVIO contravention occurs.

c) That a file be created and forwarded to the EPSO, Southern Region, for allocation in relation to the member's duty failure on 24 November 2021.

78. I support the above recommendations and concur with the findings of the FDA. However other practice or compliance issues that were not canvassed in the FDA. For example:

a) Police did not follow through with their commitment to return to the home in the coming weeks or to call THN in two days' time to provide him with information about

support services in relation to his request for anger management assistance. Police also did not make the promised referral to YSAS Dandenong. I note that a member of the local Family Violence Investigation Unit (**FVIU**) made a note on the file to suggest that the investigating members encourage HDS and THN "*to engage with support services*".

b) When police returned the next day, they had an opportunity to provide THN with the information and support as promised the day before, and to offer support services (as suggested by the FVIU), but did not do so. This may represent a missed opportunity to provide THN with timely support to address his use of violence while he was expressing motivation/desire to do so.

c) When police canvassed the FVR L17 risk assessment questions with HDS, they asked them in a rapid manner, which is unlikely to have elicited any detailed disclosures of family violence risk from HDS. HDS answered "*no*" when asked whether THN had ever threatened to seriously hurt her, despite police witnessing THN threatening to "*smash a bong*" over her head that day. While HDS was very protective of THN and may not have been willing to make disclosures about him, I am concerned that the members' rapid approach to asking questions may have reduced her willingness or ability to engage.

d) During the FVR L17 questioning, HDS advised police that she and THN shared a mobile phone. It does not appear that the members advised her that they would be making a referral to a specialist family violence service via the L17 portal and did not appear to consider how sharing a phone would impact her ability to engage with the service. The FVR L17 stated that HDS could be contacted "*at any time*" and did not note that she was sharing a phone with THN. Therefore, the referral services would have been unaware of this situation.

79. These deficiencies did not cause or contribute to HDS's death. However, they may represent missed opportunities to better engage with HDS and THN and potentially hold THN to account for his perpetration of family violence.

Victoria Police response

80. At my direction, the Court wrote to Victoria Police and provided them with an opportunity to respond to the above concerns.

81. Victoria Police, via their solicitors, acknowledged that there was no evidence that members followed up with THN as they advised on 24 November 2021. As noted in the FDA, appropriate referrals were made by the members for THN through the FVR L17.

82. Victoria Police accepted that while the risk assessment questions appeared to have been asked in a rapid manner, it observed that this appeared to be consistent with the member's general dialogue and communication style. Victoria Police further noted that HDS appeared to have been engaged with the questions and expanded her answer to certain questions such as the one about her mental health. Given the length of time that police had already been present at the property, Victoria Police submitted that the exchange might be consistent with the rapport they built over time.

83. Furthermore, Victoria Police noted that a response of 'yes' to the question about previous threats would not have altered the FVR score, as that question is unscored. However, Victoria Police acknowledged that exploring the question further may have elicited a different response from HDS.

84. Finally, Victoria Police noted that the shared mobile phone (referenced above) appeared to be owned by HDS and used by THN. Victoria Police acknowledged that this information could have been recorded for clarity, however it was not clear that HDS's engagement with services was impacted as a result.

85. Victoria Police concluded and advised that it remains committed to building capacity and uplifting member capability, supporting a process of continuous improvement in the police response to family violence. I accept Victoria Police's submissions on the above issues and commend the organisation for acknowledging its deficits and continuing its efforts towards continuous improvement.

Co-responder programs

86. I note that if a co-responder program was available to HDS and THN, this may have had a preventative effect by addressing some of the issues outlined above, including through assertive outreach.

87. Co-responder programs involve the presence of a specialist family violence worker during or after police attend family violence incidents to provide a collaborative response. Research has identified key benefits to co-responder programs, including higher satisfaction of victims with police, increased willingness of victims to contact police in future, more information sharing

and coordination of services for victims, and greater understanding of family violence by police when responding to family violence.

88. I note that other coroners have made recommendations and comments in support of the expansion of co-responder models in Victoria.[5] In (then) State Coroner, Judge Cain's finding into the passing of Noeline Dalzell, his Honour recommended:

> *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.*[6]

89. Victoria Police accepted this recommendation in principle, however noted that it required external funding to implement the recommendation.

90. Most recently, Coroner Ingrid Giles recommended[7] that the Department of Families, Fairness and Housing (**DFFH**) resource an expansion of co-responder programs, such as the Alexis Family Violence Response Model, across Victoria.

