



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002317

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:	EYR
Date of birth:	[REDACTED]
Date of death:	30 April 2022
Cause of death:	1(a) Stab wounds to the neck and chest
Place of death:	[REDACTED] [REDACTED]
Keywords:	Family violence; intimate partner homicide; history of family violence; private mental health services; identification of family violence

INTRODUCTION

1. On 30 April 2022, EYR was 35 years old when she died from stab wounds inflicted by her husband, BAQ. At the time of her death, EYR lived with BAQ and their (then) two-year-old son in a suburb of Melbourne, Victoria.
2. EYR was born in overseas. She was raised overseas, where she completed university studies in environment and art design. EYR's father passed away when she was a child, and she had one stepsister. EYR moved to Australia to pursue her studies in 2014.
3. EYR's family and friends described her as a kind-hearted person who was tolerant, strong, brave, and willing to help others. She was very close with her mother, MLH, and spoke to her almost every day. Despite their close relationship, EYR did not always share information with her mother that she believed would cause her to worry. One of her friends noted that she *"didn't really like to share her relationship or private things"*, even with her close friends.
4. BAQ was 40 years old when he killed EYR. The sentencing remarks for BAQ noted that he had a stable and happy childhood, however mental health records available to the Court indicate that BAQ witnessed his father perpetrate family violence against his mother whilst intoxicated. BAQ disclosed to a psychologist that he was not *"allowed to express any type of emotion in the household"*. He later told a forensic psychiatrist that his father had *"anger and jealousy issues"*.
5. At the time of the incident, BAQ was employed in the field of education and reportedly worked very long hours.

Relationship and mental health background

6. EYR met BAQ in 2016 while she was studying and the pair married in 2017, overseas. They welcomed a son together in 2020, which was a reportedly traumatic birth for EYR. When her grandson was born, MLH travelled to Australia to support her daughter. She was present for the birth and remained in Australia until 15 March 2020. While staying with her daughter, MLH formed the view that BAQ and EYR's marriage was unhappy and that BAQ was *"a very controlling person"*. She noted that BAQ was critical of EYR and observed him arguing with her in a *"fierce"* and *"very loud"* manner, while EYR spoke very softly. MLH spoke to EYR daily after she returned overseas, as she was concerned for her daughter and wanted to monitor her wellbeing.

7. The evidence available to the Court suggests that following the birth of their son, EYR and BAQ argued frequently, particularly in relation to parenting their child in the context of their differing cultural backgrounds. EYR told a psychologist on several occasions that she believed BAQ lacked empathy.
8. In early-2021, MLH formed the view that her daughter might not be safe with BAQ. She stated that EYR told her that she “*felt like she wasn’t safe and felt threatened*” during an argument with BAQ.
9. In February 2021, EYR returned to work after parental leave, however she unexpectedly resigned a few weeks later. At the time, EYR and BAQ were “*arguing a lot*” and EYR was suspicious of her work colleagues. She was also reportedly concerned about the level of care provided by BAQ and the childcare centre to her son. On 13 March 2021, EYR called Triple Zero stating that she felt unsafe and had a “*concern with [her] husband*” as her son had a rash on his bottom. She was advised to take her son to a general practitioner (GP). EYR later advised that these concerns were “*wrong*” and that she did not believe anyone was abusing her son.
10. On 15 March 2021, BAQ contacted the local Maternal and Child Health Nurse (MCHN) with concerns about EYR’s mental state. EYR attended the MCHN clinic, and the MCHN contacted the local Crisis and Assessment Treatment Team (CATT). The MCHN confirmed with the CATT that EYR’s presentation was “*out of character*” and advised that “*EYR denied FV although alluded to power and control*”. EYR also spoke to the CATT clinician and advised that she and BAQ had argued in front of their son one week prior, because BAQ did not want her to quit her job. The CATT records from this contact noted “*Power and control from BAQ. Needs 2 way communication, feels BAQ is being judged too much and he is not there*”.
11. From 15 to 24 March 2021, EYR was a voluntary inpatient of the Psychiatric Unit at the Maroondah Hospital. During this time, EYR was diagnosed with brief psychotic disorder (post-partum onset). Her treating psychiatrist noted that her main symptoms were “*excessive worry and poor sleep*”. She told clinicians at the time that BAQ was “*not who he says he is*” and she was “*concerned about the safety of herself and [her baby]*”. The records from this admission noted that EYR’s concerns about her son being abused were not “*founded by evidence*”.

12. While an inpatient, EYR made several disclosures to staff about BAQ allegedly perpetrating family violence against her, including:
- a) The inpatient safety record noted that EYR “*reported domestic violence with husband*” but was unable to elaborate on same. This disclosure occurred on the morning of 16 March 2021 while EYR was acutely psychotic and distressed at the time.
 - b) A consultant psychiatrist recorded on 16 March 2021 that EYR disclosed BAQ was verbally abusive and had broken her property. The consultant psychiatrist recorded a plan to refer EYR to a social worker regarding the disclosures “*when her mental state improved*”. EYR’s mental state was markedly tangential and suspicious and was on a temporary treatment order.
 - c) Additionally, during this review, the consultant psychiatrist documented that EYR reportedly disclosed that she had a “*very bad verbal altercation w/ husband a few days ago*”. EYR further disclosed that she and BAQ had a “*couple*” of similar fights in 2020. EYR reported that BAQ “*didn’t hurt her however was physically destructive, reports that he has punched walls*”. She noted that their fighting was an issue prior to the birth of their son, however it escalated following their child’s birth.
 - d) The patient safety record dated 17 March 2021 noted that EYR “*report[ed] domestic violence*”. On 18 March 2021, EYR disclosed that BAQ was verbally abusive, aggressive during arguments and “*broke something in the house*”.
 - e) On 18 March 2021, EYR disclosed that BAQ was aggressive during arguments. EYR was still noted to be suspicious and hypervigilant and also reported concerns that her child was being abused at daycare.
13. From 19-20 March 2021, EYR reported that she was ‘safe’ when asked by staff (in relation to family/visitors). She denied any current risks on 20 March 2021.
14. EYR met with a hospital social worker on 23 March 2021. The social worker spoke to EYR about her recent disclosures of family violence, however EYR reportedly framed them “*as differences in their communication styles*”. The social worker liaised with the Maternal and Child Health Nurse (MCHN) one day earlier, and the MCHN reported that they had explored similar issues with EYR prior to her admission.

