IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003659

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Catherine Alison Lynch
Date of birth:	6 August 1980
Date of death:	4 July 2022
Cause of death:	1(a) Mixed drug toxicity (alprazolam, clonazepam, diazepam, methadone, metoclopramide, mirtazapine, morphine, nitrazepam, ondansetron, oxycodone, tramadol)
Place of death:	66 Clarke Drive Gladstone Park Victoria 3043
Keywords:	Family violence; suicide; coercive control; private mental health services; controlling behaviour

INTRODUCTION

1. On 4 July 2022, Catherine Alison Lynch (**Catherine**)[1] was 41 years old when she died in circumstances suggestive of suicide. At the time of her death, Catherine lived with her mother, Maureen Lynch (**Ms Lynch**) and her maternal aunt in Gladstone Park, Victoria.

2. Catherine was the second child born to Ms Lynch and her first husband, Mr Lynch. She had an older brother. While Catherine was a child, Mr and Ms Lynch separated, and Catherine lived with her mother, while her brother lived with Mr Lynch.

3. Ms Lynch described her daughter as a lovely child who was never in trouble, loved sports, was well-liked by her peers and had a kind heart. Her brother described Catherine as a proud and loving aunt to his children and who often sent presents and care packages to him overseas.

4. After completing high school, Catherine studied nursing and later started working at the Northern Hospital as a nurse. She worked at Northern Health for the entirety of her career, in various departments.

5. Catherine's first two long-term relationships were noted to be positive and loving relationships. However, from about 2014 or 2015 until 2018, Catherine was in a relationship with a man who was reportedly very controlling of her.

6. Ms Lynch first observed mental health issues in her daughter after the end of her second long-term relationship. Catherine's medical history included borderline personality disorder, major depressive disorder, post-traumatic stress disorder (**PTSD**), and suicide attempts.

7. In 2018, Catherine had a medication overdose in the context of relationship stressors. Her medical records refer to this incident as a suicide attempt, however Catherine described it as a desire to sleep and manage anxiety and denied it was a suicide attempt. Following the 2018 incident, Catherine had a lengthy admission to the intensive care unit and sustained an acquired brain injury (**ABI**). This impacted her memory, mobility and ability to write. Due to the ABI, she was unable to work as a nurse for some time, while the Australian Health Practitioner Regulation Agency (**Ahpra**) investigated her ability to practice. In the months prior to her passing, she was able to start working again, taking phone calls for a COVID-19 hotline.

[1] Referred to throughout my finding as 'Catherine' unless more formality is required.

8. Catherine's psychiatrist diagnosed her with persistent depressive disorder, borderline personality disorder, and after her ABI, neurocognitive disorder.

Relationship with Mr TT

9. In 2019, Catherine met a man (hereinafter referred to as **'Mr TT'**)[1a] while he was working as a registered nurse at the Royal Talbot Rehabilitation Centre (**RTRC**), operated by Austin Health. Catherine was receiving treatment at the RTRC in relation to her ABI.

10. When their relationship commenced, Mr TT was still married to his wife, who was also an employee at RTRC. His wife notified Austin Health, and they terminated his employment. Ahpra subsequently commenced an investigation into Mr TT. As of October 2025, the information before me is that the Ahpra investigation and subsequent Victorian Civil and Administrative Tribunal proceedings are due to be finalised following a final hearing scheduled in April 2026.[2]

11. While in a relationship with his former wife, Mr TT reportedly perpetrated family violence against his wife and their two children. These allegations included physical violence and threats. Mr TT alleged that his former wife fabricated these allegations when they separated. Child Protection received five reports about Mr TT, one of which resulted in protective intervention in relation to alleged physical abuse perpetrated by Mr TT against his children.

12. From a review of the available records, it appears that Catherine and Mr TT had differing views about the status of their relationship. Catherine sometimes referred to him by name, and other times she referred to him as a 'friend' or by a nickname. When speaking to services, Catherine referred to Mr TT as a 'friend' and outlined her frustrations at his lack of respect for her boundaries. She did not live with him and told him that she would not marry him if he

[1a] I have referred to this man as 'Mr TT' in the published version of my finding. I have <u>not</u> made a formal pseudonym order. My reasons for referring to the man as 'Mr TT' in my published finding include: (i) the present finding contains reports of family violence allegedly perpetrated by Mr TT against his wife and children, resulting in Child Protection intervention, and using his actual name may risk identifying them, which may in turn risk compromising their privacy, wellbeing and/or safety in circumstances where they have not been consulted about publication, triggering considerations under, *inter alia*, s 8(e) of the Act; and (ii) there are currently Ahpra proceedings on foot against Mr TT that I am advised will not finalise until April 2026, and I do not wish to risk compromising any aspect of those proceedings through use of Mr TT's name in my published finding (regardless of the fact that he may in fact ultimately be named in the Ahpra proceedings). Further, I am satisfied on the balance of probabilities that references in the coronial brief to Mr TT's nickname[s], which are contained in the coronial brief in numerous places and also referred to in this finding, are references to this same man.