91. In response, DFFH advised that the Department will fund two family violence co-responder programs, with commencement during 2025-2026. The program will embed specialist family violence practitioners into Victoria Police FVIUs to deliver an assertive approach to risk assessment and management, focusing on high-risk, repeat family violence contexts. DFFH further noted that it will continue to develop options for how this recommendation can be implemented across Victoria, noting that any further expansion of a co-responder program is subject to future Victorian Government funding decisions.

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[5] See for example: Finding into passing with inquest – Noeline Dalzell; Finding into death without inquest – EDH, Finding into death with inquest – Carolyn James; Finding into death without inquest – Ms KSQ; Finding into death without inquest – Jessica Geddes; Finding into death without inquest – Tracey Knowles; Finding into death without inquest – ZSQ; Finding into death without inquest – Narelle Simmons.

[6] Finding into passing with inquest – Noeline Dalzell.

[7] Finding into death without inquest – Ms KSQ.

92. While this is positive, the expansion into two new sites (at this stage the location is unknown) will only benefit victim-survivors in those particular areas. Currently, Alexis runs in Prahran, Bayside, Morwell and Wonthaggi, with two new sites to be added (as above). This leaves most Victorian victim-survivors without access to this program.

93. I therefore intend to recommend that the Victorian Government fund the expansion of the Alexis co-responder program across Victoria.

The Orange Door

94. I have not identified any issues with respect to the service contact between The Orange Door (**TOD**) and HDS and THN. However, I note that HDS and THN did not substantively engage with TOD, which provides further support for the expansion of co-responder programs (as discussed above).

Contact with HDS

95. TOD received a L17 referral for HDS and THN from police on 25 November 2021. The referral did not include any information about MJU: however, TOD was informed that MJU was present during the incident during the information gathering process.

96. TOD made several attempts to contact HDS in the days after the referral was received, however were unable to speak to her. On 2 December 2021, TOD spoke to HDS's NDIS support coordinator after finding her details in the Specialist Homelessness Information Platform (**SHIP**). The support coordinator stated that HDS was "*very well supported*" by services and by REW, and that she had "*no concerns*" for HDS, however noted that THN had taken her phone to use as his own. TOD records reflect that the support coordinator reported "*no concerns about her experience of the relationship between client and the perpetrator and reported perpetrator was supportive of client*".

97. TOD spoke to HDS on 8 December 2021 via phone. She stated that she felt safe and that she had "*a good relationship with her son generally, they just fight sometimes*". HDS explained that she did not need any support and declined to complete a risk assessment or safety plan with the worker. TOD provided HDS with family violence service contacts, then closed her file on 9 December 2021.

Contact with THN

98. TOD tried to contact THN several times after receiving a referral, however, were unable to reach him. On 29 November 2021, TOD established that THN had a profile with WAYSS (a family violence and housing support service), but no notes or information were associated with his profile. WAYSS has since confirmed with the Court that this profile was created because of their engagement with THN's former partner, and WAYSS did not have any actual contact with THN. TOD reviewed THN's previous L17 referrals and confirmed that a FVIO was in place against him, in protection of HDS. TOD closed THN's referral on 20 December 2021.

99. Despite being named the respondent in five FVR L17s in 2021, it does not appear that THN ever spoke to or engaged with TOD or any other family violence services. After receiving L17 referrals for THN, TOD was either unable to contact him or did not attempt to contact him because police had not sought his permission to submit the referral. This is a common theme in cases seen by this Court. I note that TOD's most recent annual report states that only 10% of adults using family violence engaged with the service system.

100. On the other hand, I note that the Alexis co-responder model (as referenced above) demonstrated a successful contact rate of 83%, possibly due to their methods of engagement which include assertive outreach. The most common reason for Alexis case closure (for both respondents and AFMs) was because their needs were met by the service. As discussed above, I note the potential of co-responder models to increase engagement with specialist family violence services by both perpetrators and victim-survivors, and to significantly reduce the risk of both. HDS and THN's lack of meaningful engagement with TOD provides further support for expanding co-responder models.

Flair & Fine Care

Background

101. HDS received twice-weekly support from her NDIS-funded Flair & Fine Care (**FFC**) support worker for a year before her passing. The support worker explained that she and HDS became good friends over the course of their working relationship.

102. The support worker noted that HDS often told her about THN's abuse and that "*he was very abusive towards HDS*". The support worker stated that she witnessed THN being verbally abusive towards HDS and observed him "*yelling and screaming at her*" about once a month.