15. Following discharge from Maroondah Hospital, EYR was admitted to Mitcham Private Hospital from 24 to 29 March 2021, under the care of a private psychiatrist. Upon discharge from Mitcham Private Hospital, EYR engaged with the Murrnong Continuing Care Team (MCCT) and two private psychologists.
16. While EYR recovered during 2021, the available evidence suggests that BAQ was the primary carer for their son, however EYR noted she was able to provide more care to her son in the months prior to the fatal incident. Over time, EYR returned to work and gradually increased to three days of work per week.
17. Notwithstanding EYR's improving mental health, EYR and BAQ continued to have "*frequent arguments*", and EYR told MLH that she wanted to divorce BAQ. She also disclosed to her mother that she believed BAQ would not "*let her go easily*". BAQ told police after the fatal incident that he and EYR would insult one another and say "*nasty things*" to each other during arguments, but that they argued less than once a week on average, prior to the fatal incident.

THE CORONIAL INVESTIGATION

18. EYR'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.
19. 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.
20. 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.
21. Victoria Police assigned Detective Senior Constable David Martin-Alcaide to be the Coronal Investigator for the investigation of EYR's death. The Coronal Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

22. 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.
23. This finding draws on the totality of the coronial investigation into the death of EYR, 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

24. On 11 May 2022, EYR, [REDACTED] was visually identified by her [REDACTED], AGT.
25. Identity is not in dispute and requires no further investigation.

Medical cause of death

26. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy on 1 May 2022 and provided a written report of her findings dated 19 July 2022.
27. The post-mortem examination revealed multiple sharp force injuries. Sharp force injuries are caused by the application of force with sharp-edged implements or objects, such as knives, razors, swords and glass. They result in clean division of the skin and underlying tissues. A differentiation is made between incised wounds and stab wounds. Incised wounds are greater in length than depth while stab wounds are greater in depth than in length.
28. There were three stab wounds identified in total, located on the neck and right side of the chest. In relation to one of the stab wounds to the neck, the left jugular vein and the left internal and external carotid arteries were perforated. Damage to these blood vessels results in rapid blood loss which can rapidly progress into clinical deterioration and death. Dr Fronczek noted a pale spleen and thyroid which were in keeping with severe blood loss. the stab wound to the

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.

right side of the chest also perforated the right pleural cavity and right lung which would have caused the right lung to collapse (pneumothorax), limiting respiratory function.

29. In relation to the other stab wound, and the multiple incised wounds, no vital structures were damaged, such as large blood vessels or vital organs. However, Dr Fronczek explained that blood loss associated with these injuries may have contributed to the death.
30. There were multiple linear and irregular abrasions on the head, neck, upper chest and left arm. These were consistent with superficial contact (scratches) with the end of a sharp implement.
31. There were also several sharp force injuries located on the hand. Given their location, Dr Fronczek opined that they were suggestive of so-called ‘defence wounds’, as they can be sustained in the act of warding off an attacker.
32. Dr Fronczek was unable to determine the order in which the sharp force injuries were sustained. She noted that estimates for the survival time after infliction of stab wounds are extremely difficult to give. She explained that a person with injuries as observed in this case does not necessarily die immediately and may be able to act and move for a considerable amount of time.
33. There were scattered bruises on the arms and legs which were the result of non-specific blunt force trauma such as falling, being hit, or being held. These were not related to the cause of death.
34. Toxicological analysis of post-mortem samples identified the presence of mirtazapine².
35. Dr Fronczek provided an opinion that the medical cause of death was 1(a) Stab wounds to the neck and chest.
36. I accept Dr Fronczek’s opinion as to the medical cause of death.

Circumstances in which the death occurred

37. In early-2022, BAQ disclosed to a friend that “*the word ‘divorce’ [was] being thrown around quite a bit at home at the moment*” but also told the same friend that his relationship had improved once EYR returned to work. In February 2022, one of EYR’s friends formed the view that EYR and BAQ were not happy in their relationship, particularly as EYR explained

² Mirtazapine is indicated for the treatment of depression.

that she needed to make legal arrangements to ensure that BAQ could not claim ownership of any home her mother purchased in Melbourne (which she was considering at the time).

38. About one month prior to the fatal incident, MLH stated that during a video-call with BAQ and EYR, BAQ told EYR to ask MLH if she had seen a video on TikTok about a woman who was being held captive in a room with a metal chain around her neck by the husband. BAQ asked EYR to translate the video for MLH, and MLH felt “*weird*” that he asked her about the video. MLH also recalled that she felt “*shocked and terrified*” about the video and was concerned about BAQ’s mental health.
39. On the evening of 30 April 2022, EYR, BAQ and their son were all at their residence. EYR spoke to MLH via a video-call communication platform at about 5.30pm for a few minutes, while BAQ left the house to purchase dinner. EYR had another video-call with MLH later that evening, lasting about 77 minutes. EYR had dinner with BAQ while on the video-call with her mother, however BAQ was not in view during that time.
40. BAQ spoke to his sister for about 10 minutes at 7.30pm. BAQ’s sister did not recall anything unusual about their phone call.
41. At about 9.30pm, neighbours first heard loud sounds emanating from EYR and BAQ’s unit. From 9.46pm to 10.00pm, neighbours heard EYR again, this time with her voice escalating in volume and concern. Neighbours heard her screaming and crying and saying “*help*”, “*please stop*”, “*please help me*” and “*I’m sorry*” on several occasions. A neighbour also heard BAQ assertively saying “*stop*”, “*get down*” and “*shut up*”.
42. At 10.02pm, two neighbours exited their homes after hearing EYR screaming. They met in the shared driveway of the block of units where EYR and BAQ lived. One of the neighbours knocked on BAQ and EYR’s window and called out BAQ’s name. That neighbour also heard EYR yell “*help me, help me, he’s trying to kill me*”. The other neighbour called Triple Zero to request police attendance. EYR’s screaming started inside the house, however later moved to the backyard, where it ceased.
43. BAQ called Triple Zero at 10.14pm. He told the Triple Zero call-taker that he and EYR had an argument, that EYR had “*mental health issues*”, that she had beaten him and had “*taken a knife*” and “*we both stabbed each other*”.
44. Police arrived on scene at 10.26pm where they located EYR lying unresponsive in the backyard. A neighbour was performing cardiopulmonary resuscitation (**CPR**) on EYR. Police

arrested BAQ at the scene. He told police that he and EYR were both armed with knives and that she tried to assault him. Paramedics also attended the scene and attempted to revive EYR; however, she died of her injuries at the scene.