[2] I have further confirmed with Ahpra its view that the finalisation of the coronial proceedings will not adversely impact that of the disciplinary proceedings against Mr TT and note for completeness that it is beyond the coronial jurisdiction to make any sort of comment in relation to the same (*see for example* s 69 of the Act).

asked. Catherine's friend of more than 25 years provided a statement to the Court indicating that Catherine never referred to Mr TT as anything other than a friend.

13. In contrast, Mr TT told the Court that he was intending to propose to Catherine on a trip to the Gold Coast that was planned for a few days after she passed. He alleged that Catherine wanted to have children with him and that they were planning to knock down and rebuild the home that she owned to live in together. He repeatedly noted that he was "*her faithful, dedicated, qualified, rehabilitation nurse partner*".

14. Victoria Police recorded Mr TT as Catherine's 'intimate partner' in its records.

History of family violence

15. Throughout the records and evidence provided to the Court, there are allegations of family violence perpetrated by Mr TT against Catherine including physical, sexual and psychological violence, including coercive control. Extracts from Catherine's diary (which sometimes referred to Mr TT by name; other times noted as 'he' or 'him') included:

    (a) Multiple references to Mr TT allegedly restricting her movement, including not allowing her out of a house, forcing her to attend events or forcing her to see him when she did not want to do so.

    (b) When Catherine attempted to manage Mr TT's controlling behaviour (e.g., by turning off her phone), Mr TT allegedly responded by attending her home and banging on a window.

    (c) Mr TT allegedly made threats to Catherine in front of his son, and threatened his son for intervening, stating, "*mind your own business [son's name] before I break your neck*".

    (d) Mr TT allegedly made threats to kill Catherine (including if she did not support his statement in response to a complaint to police) that he would slit her throat.

    (e) Catherine reported being fearful of the consequences of not doing what Mr TT wanted.

    (f) Multiple instances of jealous behaviour, including Mr TT posting on social media to find out the name of Catherine's male friend and stating that she was having sex with multiple men.

(g) Multiple alleged instances of Mr TT stalking Catherine.

16. Ms Lynch reported that Mr TT was obsessive and jealous towards her daughter, and she banned him from attending their home. Ms Lynch reported multiple instances of Mr TT attending her house (after being banned), yelling out the front of the house for Catherine to come outside, repeatedly calling Catherine and parking in the driveway and flashing his headlights.

17. Catherine's brother stated that Mr TT was physically and mentally abusive of Catherine and noted the numerous family violence intervention orders (**FVIOs**) in place to protect her. Catherine's brother reported that she feared for her life daily and tried to leave the relationship many times. Catherine's brother stated that Mr TT once stalked Catherine to San Remo while she was with a male friend, and he allegedly threatened them both. After her passing, Catherine's brother reported that Mr TT accessed Catherine's Facebook account to notify others.

18. One of Catherine's friends recalled Mr TT contacted her in 2020 with detailed messages explaining Catherine's ABI and other medical issues. Catherine's friend believed that this information would have only been available to Mr TT by virtue of his professional relationship with Catherine. Catherine's friend told Catherine, who confronted Mr TT about the invasion of privacy. He reportedly admitted to sending similar messages to other people.

19. The first FVIO issued by police to protect Catherine from Mr TT was issued on 18 June 2020 with limited conditions (not to commit family violence). Catherine was reportedly unsupportive of a full FVIO at the time.

20. On 4 March 2022, a final FVIO was granted against Mr TT and prevented him from committing family violence, damaging property, getting another person to breach the order and going within 200 metres of where Catherine lived/worked/attended school or childcare, unless invited in writing. The order permitted in-person contact at a neutral location (e.g., shopping centre or restaurant) and communication via phone/text/email.

21. On 24 April 2022, Catherine and Mr TT travelled to Sri Lanka together. Mr TT reported that he intended to obtain his family's blessing prior to him proposing to Catherine on an upcoming trip to the Gold Coast.

THE CORONIAL INVESTIGATION

22. Catherine'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.

23. 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.

24. 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.

25. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Catherine's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

26. A colleague of mine initially held carriage of the investigation into Catherine's death. I assumed carriage in July 2023 for the purposes of conducting additional investigative steps, finalising the case, and making findings.