The support worker described THN standing "*close to her and over [HDS]*" and being "*very aggressive in his demeanour*".

103. HDS told her support worker "*on numerous occasions that [THN] had assaulted her. She would show me bruises on her arms and her legs and [told her] that this was from THN having grabbed her or pinched her*". HDS had spoken to her support worker about potentially applying for an FVIO against THN.

104. HDS's support worker stated that she "*did not do anything when [she] witnessed this [abuse] because [she] was also terrified about him*". She explained that she "*wish[ed] now that [she] had called police on those occasions*".

105. In the weeks prior to the fatal incident, HDS told her support worker about two recent assaults by THN, showed her new bruises to her legs and arms, and told her about bruises to her back and stomach. The support worker did not make any records in relation to THN's family violence perpetration until 3 February 2022, one week prior to the fatal incident. Their notes on this occasion included:

> *[W]hile driving HDS told me that her eldest son has been abusive towards her. both threatening and physical.*
>
> *she does not want him in the house.*
>
> *while I was with her she called her ex husband to talk to him. he has recommended that HDS call the police and put a restraining order on him. I have given HDS a number for family violence. I let her know there are people out there that can help her and I will do some research on it.*

Analysis

106. I note that HDS's support worker developed an excellent rapport with her and provided her with significant support over the period they worked together. As noted above, the support worker was "*terrified*" of THN and this impacted her decision-making with respect to her response to family violence.

107. Unfortunately, HDS's support worker did not make a record of the family violence perpetrated by THN until one week prior to the fatal incident. It does not appear that they escalated their concerns within FFC or to HDS's NDIS support coordinator. Consequently, the NDIS support coordinator was not aware of the family violence that was occurring when they were contacted

by TOD and provided incorrect information. This may have impacted TOD's risk assessment and decision-making. In my view, the support worker's inaction with respect to the family violence perpetrated by THN may represent a missed opportunity to assess and manage risk, including by consulting with specialist family violence services.

108. I am not of the view that the support worker's conduct contributed to the fatal incident. However, this represents a broader issue of NDIS providers being unable to adequately identify and respond to family violence, which is negatively impacted by a lack of family violence training for disability service workers. This lack of training is problematic given the prevalence of violence against people with disabilities, particularly women with disabilities. Notably, 65% of women with disabilities experienced at least one incident of violence since the age of 15.[8]

109. In response, FFC did not seek to challenge or dispute the concerns raised above, however requested that I not refer to the organisation by name. FFC explained that by naming the organisation in my findings, it "*may create a challenging situation for our team members, and we request that our business name be omitted from the finding*". FFC elaborated and claimed that by naming the organisation, "*the situation will likely arise where our team members are asked whether they were the support worker referred to*."

110. The Court clarified with FFC if they were seeking a suppression/pseudonym order, noting my preliminary view that there did not appear to be any grounds for such an order. FFC advised that it did not wish to take any further action or make any further submissions.

Systemic issues

111. The Victorian Royal Commission into Family Violence (**RCFV**) recommended that the Victorian Government fund training and education programs for disability workers and that all disability services workers complete certified training in identifying family violence. Following these recommendations, the Victorian Government trained the (then-named) Department of Health and Human Services (**DHHS**) disability workforce to recognise and respond to family violence. The Victorian Government also funded family violence training delivered through the vocational education and training system. However, this training is not mandatory for all disability workers.

[8] Sutherland, G et al, *Primary prevention of violence against women with disability: Evidence synthesis* (2021, The University of Melbourne).

112. The Victorian Government has also funded training on the MARAM for disability workers employed by organisations which are prescribed under the MARAM. However, most disability support work is now funded by the NDIS, which is not prescribed under the MARAM.

113. NDIS providers are also not prescribed under the Family Violence Information Sharing Scheme (**FVISS**). The FVISS underpins the MARAM and provides a framework for prescribed organisations to request and share information for family violence risk assessment and protection purposes. Prescription under the FVISS could improve information sharing practices between professionals who support people with disabilities, for example, by providing guidance on when and how to seek consent before sharing family violence related information.

114. The NDIS Participant Safeguarding Policy was released in 2021 but does not indicate that disability support workers will receive family violence training, nor does it reference the MARAM. The Participant Safeguarding Policy recommends that critical incidents[9] involving people with a disability in home or community settings be reported by NDIS providers to the National Disability Abuse and Neglect Hotline. This Hotline provides information on relevant support services but does not provide a safeguarding response.