45. Police interviewed BAQ who explained that he had a conversation with EYR which turned into an argument about childcare arrangements for their child. BAQ alleged that EYR raised her voice and became angry. He claimed that EYR spat in his face and beat him around the ears, and in response he tried to restrain her. The argument started upstairs, however the pair moved downstairs and continued the argument, where BAQ alleged that EYR armed herself with a knife, so he did the same. This resulted in a physical altercation, during which BAQ alleged that EYR bit him on the arm. The altercation moved out of the kitchen and into the backyard, where BAQ realised that EYR had sustained serious injuries. BAQ did not explain how EYR sustained those injuries. During the subsequent criminal prosecution, BAQ conceded that EYR did not attack him with a knife.
46. After the interview, BAQ was examined by a clinician from the VIFM which identified small red lesions behind his right ear, bruising around the chest and arms, a possible bite mark on the left forearm and incised wounds to the hands and left calf.
47. BAQ was charged with EYR's murder and pleaded guilty at the first committal mention on 13 September 2022. He was sentenced to 24 years' imprisonment with a non-parole period of 17 and a half years.
48. As part of the sentencing process, BAQ was assessed by a forensic psychiatrist who noted BAQ's personality style is marked by distinctive personality features which include a strong work ethic and significant obsessional traits amounting to sub-clinical "*personality difficulties*". The psychiatrist observed that these traits have a potential "*dark side*", one that ultimately rendered BAQ vulnerable to significant psychiatric difficulties when faced with immense and sustained stress. The report also noted that by late-2021, BAQ was diagnosable with adjustment disorder with depressed mood and suggested that this disorder contributed to the offending.

CPU REVIEW

49. As EYR's death occurred in circumstances of family violence, Judge Cain requested that the Coroner's Prevention Unit (CPU)³ examine the circumstances of EYR's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD)⁴.
50. I make observations concerning service engagement with EYR and her family as they arise from the coronial investigation into his death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and EYR's death.
51. 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*".⁵ I make observations about services that had contact with EYR and her family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

History of family violence

52. During the criminal proceedings, the prosecution did not allege that BAQ had a history of perpetrating family violence against EYR. Although EYR was noted to be a private person, the available evidence suggests that EYR *did* experience family violence in her relationship with BAQ, including emotional, psychological and physical abuse. Some examples of this alleged abuse are listed below. I note for clarification that not all services involved with EYR and BAQ were aware of the full extent of these allegations at the various times they engaged with EYR and/or BAQ. The below list is derived from all of the available records.

- a) MLH described BAQ as "*a very controlling person*" in the context of describing EYR's relationship with BAQ.

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.

⁵ *Adameczak v AlSCO Pty Ltd (No 4)* [2019] FCCA 7, [80].

- b) After her grandson was born, MLH noted that BAQ was very critical of EYR, and that BAQ argued with her in a “*fierce*” and “*very loud*” manner.
- c) EYR was afraid of BAQ and attempted to record him at times due to this fear.
- d) EYR told a psychologist that after her March 2021 hospital admission, BAQ screamed and swore at her, including in front of their child, which was why she recorded him.
- e) EYR disclosed to mental health clinicians that BAQ was aggressive and physically intimidating, including punching walls, banging on the bed, damaging property and making a lot of noise.
- f) EYR disclosed verbal abuse by BAQ to her MCHN.
- g) Around the time of the March 2021 admission, BAQ reportedly intervened to prevent EYR from transferring several thousand dollars to her mother and her aunt. BAQ alleged that this was related to EYR’s mental illness, while EYR alleged that she was “*scared for her safety*”. MLH stated that BAQ removed EYR’s phone from her and closed their joint bank account as a result. EYR later disclosed to her psychiatrist that BAQ would not permit her to access their bank accounts.
- h) In April 2021, EYR told her psychiatrist that BAQ would not allow her to drive, would not allow her to take their son out in the car, or go outside with their son when he was at work.
- i) Additionally in April 2021, EYR told her psychologist that BAQ would not let her settle their son at night. In response, BAQ alleged that EYR was “*close to relapse*”, which the psychologist interpreted as BAQ’s “*tactics to brainwash*” EYR.
- j) BAQ referred to EYR as “*close to relapse*” on another occasion, in relation to a disagreement the pair had about how to dress their son. He expressed his frustration that EYR would not adhere to his “*scientific*” opinion. The psychologist’s view at the time was that EYR was recovering well and that the disagreement was due to EYR and BAQ’s differing world views, rather than EYR’s mental ill-health.
- k) In April 2021, the couple’s relationship counsellor suggested that BAQ’s behaviour made EYR feel “*controlled*” and referred to it as “*situational abuse*”.

- l) In May 2021, EYR's psychologist "*noted some elements of emotional/psychological abuse*" by BAQ.
- m) In late-2021, EYR told her psychologist that BAQ would not permit her to feed their son and would not permit her to take their son to visit family overseas. BAQ also refused to allow MLH to stay in their home during any future visits, despite EYR being "*desperate*" to see her mother.
- n) In early-2022, MLH reportedly witnessed (via video-call) BAQ speaking to EYR in a "*very fierce*" and "*loud*" manner. She believed her grandson was terrified at the time.
- o) On 9 February 2022, EYR told her psychologist that she was "*worried that she'd gained weight through the medication*" and that she was "*upset because BAQ didn't like her being overweight*".
- p) On 30 March 2022, EYR disclosed to her psychologist that BAQ "*had 'put' her up against a wall*" during an argument. The psychologist's notes refer to BAQ being "*angry*" and "*aggressive*".
- q) On an unknown date, EYR reportedly told her cousin that if anything happened to her by BAQ, that her cousin should call police.
- r) Following the fatal incident, BAQ alleged that EYR assaulted him on a few occasions, during arguments.
- s) BAQ maintained notes on his phone in relation to his relationship with EYR, which are suggestive of controlling behaviours by BAQ.
 - i. On 22 April 2021, BAQ alleged that EYR tried to snatch their son away from him during an argument, and she accused him of aggressively pushing her away. BAQ alleged that EYR "*almost dropped [son] when [BAQ] had stopped her driving in an agitated state a few weeks ago*".
 - ii. Additionally on 22 April 2021, BAQ alleged that he became angry when he discovered EYR was recording him. He took her phone and "*demand[ed] to know/see how often she had been recording me*". There was a physical struggle "*as EYR tried to take back phone without answering my questions*". He stated that he accidentally stepped on EYR's foot and immediately apologised. BAQ alleged that EYR threatened to call police, took his phone and "*intentionally*