27. This finding draws on the totality of the coronial investigation into the death of Catherine Alison Lynch 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.[3]

[3] 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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

28. In the months prior to her death, Catherine's diary contained entries to the effect that Mr TT was perpetrating significant verbal, emotional and psychological abuse against her, including by breaching the FVIO in place to protect her and encouraging her to take her own life. Catherine's entry dated 20 May 2022 read:

> *We argued the whole way home because I have no idea what I'm doing, you're a fucking cunt, you're a fucking bozo, dumb bitch, fucking dog, etc, etc. He actually dropped me straight home but called me after from a number I don't know and now its disappeared out of my phone. He told me to go home + OD and never wake up again.*

29. About two weeks prior to her death, Catherine visited her stepmother in San Remo, and they had lunch together at a pub owned by one of her brother's friends, Mr Say. Mr Say allegedly received threatening text messages from Mr TT based on Mr TT's apparent belief that Mr Say was in a relationship with Catherine. It is not clear how Mr TT obtained Mr Say's mobile number.

30. According to Mr TT, Catherine experienced a "*stint of depression*" in the 10 days prior to her death.

31. On 2 July 2022, Mr TT attended Catherine's home, called her to come out and allegedly banged on Catherine's window and Ms Hogan's bedroom window. Catherine relented and attended Mr TT's home, and Victoria Police were later called to attend. This attendance is canvassed in further detail below.

32. On 3 July 2022, Catherine borrowed Ms Hogan's vehicle to drive to Bunnings, however she crashed into a parked car near her home. According to Mr TT, Catherine called him after the collision and alleged that a family member verbally abused her about the collision. The family member stated that she spoke to Catherine after the collision and said she was disappointed in her. She noted that Catherine seemed very agitated and queried whether she was driving a different car because she was concerned about Mr TT stalking her.

33. Mr TT advised the Court that he called Catherine later that evening and she reportedly stated:

I want to die [Mr TT], I want to die, I wish I could kill myself [Mr TT], but I can't because there's no one to look after Brinson [Catherine's dog], [Mr TT] I just want to die, I can feel a massive mental breakdown coming on now, and I wouldn't be able to get over it.

34. Mr TT stated that Catherine later calmed down, however noted that the next day (4 July 2022) was the date of her late father's birthday.

35. On the morning of 4 July 2022, Ms Lynch walked into her daughter's room and observed Catherine lying on her side, facing the wall. Ms Lynch told her to get out of bed and Catherine responded "*yeah, yeah*". Ms Lynch did not think this was unusual at the time, she thought Catherine had taken her usual medication and was sedated from same.

36. Between 9.00am and 10.00am, Ms Lynch and Ms Hogan left the house to drive to a mechanic in Airport West. They intended to get Ms Hogan's car repaired, following Catherine's collision one day earlier.

37. When Ms Lynch and Ms Hogan returned home at about 1.00pm, they entered the house and located Catherine, unresponsive, sitting in a computer chair, in front of a computer, slumped forward and "*half on the ground*". Ms Lynch and Ms Hogan removed Catherine from the chair and placed her on the ground. Ms Lynch commenced cardiopulmonary resuscitation (**CPR**) while Ms Hogan called Triple Zero.

38. Fire Rescue Victoria (**FRV**) members attended the scene first. When they arrived, Ms Lynch observed six vials of medication (believed to be morphine) and an empty box of morphine on the kitchen bench. She collected all the vials and the empty box and presented them to the FRV members.

39. Paramedics attended shortly thereafter and confirmed Catherine had passed away. Police also attended the scene and investigated the circumstances of the death. Police observed eight glass vials of Physeptone (methadone) and numerous unused and empty blister packets of prescription medication including Dozile (doxylamine), Paxam (clonazepam), Xenical (orlistat), pregabalin, metoclopramide, mirtazapine, Phenergan (promethazine), and esomeprazole. Police did not identify any suspicious circumstances or evidence of third-party intervention in connection with the death.

40. Following the death, Mr TT provided the Court with a screenshot of a message from Catherine to a friend sent at 10.29am on 4 July 2022. Catherine stated she had been "*kicked out of home*"

for damaging the car and that "*they're [her family members] going to get a nice surprise when they get home*".

Identity of the deceased

41. On 4 July 2022, Catherine Alison Lynch, born 6 August 1980, was visually identified by her mother, Maureen Lynch.

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

Medical cause of death

43. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 7 July 2022 and provided a written report of her findings dated 14 July 2022.

44. The post-mortem examination revealed findings consistent with the reported circumstances.

45. Examination of the post-mortem computed tomography (**CT**) scan showed no abnormalities.

46. Toxicological analysis of post-mortem samples identified the presence of methadone,[4] oxycodone,[5] morphine,[6] tramadol,[7] alprazolam,[8] clonazepam and its metabolite 7-aminoclonazepam,[9] nitrazepam and its metabolite 7-aminonitrazepam,[10] diazepam and its metabolite nordiazepam,[11] mirtazapine,[12] doxylamine,[13] ondansetron[14] and metoclopramide.[15]

47. Oxycodone was detected at levels consistent with excessive use. Dr Parsons confirmed that the combination of drugs detected could cause death in the absence of other contributing factors. Information obtained from the Department of Health indicated that there was no permit to treat the deceased with methadone.