115. I note recent a finding into the death of William Heddergott by (then) State Coroner, Judge Cain, in which his Honour made the following recommendation:

> *That the Department of Families, Fairness and Housing engage with the Commonwealth Government in relation to the prescription of Commonwealth Government entities such as the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission as Information Sharing Entities (**ISEs**) under the Family Violence Information Sharing Scheme (**FVISS**) and in respect of the Multi-Agency Risk Assessment and Management Framework (**MARAM**).*[10]

116. His Honour also recommended in his Finding into the death of PLM:

[9] Critical incidents include allegations of unexpected death, serious injury, abuse, or neglect, unlawful sexual or physical contact or misconduct, unauthorised use of restrictive practices or threatening self-harm.

[10] Finding into death without inquest - William Heddergott; Noting that a similar recommendation was made by the Victorian OPA in *Line of Sight: Refocussing Victoria's Adult Safeguarding Laws and Practices* (Review, 18 August 2022) 16.

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.[11]

117. In response to the recommendation in PLM, the Department of Prime Minister and Cabinet 'noted' the recommendation and responded:

> *[T]he NDIS Quality and Safeguards Commission (NDIS Commission) would welcome engagement with the Victorian Government to understand the requirements for prescribed bodies under MARAM and potential applicability in the NDIS context, noting the NDIS is currently in a period of regulatory reform following recommendations by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability and the NDIS Review.*

118. I note that while the NDIS is currently in a period of regulatory reform, it would be prudent for that reform to include responses to family violence. I therefore intend to recommend that the NDIS Quality and Safeguards Commission engage with the Department of Families, Fairness and Housing (**DFFH**) to understand the requirements for prescribed bodies under MARAM and its applicability in the NDIS context. This engagement should be informed by this finding and Judge Cain's findings into the death of William Heddergott and PLM.

119. I also intend to recommend that the NDIS Quality and Safeguards Commission work with DFFH to expand the MARAM framework to include NDIS service providers in Victoria and make them MARAM-prescribed entities.

Systemic issues

Parents killed by adult children

120. This case is sadly one of many cases before the Court where an adult child or grandchild has killed their parent or grandparent, often while acutely mentally unwell.[12]

121. The Australian Institute of Criminology found that parricide was the third most common form of family violence homicide in Australia between 2014 and 2024, with 131 incidents reported

[11] Finding into death without inquest – PLM.
[12] See for example: Finding into death without inquest – Shirley Kidd; Finding into death without inquest - TCW; Finding into death without inquest – Stephen O'Brien.

nationally during this period.[13] Of the 18 incidents of parricide reported in 2023-2024, 15 offenders were male and three were female.[14] While the majority of female homicide victims are killed by a male intimate partner, aging women face a dual risk, as the likelihood of being killed by an adult child also increases with age.[15] In the 2023-2024 period, 54 women were killed by either an intimate partner or a child, in contrast to 19 men who were killed by a family member under comparable circumstances.[16]

Safeguarding

122. I note that if an adult safeguarding agency existed in Victoria at the time of HDS's death, this may have provided a clear referral pathway for HDS's family and support worker to report their concerns about THN's violence towards her. HDS may have met the criteria for an adult safeguarding response, given:

    a) She had needs for care and support related to her mobility issues

    b) She was experiencing abuse from THN

    c) Her needs for care and support likely prevented her from protecting herself from the abuse.

123. I note that this issue has been thoroughly canvassed by (then) State Coroner, Judge Cain, in a series of findings published in 2025 including the deaths of CFT,[17] William Heddergott,[18] YTR,[19] DRF,[20] and MHT.[21] I reiterated his Honour's recommendation in my recent finding into the death of JZA:

    a) That the Victorian Government make available appropriate funding to the Office of the Public Advocate to enable it to implement all of the recommendations from the VAGO report.

[13] Miles H & Bricknell S 2025. *Homicide in Australia 2023–24.* Statistical Report no. 52. Canberra: Australian Institute of Criminology. https://doi.org/10.52922/sr77826.
[14] Ibid.
[15] The Guardian Australia, 'Older women allegedly killed by family members a "silent crisis", experts say', Kate Lyons (27 January 2025) < https://www.theguardian.com/global/2025/jan/27/older-women-killed-by-family-members-a-silent-crisis-no-one-is-talking-about-experts-say-ntwnfb>.
[16] Miles H & Bricknell S 2025. *Homicide in Australia 2023–24.* Statistical Report no. 52. Canberra: Australian Institute of Criminology. https://doi.org/10.52922/sr77826.
[17] Finding into death without inquest – CFT.
[18] Finding into death without inquest – William Heddergott.
[19] Finding into death without inquest – YTR.
[20] Finding into death without inquest – DRF.
[21] Finding into death without inquest – MHT.