stepped on [his] foot in return". EYR and BAQ both had bruised feet as a result of the incident. EYR took a photo of her foot and BAQ *"made it clear her behaviour was increasingly threatening to me and that her concern over [their son's] warmth is not entirely different to what led to her psychotic breakdown"*. BAQ finally noted that EYR had made allegations about his care of their son and that he *"needed to get this on the record to protect [him]self and him"*.

- iii. On 21 August 2021, BAQ documented the actions he had taken to support/care for EYR and their son which included *"Didn't get angry when [their son] was almost sleeping on you"*. He also stated, *"You think I started it and can't control myself but you're the one calling your mental health case manager"*, *"Your decision making is compromised Your situation is affecting this family"*.
- iv. On 15 November 2021, BAQ recorded his *"goals"* including regaining his trust in EYR and working *"on anger and emotional well being [sic]"*.

EACH

- 53. EYR engaged with EACH for birth trauma counselling from February to May 2021. There were no disclosures of family violence, nor indicators of same.

Maternal and Child Health Nurse

- 54. As noted above, EYR attended her MCHN on 15 March 2021 after BAQ raised concerns about her mental health. The MCHN recorded that they asked EYR *"MARAM⁶ questions"*, however did not record EYR's answers. The records show that EYR may have been disoriented at the time, and she may have struggled to answer some of the questions. The MCHN contacted the CATT and advised that EYR *"denied FV although alluded to power and control"*. Prior to this date, it does not appear that MCHN identified any concerns about family violence.
- 55. On 22 March 2021, the MCHN spoke to the Maroondah Hospital social worker who discussed *"EYR's FV concerns"*, including *"BAQ being aggressive/verbally abusive in the home"*. The MCHN noted that in her view, EYR was a very loving and appropriate carer, and that her son was healthy.

⁶ Multi-Agency Risk Assessment and Management (**MARAM**) framework.

56. Upon EYR's discharge from Maroondah Hospital, the social worker provided a handover to the MCHN, however family violence was not referenced in the records of this discussion.
57. The family were involved with the enhanced MCHN (**EMCHN**) from March to May 2021, then were discharged back to the regular MCHN service. The available records indicate that EYR and BAQ attended all EMCHN and MCHN appointments after EYR's hospital admission. The records reflect that there was some "*tension*" in the marriage, however the couple reported that their relationship was "*going well*" in May 2021.
58. Based upon a review of the records, the (E)MCHN provided EYR with a responsive and supportive service, particularly while she was acutely unwell in March 2021. However, I note that given she struggled to answer the MARAM questions on 15 March 2021, a further follow-up risk assessment may have been warranted, particularly as there are no records to suggest that the Maroondah Hospital social worker spoke to the MCHN about family violence again after 22 March 2021. At the relevant time, MCHNs were prescribed under the MARAM and therefore were (and are) required to carry out family violence risk assessments.
59. Given that BAQ was present at all MCHN appointments from March 2021 until the fatal incident, it may have been prudent for the MCHN to attempt to see EYR individually, in order to enquire about family violence. I note that EYR was a very private person and therefore may not have disclosed any family violence. Nevertheless, it may have presented an additional opportunity to explore issues of family violence and offer support to EYR.
60. When provided with an opportunity to respond to these concerns, Maroondah City Council (the entity responsible for EYR's MCHN service) advised that they did not wish to add any further information or provide a response.

Maroondah Hospital – Eastern Health

61. As noted above, EYR was admitted to the Maroondah Hospital Psychiatric Unit from 15 to 24 March 2021. She made several disclosures to staff relating to BAQ perpetrating family violence against her, including verbal abuse, aggression, and property damage (including punching walls).
62. On 22 March 2021, the hospital's social worker contacted EYR's MCHN and updated her on "*EYR's FV concerns – BAQ being aggressive/verbally abusive in the home*". The MCHN stated that they "*had begun to explore this [with] EYR shortly before admission*".

63. The social worker met with EYR for the first time one day prior to her discharge (23 March 2021). During this conversation, the social worker noted that EYR was “*mildly guarded or suspicious on occasion*” and “*did not share more than she was directly asked*”. EYR consented to an EMCHN referral, stated that she wanted to talk to BAQ about the referral, and that she was content for BAQ to be involved in her care.
64. The social worker documented that they discussed the concerns raised in relation to family violence, and that “*EYR discussed the trauma BAQ had experienced (death of brother/trauma of watching birth) & framed these arguments more so as differences in their communication styles*”. The social worker also noted that EYR “*confirmed she is not afraid of BAQ*”. The social worker asked EYR about her concerns regarding BAQ allegedly abusing their son, and EYR replied that she could not recall exactly what her concerns were, but that she no longer had any concerns about BAQ’s care of their son. The social worker did not make any further records with respect to EYR’s disclosures of family violence.
65. Prior to EYR’s discharge from hospital, the social worker ensured an EMCHN referral would be completed and provided the MCHN with an update. However, there was no mention of family violence in the record of the handover. The social worker also provided a written handover to Mitcham Private Hospital, including records of the contact between CATT and the MCHN on 15 March 2021, which references possible “*power and control*” issues “*alluded*” to by EYR.
66. I note that staff did not perform a family violence risk assessment, upon EYR’s disclosure of family violence. Additionally, it may have been prudent for the social worker to offer EYR information about family violence services, and to consider following up with her about her disclosures to other services, as part of her discharge planning.
67. I note, however, that this may have been challenging, given that the social worker only met with EYR on the day before her discharge from hospital, when she was noted to be guarded and suspicious. Furthermore, the MARAM framework was not yet implemented across Eastern Health at the time.