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[4] Methadone is equipotent to morphine as an analgesic but produces noticeable sedative effects with repeated administration due to its accumulation in plasma.
[5] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.
[6] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.
[7] Tramadol is a synthetic opioid analgesic indicated for moderate pain.
[8] Alprazolam is a triazolobenzodiazepine derivative indicated for some depression symptoms, panic attacks, panic disorder and agoraphobia.
[9] Clonazepam is a nitrobenzodiazepine indicated for the treatment of seizures.
[10] Nitrazepam is a sedative (hypnotic drug) of the benzodiazepine class.
[11] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[12] Mirtazapine is indicated for the treatment of depression.
[13] Doxylamine is an antihistamine agent and sleep-inducing agent.
[14] Ondansetron is indicated for post-operative nausea and vomiting due to cancer chemotherapy.
[15] Metoclopramide is an anti-emetic drug used for the treatment of nausea and vomiting.

48. Dr Parsons provided an opinion that the medical cause of death was 1*(a) Mixed drug toxicity (alprazolam, clonazepam, diazepam, methadone, metoclopramide, mirtazapine, morphine, nitrazepam, ondansetron, oxycodone, tramadol).*

49. I accept Dr Parsons' opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

50. As Catherine's death occurred in circumstances where she was experiencing family violence in the lead-up to her passing, I requested that the Coroners Prevention Unit (**CPU**)[16] examine the circumstances of Catherine's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[17]

51. I make observations concerning service engagement with Catherine and Mr TT 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 Catherine's death.

52. 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*".[18] I make observations about services that had contact with Catherine and Mr TT to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Mr TT

53. As a matter of procedural fairness, the Court wrote to Mr TT and provided him with an opportunity to respond to the allegations made by Catherine during her life that were contained within the various records obtained by the Court. In his response, Mr TT provided his version of events with respect to meeting Catherine and how their relationship formed. Mr TT alleged that Catherine "*exploited*" him, and that their relationship caused "*profound harm to [his]*

[16] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

[17] 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.

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

personal, professional, emotional, and financial wellbeing". He further alleged that he was "*manipulated by means of gaslighting and breadcrumbing behaviour and systematically harmed while being used to compensate for Catherine's impairments and unmet needs*". Mr TT did not categorically deny any of the allegations of family violence; rather he appeared to allege that Catherine was the aggressor in their relationship.

54. It is not my role to determine criminal or civil liability or assign blame, and further, it is not my role to determine the merits of the allegations made by Catherine or Mr TT. The allegations are listed and explored in this context as they are relevant to the circumstances in which Catherine died.

55. However, it is relevant to note for the present purposes that there was no evidence in the available records to suggest that Catherine perpetrated any controlling behaviour towards Mr TT. Furthermore, I note that Victoria Police members were satisfied that a FVIO was required to protect Catherine and issued charges against Mr TT for breaching the FVIO (noting these charges were withdrawn after Catherine's death), and there are also numerous witness accounts in the coronial brief of Catherine's experience of family violence. In those circumstances, and while noting Mr TT has provided a different account of the relationship, I am satisfied to the requisite standard of Catherine's experience of family violence for the purposes of analysing the circumstances in the lead-up to her death.

Victoria Police

Historical family violence

56. In 2005 and 2008, Mr TT was recorded by Victoria Police as the respondent in episodes of family violence against his wife. The allegations included physical assault in front of a child. His wife later submitted a 'statement of no complaint' (i.e. did not want the complaint to proceed).

57. In September 2019, Mr TT's wife reported him to police and alleged that he grabbed her phone and assaulted their child when they tried to intervene. His wife again filed a 'statement of no complaint'.

2020

58. In June 2020, Catherine ended her relationship with Mr TT after he reportedly called her psychiatrist and shared information without Catherine's consent. The pair were in a car which

stopped in a dangerous location on a freeway near the Mill Park Police Station and engaged in a heated verbal argument, prompting police involvement.

59. Catherine told police that she did not want to have any further contact with Mr TT, and police advised him not to contact her or attend her home. It does not appear that a family violence report (**FVR L17**) was submitted in relation to that incident.

60. Later that day, Mr TT drove to Catherine's home and entered the vehicle that she was in, prompting Catherine to call police. While on the phone, police heard Mr TT threaten to take his life, and he tried to take the phone from Catherine. The police report noted escalating controlling behaviours by Mr TT, including multiple suicide threats if Catherine ended the relationship. Police completed a FVR L17, referred both parties to family violence services and applied for a FVIO against Mr TT. A limited (safe contact) FVIO was issued on 18 June 2020.

2021

61. In December 2021, Mr TT attended Catherine's home and allegedly knocked on the front window for about 20 minutes and demanded she turn her phone on. Catherine called police and advised them that she turned her phone off one day prior following an argument with Mr TT about his controlling behaviour. She also alleged a history of emotional abuse, including coercive control, throughout their relationship. Police submitted a FVR L17 and referrals to family violence services and applied for another limited (safe contact) FVIO against Mr TT.