b) *The Victorian Government implement as a priority, adult safeguarding legislation to establish adult safeguarding functions including but not limited to the assessment and investigation of, and coordination of responses to allegations of abuse, neglect, and exploitation of at-risk adults.*

c) *In framing legislation, the Victorian Government review the circumstances of JZA's passing and similar cases together with the safeguarding recommendations of the ALRC, the OPA and the DRC.*

d) *That any new adult safeguarding agency be adequately funded by the Victorian Government to function in an effective manner.*

e) *That the Victorian Government, when establishing a new safeguarding agency, should ensure that the agency works cooperatively with other service providers to facilitate the timely provision of, or changes to, the support services provided to at risk adults.*

f) *That the Victorian Government introduce legislation to permit an adult safeguarding agency to receive and share information in a timely manner, including information about neglect, with police, healthcare entities, government departments, the Office of the Public Advocate and any other agencies involved.*

g) *That the Victorian Government implement the recommendation of the Office of the Public Advocate, namely, to build the capacity of mainstream service providers to be able to identify and respond to the abuse of at-risk adults.*

h) *That the Victorian Government make funding available for regular community awareness, media engagement and education campaigns about any new adult safeguarding function, as suggested by the Disability Royal Commission.*[22]

124. While DFFH are yet to respond to the recommendations made in my finding into the death of JZA, I will direct that a copy of this finding be provided to DFFH to consider as part of their response to the JZA finding.

FINDINGS AND CONCLUSION

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

[22] Finding into death without inquest – JZA, 18.

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

b) the death occurred on 10 February 2022 at [redacted] from multiple injuries; and

c) the death occurred in the circumstances described above.

COMMENTS

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

126. I endorse the recommendations I made in my finding into the death of JZA, namely:

a) That the Victorian Government make available appropriate funding to the Office of the Public Advocate to enable it to implement all of the recommendations from the VAGO report.

b) The Victorian Government implement as a priority, adult safeguarding legislation to establish adult safeguarding functions including but not limited to the assessment and investigation of, and coordination of responses to allegations of abuse, neglect, and exploitation of at-risk adults.

c) In framing legislation, the Victorian Government review the circumstances of JZA's passing and similar cases together with the safeguarding recommendations of the ALRC, the OPA and the DRC.

d) That any new adult safeguarding agency be adequately funded by the Victorian Government to function in an effective manner.

e) That the Victorian Government, when establishing a new safeguarding agency, should ensure that the agency works cooperatively with other service providers to facilitate the timely provision of, or changes to, the support services provided to at risk adults.

f) That the Victorian Government introduce legislation to permit an adult safeguarding agency to receive and share information in a timely manner, including information about neglect, with police, healthcare entities, government departments, the Office of the Public Advocate and any other agencies involved.

g) *That the Victorian Government implement the recommendation of the Office of the Public Advocate, namely, to build the capacity of mainstream service providers to be able to identify and respond to the abuse of at-risk adults.*

h) *That the Victorian Government make funding available for regular community awareness, media engagement and education campaigns about any new adult safeguarding function, as suggested by the Disability Royal Commission.*[23]

RECOMMENDATIONS

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

(i) That the **NDIS Quality and Safeguards Commission** engage with the Department of Families, Fairness and Housing to understand the requirements for prescribed bodies under MARAM and its applicability in the NDIS context. This engagement should be informed by this finding and Judge Cain's recent findings into the death of William Heddergott and PLM.

(ii) That the **NDIS Quality and Safeguards Commission** work with DFFH to expand the MARAM framework to include NDIS service providers in Victoria and make them MARAM-prescribed entities.

(iii) That the **Victorian Government** provide ongoing funding for the expansion of the Alexis Family Violence Response Model, across Victoria.

I convey my sincere condolences to HDS's family for their loss.

[23] Finding into death without inquest – JZA, 18.

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:

CDE Senior Next of Kin

FRT, Senior Next of Kin

Department of Families, Fairness and Housing

Department of Premier and Cabinet

Flair & Fine Care

Mercy Health

NDIS Quality and Safeguards Commission

Office of the Public Advocate

Victoria Police

Detective Acting Sergeant Leigh Smyth, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 20 March 2026

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