Procedural fairness response

68. In response to the concerns that Eastern Health did not perform a risk assessment and did not provide EYR with information about family violence services, Eastern Health made the following submissions:

- a) EYR denied any ongoing family violence concerns when she was reviewed by a social worker on 23 March 2021.
- b) EYR confirmed she was not afraid of her husband.
- c) The social worker documented the concerns raised by EYR and liaised with the MCHN.
- d) EYR was being transferred to another health service for ongoing management and support.
- e) The MARAM framework had not yet been implemented at Eastern Health at the time, and compliance with that framework was not yet required by legislation.

69. I acknowledge the circumstances in which EYR's admission occurred, as highlighted by the submissions above.

Changes implemented at Eastern Health

- 70. Eastern Health noted that since EYR's admission, there have been significant changes to legislative requirements, organisational policies and clinical practices in relation to family violence. Eastern Health provided a statement outlining these changes and how the service identifies and responds to family violence in 2026.
- 71. Since the implementation of MARAM, Eastern Health has implemented a range of measures to align with the framework. This includes mandatory staff training, family violence risk assessments, safety planning processes, referral pathways and information sharing processes. All Eastern Health staff are required to complete MARAM training that is appropriate/specific to their role. In addition to mandatory training, staff also undertake ongoing education and refresher training. Topics for ongoing education/refresher training includes family violence identification, screening, risk assessment and referral pathways.
- 72. Eastern Health has also implemented and maintained policies and guidelines in relation to:
 - a) Family violence identification and response;
 - b) Family violence risk assessment and safety planning;
 - c) The Family Violence Information Sharing Scheme (**FVISS**) and the Child Information Sharing Scheme (**CISS**); and

d) Referral pathways for victim-survivors.

73. Eastern Health explained that if staff have concerns that a patient may be experiencing family violence, they are expected to undertake sensitive inquiries in accordance with the organisation's policies. This may include speaking with the patient privately, asking about the patient's safety and wellbeing in a sensitive manner and responding in a supportive and non-judgmental way.
74. If Eastern Health staff identify that family violence is occurring (or it is disclosed), they are expected to identify any relevant risk factors, perform a MARAM risk assessment and undertake safety planning. The purpose of these actions is to assess risk, support patient safety and determine the appropriate referral/support pathways.
75. Following assessment, staff may undertake safety planning, provide information about relevant support services and facilitate referrals to internal or external services. Depending upon the patient's circumstances and needs, this may include a referral to Safe Steps, The Orange Door, mental health services and other supports.
76. If a patient does not consent to a risk assessment, safety planning or referral, staff are still expected to consider identified risks and determine whether any further action is required. This includes consultation with specialist services or information sharing, where authorised.
77. The Eastern Health framework promotes collaboration and information sharing with relevant internal and external service providers, where appropriate and lawful. Communication may occur with a patient's GP, MCHN, psychologist, family violence service provider and other prescribed entities under the FVISS/CISS.
78. I note the significant changes that have occurred at Eastern Health since EYR's presentation, and I am satisfied that no further recommendations are required.

Murrnong Continuing Care Team (MCCT)

79. EYR engaged with MCCT from 7 April to 18 November 2021. At the time of discharging EYR, the MCCT staff assessed that EYR's mental health had significantly improved and that BAQ was "*very supportive*" of her. The records provided to the Court do not include any indication that MCCT were aware of EYR's previous disclosures of family violence, nor that she disclosed family violence while engaged with them. I have not identified any deficiencies with MCCT's contact with EYR.

Private psychiatrist

80. EYR engaged with a private psychiatrist while admitted to Mitcham Private Hospital from 24 to 29 March 2021, and then as an outpatient at Mitcham Private Consulting Suites. The psychiatrist discharged EYR from his care on 6 April 2022, a few weeks prior to the fatal incident.
81. In March 2021, Maroondah Hospital sent a handover to Mitcham Private Consulting Suites, including records of the contact between CATT and MCHN, which referenced possible “*power and control*” issues “*alluded*” to by EYR.
82. On 7 April 2021, EYR and BAQ attended an appointment with the private psychiatrist. During this session, EYR referred to “*relationship issues and conflict due to cultural issues between the couple*”. EYR also noted that BAQ “*would not let her drive or access their bank accounts*”. The psychiatrist stated that at this time “*the couple agreed on gradual steps for the relationship to revert to normal*”. His records reflect that he discussed with EYR and BAQ “*EYR accessing her account (but with limit), slow access (in a compromised way)*”.
83. On 14 April 2021, EYR and BAQ again “*reported ongoing disagreements around parenting styles and EYR’s illness*”. On 12 May 2021, the psychiatrist recorded that there had been “*some aggressive interaction*” between the couple.
84. Despite the above indicators of possible family violence, the psychiatrist did not record completing a family violence risk assessment and did not ask EYR about family violence. Given that EYR attended several appointments on her own, it appears that there were opportunities to ask her about her experiences.
85. I note again, as above, that EYR was a private person who did not often speak about her relationship with friends or clinicians, however it would appear that this was a missed opportunity to assess the level of risk BAQ posed to EYR and offer her supports.
86. As a matter of procedural fairness, the Court wrote to the private psychiatrist to provide them with an opportunity to respond. The private psychiatrist noted that they have started to use the MARAM tool in their private inpatient work but otherwise had no other comments or submissions.