2022

62. On 2 July 2022, Catherine called police who subsequently attended Mr TT's home. The members identified that there was a limited FVIO in place (as noted above) and both Catherine and Mr TT disclosed behaviour that was allegedly in breach of same. This included allegations that Mr TT prevented Catherine from leaving the home when she wanted to, by exposing himself to her and demanding sexual acts.

63. The members appropriately separated Catherine and Mr TT when speaking to them and reassured Catherine that the situation was not her fault. When the members asked her if she was in fear of him, she said "*I don't know…he's never assaulted me…he's unpredictable…I've pushed him to get him away…There's been a couple of times he hasn't let me go and I've screamed the house down*". The members observed and commented that Catherine appeared fearful and anxious.

64. Mr TT gave an alternative narrative to police, in which appears to have been an attempt to undermine Catherine's credibility to police. He advised that Catherine "*has BPD…three failed suicide attempts...hypoxic brain injury from a suicide attempt…she was my patient…she has psychological issues and ABI…On Fridays she does emotional wellness for depression…When she escalates she goes from 0-10 in seconds.*"

65. The members advised Catherine that Mr TT's actions were a breach of the FVIO and asked her if she wanted to make a statement. They noted that she could make the statement later if she preferred. The members also advised Catherine that they were concerned for her safety, would take Mr TT to be interviewed in relation to the alleged FVIO breach and were planning to vary the conditions of the FVIO to prevent all contact. Catherine indicated she was supportive of this plan. The members further advised that they would contact Catherine after interviewing Mr TT to explain the next steps.

66. Police interviewed and charged Mr TT in relation to the alleged breach and successfully applied to vary the FVIO to a full, no contact order. Police bailed Mr TT to appear at court on 6 July 2022.

67. On 3 July 2022, Catherine attended her local police station to collect the updated FVIO paperwork. She spoke about Mr TT gaslighting and disrespecting her. The charges against Mr TT were withdrawn after Catherine's death.

68. Following Catherine's passing, Ms Lynch and Ms Hogan reported to police that Mr TT attended their home, stood at the end of their driveway and shouted, "*you did this to her*" and drove back and forth past the home. Ms Lynch reported being in fear for her safety because of his past behaviour towards Catherine.

The Orange Door

Background

69. The Orange Door (**TOD**) provides referrals to family violence services for people using and experiencing family violence, and to which people are required to be referred following police involvement at a family violence incident. Catherine's TOD records reflect that she was referred to Berry Street in response to the June 2020 report of family violence. It is not clear if she engaged with this service. Berry Street contacted Catherine in December 2021 in response to a high-risk L17 referral, however she declined engagement. A referral was made

to the High Risk Team for Mr TT, however there is no record of same in Mr TT's TOD file (see below).

70. A review of TOD records for Mr TT revealed:

    (a) In 2019, Mr TT's file was closed as he did not respond to contact attempts.

    (b) In July 2020, TOD contacted Mr TT. His responses indicated "*nil insight into his behaviour and how that had an impact on his ex-partner [ex-wife]*". The records further noted that Mr TT's wife was willing to take responsibility for his choice to use emotional abuse against Catherine, was engaged with a psychologist, attending family therapy with his children, and had completed a Men's Behaviour Change Program (**MBCP**) in 2016.

    (c) TOD contacted Mr TT on 18 August 2022 via phone and text, however he did not respond.

71. The final outcome for both parties (in relation to the referral made for the 2 July 2022 incident) indicated "*client engaged with service*". However, Mr TT only received one attempted call and one text message, and Catherine died two days after the referral was generated.

Analysis

72. From the records available, it does not appear that Catherine or Mr TT meaningfully engaged with TOD or any other family violence service proximate to Catherine's death.

73. I note that this is not the only case before the Court in which men's family violence services did not successfully engage with perpetrators of violence from L17 referrals. These organisations often cite lack of police contact with the offender, delayed processing, and concerns that contact might increase risk to the victim as reasons for lack of contact. I note this not as a criticism of TOD, rather, an ongoing issue with victim-survivors and perpetrators not engaging with services offered through the family violence service sector.

74. The most recent TOD Annual Report acknowledged that in relation to referrals for people using violence:

    (a) 8% had their needs met by TOD;

    (b) 10% engaged with the service system;

(c) 17% declined/disengaged;

(d) 40% of cases were closed as the person was unable to be contacted; and

(e) 25% closed for 'other' reasons.[19]

75. In relation to referrals for victim-survivors (adults/children):

(a) 23% had their needs met by TOD;

(b) 23% engaged with the service system;

(c) 26% declined/disengaged with the service;

(d) 20% of cases were closed as the person was unable to be contacted; and

(e) 8% closed for 'other' reasons.

76. In relation to people using violence, 40% of referrals were closed because the person was unable to be contacted. Although the recorded outcome for the 2 July 2022 referrals was "*client engaged with service*", Catherine passed away two days later, and Mr TT did not respond to TOD's contact in August 2022.

77. I note other coroners in Victoria have expressed support for expansion and adequate resourcing of co-responder programs. Co-responder programs involve the presence of a family violence specialist worker during police attendance at family violence incidents to provide a collaborative response.

78. Research has identified key benefits to co-responder programs, including higher satisfaction of victims with police, increased willingness of victims to contact police in the future, more information sharing and coordination of services for victims, greater understanding of family violence by police, and a perceived increase in the accountability taken by police in responding to family violence.

79. I note that both Family Safety Victoria and Victoria Police expressed support for the expansion of co-responder programs in principle, however have noted there were barriers to implementation. The most notable concerns were workforce capacity and funding, given that current co-responder programs are considered relatively resource-intensive, and the family

[19] Family Safety Victoria, Case closure results: The Orange Door Annual Service Delivery Report 2022-23, https://www.vic.gov.au/orange-door-annual-service-delivery-report-2022-23/case-closure-results.

violence sector is struggling to fill vacancies. I am of the view that these challenges are not insurmountable and should not prevent a recommendation to expand such a program.

80. TOD is currently unable to successfully engage with a large proportion of the victim-survivors and people using family violence referred to them under the current system, wherein police make referrals after attending family violence incidents. It may therefore be appropriate to divert some efforts away from the current referral pathway and into co-responder programs in order to effectively engage more AFMs while reducing police misidentification of the predominant aggressor and introducing the various other benefits of co-responder programs.

81. In former 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 regions selected.*[20]

82. Victoria Police accepted the recommendation in principle and advised that it would work with the Department of Families, Fairness and Housing (**DFFH**) to identify options and funding. DFFH noted the recommendation as 'under consideration' and that it would be subject to funding decisions by the Victorian Government.

83. In my recent finding into the death of Ms KSQ, I recommended:

> *That the Department of Families, Fairness and Housing resource an expansion of co-responder programs, such as the Alexis Family Violence Response Model, across Victoria.*[21]

84. I note following my finding into the death of Ms KSQ, on 23 October 2025, the Victorian Government announced an expansion of the Alexis Family Violence Response Model.

[20] Finding into passing without inquest – Noeline Dalzell.
[21] Finding into death without inquest – Ms KSQ.

Currently, the model operates in Prahran, Bayside, Morwell and Wongthaggi, and the Government has committed to expanding it to another two sites. The precise location will be based on police advice. This is a positive step, however until it expands across the state, not all victim-survivors and their children will be able to benefit from same.

Private psychiatrist

Background

85. Catherine engaged in treatment with a private psychiatrist from 2016 until the time of her death, noting there were periods of disengagement during that time. During this time, Catherine also received treatment from private psychologists.

86. The psychiatrist treated Catherine for her persistent depressive disorder and borderline personality disorder, then following her brain injury, for her neurocognitive disorder. The psychiatrist reported that, following Catherine's brain injury, her mood states were less labile, she was better able to tolerate perceived abandonment and her suicidal ideation reduced in intensity. The psychiatrist's contemporaneous notes indicate that Catherine was experiencing family violence throughout 2020, including:

    (a) "*Friendship going well but he is apparently 'intrusive' – apparently called CAT [crisis assessment team]/police? Secondary to C's suicidal gesture 'he keeps coming to my house' Catherine seemingly oblivious to her role in this.*"

    (b) "*On/off friend/partner – I turn my phone off an [sic] he ends up calling the police for a welfare check*".

    (c) "*IVO hearing next week – against Catherine by her alleged persecutor*".

87. In the psychiatrist's correspondence to Catherine's general practitioner (**GP**), there were further references to Catherine experiencing stalking throughout 2019 and 2020, including:

    (a) Catherine disclosed that she was a victim of stalking by a friend of a friend and obtained an "*AVO*".

    (b) Catherine spoke at length about an experience where she claimed she was being stalked by a nurse from Austin Hospital with whom she had no prior connection and now intervention orders had been taken out by both parties. The psychiatrist noted that while the story did not seem to have a delusional basis, it did not make sense. The

psychiatrist noted Catherine was experiencing significant stress with ongoing legal proceedings in relation to an alleged stalking incident.

(c) Catherine was in court for what appeared to be a stalking incident from a psychiatric nurse at the Austin Hospital who made vexatious claims about her.

88. In a letter from the psychiatrist to the GP in June 2020, they noted that someone referring to themselves as Catherine's partner contacted the psychiatrist's rooms on several occasions. Catherine had advised that she was involved with a man but was reportedly reluctant to describe him as her partner. The psychiatrist further noted that Catherine described this man as obsessive, that he had followed her to medical appointments and contacted her psychologist, however Catherine's psychologist at the time was not copied into this correspondence. It does not appear that any of this information was conveyed to the second psychologist to whom Catherine was referred in 2021.