First private psychologist

87. EYR attended seven sessions with a private psychologist between 10 April and 18 June 2021. BAQ attended four of those sessions in full, and part of the final session. During the course of her engagement with the psychologist, EYR disclosed family violence perpetrated by BAQ against her. This included shouting and swearing at her, including in front of their son, physical intimidation including banging on things and making a lot of noise, and controlling behaviours such as not permitting her to settle their son at night, take their son out in the car or go outside with him while BAQ was at work. EYR repeatedly disclosed that she was fearful of BAQ at times and said that she often recorded him because she was afraid.
88. The psychologist documented that BAQ “*use[d] tactics to brainwash*” EYR during disagreements, particularly suggesting that EYR was “*close to relapse*” when they disagreed about parenting matters. The psychologist documented her conclusion that EYR felt controlled by and was fearful of BAQ.
89. Upon a review of the psychologist’s records, it is positive to note that she was the only mental health professional involved with EYR that identified that family violence was occurring. Consequently, the psychologist challenged BAQ’s apparent weaponisation of EYR’s mental health as a method of control in at least one session with the couple. The psychologist also focused on “*immediate safety*” including by working on “*basic conflict management strategies*” with the couple with respect to their “*significant challenges in conflict management*”.
90. The psychologist also engaged in information sharing, albeit in a limited fashion. In a letter to EYR’s GP, the psychologist communicated that she had noted “*some elements of emotional/psychological abuse*” by BAQ, but asked the GP to keep this confidential, noting that they had commenced couples’ counselling to address this issue and that BAQ had shown an “*intention to support wife and address issues*”. Unfortunately, EYR disengaged from the psychologist’s care shortly thereafter.
91. Although there were several positive aspects of the psychologist’s treatment, I note that the psychologist also used mutualising language when referring to the family violence with EYR and BAQ’s relationship. For example, the psychologist’s notes demonstrate that she told the couple “*you are both engaging in couple violence*”. According to the MARAM, when cross-accusations of abuse are made, professionals must take steps to identify the predominant aggressor, rather than using mutualising language. Using mutualising language risks undermining the safety of the victim-survivor and colluding with the predominant aggressor.

92. I also note that the psychologist did not engage in family violence risk assessments and safety planning with EYR. EYR attended her sixth appointment and part of her seventh appointment alone, during which time the psychologist could have engaged in risk assessments and safety planning.
93. As a matter of procedural fairness, the Court wrote to the private psychologist to provide them with an opportunity to respond. The psychologist advised that they did not wish to file a response.

Second private psychologist

94. EYR attended six sessions with a different psychologist between 15 September 2021 and 30 March 2022 and attended all sessions on her own. The psychologist's records include indicators and disclosures of family violence, some of which are discussed below.
95. On 19 October 2021, EYR disclosed that she was worried about whether her son was eating enough and stated that she wanted to feed him, but that "*BAQ had to feed him*", which was a "*point of conflict*" for them. The psychologist stated that they discussed how EYR and BAQ worked through arguments, and EYR said that they "*talked it through*" and that BAQ was "*coping with her better*".
96. On 10 November 2021, EYR told the psychologist that things were improving as the COVID-19 lockdown in Victoria had ended and she was able to get out of the house to socialise. EYR explained that she and BAQ had argued that morning as "*[s]omebody was checking emails*". EYR reiterated that she and BAQ always "*talk[ed] their arguments through*".
97. During the 10 November appointment, EYR referred to a previous argument with BAQ about a female friend of whom EYR was jealous. The psychologist stated, "*I think it wasn't uncommon for them to argue about this issue*". EYR also advised that she was trying to arrange for MLH to come to Australia, however she would need to stay elsewhere as BAQ "*wasn't happy about her staying in the house*". EYR noted that this was a "*point of contention*" and that instead of her son travelling overseas, the "*resolution was that [MLH] would come to Australia*".
98. On 9 February 2022, EYR told the psychologist that she was "*worried that she'd gained weight through the medication*" and that "*she was upset because BAQ didn't like her being overweight. She said that she was swimming and walking the dog to try to lose weight*". She disclosed that there was tension around certain topics regarding their son, for example his

sleeping and eating habits, and EYR avoided conversations about these issues in front of their son.

99. During her last appointment on 30 March 2022, EYR reported “*no more depressive symptoms*” and said she was no longer worried about her son’s eating. She reported that BAQ had “*anger issues with his own dad*”. She disclosed a “*big fight*” with BAQ, which the psychologist believed “*wasn’t a recent fight*”. EYR alleged that during this fight, BAQ “*had ‘put’ her up against a wall*” while their son was asleep. EYR said in response that she “*shutdown*” and went to her bedroom. EYR also disclosed that BAQ “*could get aggressive and angry at times*”. The psychologist noted “*I don’t know if this was in general or just in relation to this specific fight*”. The psychologist noted in her statement to the Court that she was surprised about this disclosure, as it was their last session and EYR had not mentioned it before. After killing EYR, BAQ denied that this incident occurred.
100. EYR further explained that when she and BAQ argued, she preferred to have space and to remove herself, while “*BAQ doesn’t like this and needs her to stay in the room and talk it through*”. The psychologist’s statement noted in relation to this that “*she [EYR] didn’t look scared or anything. It was just how they resolved conflict*”.
101. In response to the above disclosure, the psychologist suggested that the pair might have couples’ counselling “*so that they could resolved conflict*”. EYR and the psychologist agreed that she did not require any further sessions with the psychologist (in a one-on-one capacity). The psychologist noted that EYR still had “*communication issues*” with BAQ, however “*she wasn’t coming to me [the psychologist] for that issue*”.
102. Based on a review of the psychologist’s records, it appears that there were multiple indicators and disclosures of family violence through EYR’s engagement with her. In my view, this should have warranted family violence screening and a risk assessment, particularly having regard to EYR’s allegations of physical violence during her last appointment. Unfortunately, the psychologist described issues in the relationship as “*communication issues*”, which she did not view as relevant to her contact with EYR.

Procedural fairness response

103. As a matter of procedural fairness, the Court wrote to the private psychologist to provide them with an opportunity to respond. The psychologist provided a statement, outlining her treatment of EYR throughout the six sessions.