89. The psychiatrist last consulted with Catherine on 30 June 2020 via video call. She expressed some frustration about living with her mother and aunt, denied suicidal ideation and explained that she was increasing her working hours per week.

90. The only reference to Mr TT in the psychiatrist's statement to the Court was after Catherine's final appointment in which he received communication from Catherine's day therapy program on 1 July 2022. The day therapy program contacted the psychiatrist with concerns about Catherine's disclosure of stalking by a friend, ['*Mr TT's nickname*'], who had also punctured her tyre, and she had an FVIO against him. The psychiatrist planned to discuss this issue with Catherine at their next appointment, scheduled for 15 July 2022.

Analysis

91. I note that the psychiatrist was aware of multiple indicators that Catherine may have been experiencing family violence. Some of these were communicated to Catherine's GP, however it does not appear that he sought or obtained consent to share information with the second psychologist.

92. Based on the records provided, and while acknowledging that Catherine's references to Mr TT at times described him as a 'friend', there was no evidence to indicate that the psychiatrist spoke to Catherine about family violence specifically, assessed or otherwise considered family violence risk, nor consulted or referred to specialist family violence services.

93. The ability of private mental health clinicians to respond to family violence has been discussed in previous coronial findings and is not unique to this situation. This is considered in further detail below.

Procedural fairness response

94. As a matter of procedural fairness, the Court wrote to the psychiatrist about the concerns identified above. The psychiatrist provided a thoughtful and considered response to the Court's correspondence.

95. He explained that over the course of his treatment with Catherine, many of their sessions involved discussions concerning her interpersonal relationships, including conflict with her mother and her aunt. The psychiatrist noted that Catherine reported having many romantic partners and friends, including problematic relationships with friends, friends of friends, a female nurse and others. The psychiatrist stated his understanding was that Mr TT's involvement was more recent. The psychiatrist was aware that Catherine notified police in relation to Mr TT's alleged behaviour, although noted that the history of these interactions was (at times) difficult to clarify and decipher.

96. In accordance with his confidentiality requirements, the psychiatrist did not routinely copy all clinicians into all written correspondence, however noted that he did periodically liaise with Catherine's two psychologists.

97. In the letter to the psychiatrist, the Court indicated that this finding would include "*a discussion of the family violence perpetrated by [Mr TT] against Catherine, which she disclosed to you and her other treating clinicians*". The psychiatrist stated that "*at no stage did Catherine inform [him] that she had been the subject of physical violence; hence [he] assumes [the Court is] referring to stalking as a form of interpersonal violence*".

98. The psychiatrist noted that Catherine did not disclose physical violence, however, does not reference any of the other forms of violence she discussed. I cannot determine now what Catherine might have disclosed if she was asked about family violence (in all its forms).

99. The psychiatrist further noted that he considered the risks of interpersonal harms in Catherine's relationships seriously and discussed her relationships and the associated risks with her on multiple occasions. He also stated that he recalled having conversations about the nature of Catherine's relationships with her treating psychologists.

100. The Court's letter to the psychiatrist also included my proposed observation that "*there is no evidence to suggest [the psychiatrist] spoke to Catherine specifically about family violence…or consulted/referred her to specialist family violence services*". The psychiatrist stated that this observation oversimplified the situation and that if referring Catherine elsewhere would have been sufficient, he would have acted accordingly.

101. I agree that it would not have been as simple as referring Catherine to a family violence service to 'cure' her problems. However, in my view, a MARAM-aligned public mental health organisation would have been required made the referral, and it would have been up to Catherine in relation to whether she engaged.

102. Finally, the letter noted my intention to discuss how the private mental health system in Victoria is not sufficiently equipped to identify and respond to disclosures of family violence. The psychiatrist offered a different perspective and stated that he and the other clinicians involved with Catherine "*consistently demonstrate diligence, regular communication, and a strong commitment to supporting vulnerable individuals like Catherine*". He noted that he and many clinicians operate across a range of settings, where the impact of family violence is addressed via different systems, including the MARAM framework. He concluded that he would "*look forward to hearing recommendations on how the private mental health sector in Victoria can <u>enhance</u> its capacity to identify and respond effectively to disclosures of family violence*".

103. I acknowledge that mental health clinicians work in a complex space, managing competing responsibilities, risk and professional obligations. This finding is not intended to be critical, nor assume that I have more knowledge about a clinician's day-to-day practice than the clinician themselves. However, I remain concerned that people who experience family violence in Victoria and receive mental health treatment may have a different experience, depending on whether they are treated in the public or private system, due to differing requirements for clinicians in these systems. This is not a reflection of anyone's diligence or commitment to their role or to their patients (or scope of knowledge) but merely an illustration of how reforms have evolved over time in the public and private sectors. I will address this further below.