104. The psychologist noted that she encouraged EYR to talk and engage with the process. She tried to “*draw EYR out*” by talking about her son, for example, his likes and dislikes. The psychologist noted that over time, EYR opened up slightly. She raised issues about feeding her son and wanting to feed him more, which was a point of contention with BAQ. The psychologist did not interpret this to be an issue of coercive control by BAQ and noted in her experience of clients with psychosis and post-natal depression that the issue of feeding children is not uncommon.
105. The psychologist noted that EYR disclosed an argument with BAQ in November 2021 due to EYR checking BAQ’s emails. EYR also disclosed communication issues with BAQ, but that they had been able to work through them.
106. At her last session, EYR reported successfully weaning off her medications and that she felt good. She presented as happy and in good spirits. She noted that she and BAQ’s arguments over small issues had reduced. EYR noted ongoing conflict in relation to childcare arrangements as EYR wanted to work an extra day per week and BAQ did not want her to do so. EYR disclosed a “*previous big fight*” where BAQ had “*pushed her against a wall*”. The psychologist noted that “*this was confusing to [her] as [EYR] had never raised any concerns with him previously or any anger issues or feeling unsafe*”. The psychologist noted that EYR’s demeanour was otherwise good and she did not otherwise appear afraid or upset.
107. The psychologist otherwise noted that she had not been provided with any prior information that there had been incidents of family violence. However, in light of the documentation provided by the Court, the psychologist noted that there appeared to be a history and pattern of abuse by BAQ. The psychologist noted that if she had been aware of this history, she would have acted differently. For example, she would have asked EYR if she felt safe, would have encouraged her to speak to family violence support services and/or going to the police to obtain a Family Violence Intervention Order.
108. The psychologist otherwise noted that she received previous family violence training while working as a case manager. She also noted her experience as a psychologist working with and supporting clients who are currently or previously involved in abusive or dangerous relationships. She noted that she continues to support these clients to recognise abusive behaviours and patterns in their relationships and to assist them with their safety.

BAQ’s private psychologist

109. BAQ attended three sessions with a psychologist between 25 June and 17 November 2021. During this time, the psychologist concluded that BAQ was experiencing “*anxiety, anger sadness and grief centred around the traumatic birth*” of their son.
110. The psychologist’s records include:
- a) EYR would often accuse BAQ of abusing their son.
 - b) BAQ said his in-laws “*are often suspicious towards him*”.
 - c) BAQ was interested in pursuing support with anger management.
 - d) BAQ believed he inherited his anger from his father.
 - e) BAQ said that his anger did not surface very often “*but when it strikes I escalate quickly in raising my voice and my mood goes dark*”.
 - f) When asked about his dark mood, BAQ said “*I go quiet but feel full of rage*”.
 - g) BAQ was experiencing anger and anxiety, specific to his relationship.
111. On 3 November 2021, the psychologist also documented “*Verbally abusive when arguing (partner) – trust shattered*”. It is not clear whether this refers to verbal abuse by or towards BAQ, however on the same day, the psychologist documented one of BAQ’s goals as “*not becoming my dad*”.
112. It would appear that there were multiple indicators of family violence occurring in BAQ and EYR’s relationship and in my view, this warranted further consideration by the psychologist. I note the MARAM practice guidelines state:
- If you suspect a person is using family violence, you should not engage with them directly about family violence, unless you are trained or required to do so to deliver your service. This is because confrontation and intervention may increase risk for the victim survivor.*
113. The psychologist may not have had training on identifying or assessing family violence risk, as such training is not currently mandatory for private psychologists, and private mental health professionals are not prescribed under the MARAM.

114. As a matter of procedural fairness, the Court wrote to the private psychologist to provide them with an opportunity to respond. The psychologist advised that they did not wish to file a response.

Private mental health services identification and response to family violence

115. I note that the concerns identified above with respect to the ability for private psychologists and psychiatrists to identify and respond to family violence are not unique. Then-State Coroner, Judge Cain, previously noted concerns about private mental health clinicians in his Honour's findings into the deaths of William Heddergott⁷ and Samantha Fraser⁸.
116. As noted above, many of the clinicians involved with EYR and BAQ may not have had training on identifying and assessing family violence risk, as private mental health professionals are not prescribed under the MARAM, and family violence Continuing Professional Development (CPD) is not mandatory for private psychologists or psychiatrists in Victoria.
117. I note that in order to address family violence in the community, all health professionals must regard addressing family violence as part of their responsibility and be competent to do so. This includes health professionals who have historically seen family violence as beyond the scope of their role.
118. In Judge Cain's finding into the death of Samantha Fraser, his Honour recommended:

That measures be taken by the APS [Australian Psychological Society] and RANZCP [Royal Australian and New Zealand College of Psychiatrists] to introduce family violence mandatory CPD for registered psychologists and psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where a patient/client is identified as experiencing or suspected to be experiencing family violence.

119. In response, the APS advised that "it is not in the purview of the APS to mandate CPD requirements" but that it supported the provision of family violence CPD training to psychologists. The APS further noted that it "consistently produces CPD education on the

⁷ [Finding into death without inquest – William Heddergott \(COR 2020 6253\).](#)

⁸ [Finding into death without inquest – Samantha Fraser \(COR 2018 3600\).](#)

topic of intimate partner violence” and that it has a series of webinars in development on this topic for 2025.

120. The RANZCP response noted that they implemented this recommendation “*as feasibly possible within RANZCP structures*” after it was made in a previous finding. They advised that all RANZCP members can access their Family and Domestic Violence Learning Path online, which includes a non-mandatory module on family violence.
121. The Psychology Board of Australia (**PBA**), the national body responsible for the registration of psychologists supported by the Australian Health Practitioner Regulation Agency, also provided a response. The PBA stated that changes to Professional Competencies for Psychologists will be launched on 1 December 2025. These changes will mandate, under competency five, competency in risk assessment and management, including in situations of family violence. The PBA noted:

For Psychologists with general registration, they must complete a learning needs analysis against the professional competencies and develop an annual learning plan to maintain their individual scope of practice. The individual’s scope of practice is dependent on their work role. The CPD Registration Standard recognises and supports flexibility for practitioners to work across a variety of practice settings. For Psychologists working in settings where family violence is likely to be a component of a client’s presentation, the Professional Competencies for Psychologists are explicit in the expectation that Psychologists are competent to recognise, respond appropriately and refer on to specialist services.

122. The PBA’s response is positive; however, I note that pursuant to the MARAM practice guides, family violence is prevalent in all parts of our community. Therefore, it is likely to be a component of clients’ presentations in all settings. It is also likely to be relevant to all settings in which psychologists work, for example, research or organisational settings.
123. I also note that family violence is not explicitly referenced anywhere in the new professional competencies for psychologists, including in competency five, or in the definition of “*risk*” in the document.
124. I therefore intend to recommend that the PBA explicitly recognise, within the Professional Competencies for Psychologists, that competency in family violence risk assessment and management is relevant to all practice settings, and explicitly outline an expectation that all

psychologists practicing in Victoria are competent in family violence identification, assessment and management.

125. I also note that the Commonwealth Department of Health, Disability and Ageing have recently tasked the PBA with providing recommendations to redesign the higher education training pathway for psychology. The PBA is currently reviewing the higher education training pathway, and it is projected to finalise recommendations for redesign in November 2026. In my view, it would be prudent for the PBA to consider this finding as part of their review, as well as other findings that discuss this issue, including:

- a) Finding into the death of Samantha Fraser without inquest;⁹
- b) Finding into the death of William Heddergott without inquest;¹⁰
- c) Finding into the death of Alicia Little with inquest;¹¹
- d) Finding into the death of Fatima Batool without inquest.¹²

126. I will make a recommendation to the PBA to that effect. I also intend to recommend that the PBA include mandatory education on family violence identification, assessment and management in their recommendations to the Department of Health, Disability and Ageing on the resign of the psychology higher education pathway.

Systemic issues – misrepresentation of the drivers of family violence and the history of family violence in EYR and BAQ’s relationship

127. I note that BAQ’s sentencing remarks indicate that there was no evidence of family violence perpetrated by BAQ prior to the fatal incident, and the prosecution did not allege a history of family violence during the criminal proceedings. The sentencing remarks frequently reference BAQ’s post-offence forensic psychiatrist’s report, which is not uncommon for sentencing remarks. The forensic psychiatrist’s report thoroughly canvasses BAQ’s own narrative with respect to his relationship, EYR’s mental health, and his personality. However, there is no reference to any discussion with BAQ about his attitudes towards women and gender equality. I accept that this is often the case with forensic psychiatric reports, as the purpose of the report

⁹ [COR 2018 3600.](#)

¹⁰ [COR 2020 6253.](#)

¹¹ [COR 2017 6543.](#)

¹² [COR 2018 3266.](#)

is (often) to understand or determine whether there were any psychological aspects to the offence, for example, if the offender was experiencing psychosis at the time.

128. The forensic psychiatrist's report in the present case reflects a formulation that BAQ's murder of EYR occurred in the context of an "*uncharacteristic loss of self-control in the context of a cumulation of overwhelming stressors that had been building up for several years*". These stressors included work stress, the death of BAQ's brother, and BAQ's care responsibilities. Some of the media reporting at the time reflected this narrative.
129. The evidence suggests that while certain stressors may reinforce violence against women, and may escalate its frequency and severity, they do not drive violence against women.¹³ Men's attitude towards women and gender equality are the strongest indicator of their use of violent behaviour towards women.¹⁴ Our Watch makes this clear in their framework for the primary prevention of violence against women in Australia, which outlines the drivers of such violence as:
- a) The condoning of violence against women
 - b) Men's control of decision-making and limits to women's independence in public and private life
 - c) Rigid gender stereotyping and dominant forms of masculinity
 - d) Male peer relations and cultures of masculinity that emphasise aggression, dominance, and control.
130. Based on the evidence available to this Court, it would appear that there was evidence of BAQ perpetrating family violence against EYR. It is also apparent that there were missed opportunities in the months prior to EYR's death for mental health clinicians to better understand the family violence that was occurring and potentially intervene.

¹³ Our Watch, [Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia](#) (2nd ed, 2021), 76.

¹⁴ Family Safety Victoria, [MARAM Foundation Knowledge Guide](#), 55.

131. In order to address men’s violence against women, and to avoid narratives which perpetuate the myth of “*a good bloke*” being “*pushed too far*”, assessments of and public reporting on this violence must accurately reflect histories of violence and its gendered drivers.¹⁵
132. I make no criticism of the forensic psychiatrist who prepared the report for BAQ’s sentencing. However, in order to ensure that unhelpful narratives which perpetuate the above myths do not continue to be relied upon, I am of the view that changes could be made to the training provided to forensic psychiatrists. I intend to recommend that RANZCP’s Faculty of Forensic Psychiatry and Subcommittee for Advanced Training in Forensic Psychiatry develop training on the gendered drivers of family violence for forensic psychiatrists, having regard to Our Watch’s framework for the primary prevention of violence against women.

FINDINGS AND CONCLUSION

133. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was EYR, born [REDACTED];
 - b) the death occurred on 30 April 2022 at [REDACTED] Victoria 3136, from stab wounds to the neck and chest; and
 - c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

1. That the **Psychology Board of Australia** explicitly recognise, within the Professional Competencies for Psychologists, that competency in family violence risk assessment and management is relevant to all practice settings, and explicitly outline an expectation that all psychologists practicing in Victoria are competent in family violence identification, assessment and management.
2. That the **Psychology Board of Australia**, as part of their review and recommendations for the redesign of the psychology higher education pathway, review this finding and the following findings:

¹⁵ Family Safety Victoria, [MARAM Foundation Knowledge Guide](#), 55; Emma Buxton-Namisnyk and Anna Butler, ‘[Judicial discourse versus domestic violence death review: An Australian case review](#)’ in Adrian Howe and Daniela Alaattinoglu (ed), *Contesting Femicide* (Routledge, 2018).

- a) Finding into the death of Samantha Fraser without inquest;¹⁶
 - b) Finding into the death of William Heddergott without inquest;¹⁷
 - c) Finding into the death of Alicia Little with inquest;¹⁸
 - d) Finding into the death of Fatima Batool without inquest.¹⁹
3. That the **Psychology Board of Australia**, as part of their review and recommendations for the redesign of the psychology higher education pathway, that the PBA include mandatory education on family violence identification, assessment and management.
4. That the **Royal Australian and New Zealand College of Psychiatrists (RANZCP)**'s Faculty of Forensic Psychiatry and Subcommittee for Advanced Training in Forensic Psychiatry develop training on the gendered drivers of family violence for forensic psychiatrists, having regard to Our Watch's framework for the primary prevention of violence against women.

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

¹⁶ [COR 2018 3600.](#)

¹⁷ [COR 2020 6253.](#)

¹⁸ [COR 2017 6543.](#)

¹⁹ [COR 2018 3266.](#)

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:

MLH, Senior Next of Kin

Eastern Health (C/- Meridian Lawyers)

Psychology Board of Australia

Royal Australian and New Zealand College of Psychiatrists

Detective Senior Constable David Martin-Alcaide, Coronial Investigator

Signature:



Judge Liberty Sanger, State Coroner

Date: 17 September 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.