First private psychologist

104. Catherine consulted with the first private psychologist (**'Psychologist 1'**) initially at one clinic, then from 27 February 2018 to 2 April 2021 at another clinic. Psychologist 1 explained

in a statement to the Court that her treatment of Catherine included cognitive behavioural therapy and schema therapy for the treatment of borderline personality disorder (**BPD**). She noted that Catherine's BPD symptoms included chronic suicidal ideation, depressed mood, anxiety and difficulties with relationships. Psychologist 1's use of schema therapy focused on identifying the underlying cognitive, relational, and behavioural patterns that contributed to these symptoms, and developing adaptive cognitive and behavioural responses, and re-processing formative memories.

105. Psychologist 1 identified a series of 'crises' in Catherine's life, including:

    (a) 2017 hospital admission for a medication overdose, following a relationship break down.

    (b) In 2018, Catherine's father passed away and she experienced grief from this loss.

    (c) Re-engagement in June 2019 following a medication overdose and brain injury.

    (d) 2020-2021 Ahpra investigation to determine if Catherine was able to continue working as a nurse following her ABI.

    (e) 2019-2021 – a court case involving the partner of one of her friends who made various accusations regarding Catherine's behaviour (that she denied) and requested an intervention order against her. Catherine experienced relationship difficulties with her partner, friends and family members and difficulties living at home with her mother.

Procedural fairness response

106. As a matter of procedural fairness, the Court wrote to Psychologist 1 and advised of my intention to discuss the broader issue of the private mental health system's identification of and response to family violence. Psychologist 1 also provided a deeply considered response, noting that she did not believe Catherine ever disclosed any experiences of family violence, however if she had, Psychologist 1 was confident that her clinical training and experience in this area would have enabled her to identify risk, assess safety and take appropriate action, including communicating with the rest of her team.

107. Psychologist 1 explained that non-disclosure of family violence is extremely common among survivors of complex trauma, particularly where attachment bonds, fear of abandonment, and trauma-related loyalty are present.

108. Psychologist 1 stated that she was strongly supportive of ongoing professional development for clinicians in identifying and responding to family and intimate partner violence. She noted one systemic factor involved is the significantly under-resourced healthcare system that is unable to meet the needs of people with this level of clinical complexity.

Second private psychologist

109. The psychiatrist referred Catherine to a second private psychologist (**'Psychologist 2'**) on 18 May 2021 after she ceased consulting with Psychologist 1. The referral did not include any information about Catherine's experience of family violence or stalking. The subsequent referral from Catherine's GP for further sessions under a mental health care plan on 11 February 2022 also did not reference family violence or stalking.

110. During Catherine's first consultation with Psychologist 2 on 5 October 2021, she noted that her previous two relationships were physically violent and financially abusive.

111. In Catherine's second consultation on 26 October 2021, Psychologist 2 notes indicate that Catherine reported "*what sounded like gaslighting and poor emotional regulation by friend*". Other notes indicate that Catherine reported that "*this friend had taken upon self to contact Catherine's other friends to inform them of Catherine [sic] suicide attempts and her mental health in general*".

112. During a session on 7 December 2021, Catherine described multiple interactions where she felt dominated and controlled by Mr TT. Psychologist 2's notes reference Catherine outlining:

    (a) Situations where she did not want to go to Mr TT's house but attended due to strong guilt and feelings of obligation.

    (b) An example where Mr TT refused to let Catherine leave his home by blocking the exit.

    (c) An example where Catherine declined to attend his home and he knocked on her windows insisting she come outside and talk to him.

113. Psychologist 2's notes further indicate that Catherine had been researching coercive control.

114. During Catherine's final session on 21 June 2022, the conversation focused on conflict between Catherine, her mother and her aunt. The only reference to Mr TT is "*friendship with [him] has been less 'dramatic' lately…they have reconnected and spending more time together*".

Analysis

115. It appears that Psychologist 2 was aware of multiple indicators of family violence being experienced by Catherine, however does not appear to have discussed family violence specifically, performed a risk assessment, or consulted/referred to specialist family violence services.

116. Based on the Australian Psychological Society Code of Ethics (current at the time), Psychologist 2 could not share information without consent as she would be breaching client confidentiality. This is unless she believed that the disclosure was necessary to lessen or prevent a serious threat to life, health or safety of any individual. It remains unclear to what extent Psychologist 2 explored or assessed if Catherine was at serious risk from family violence or sought her consent to make appropriate referrals.

117. As noted above, the ability for private mental health clinicians to identify and respond to family violence is an ongoing theme in other coronial matters and will be discussed in further detail below.

Procedural fairness response

118. As a matter of procedural fairness, the Court wrote to Psychologist 2 to advise them of my proposed findings and to provide them with an opportunity to respond. Psychologist 2 advised that she did not propose to provide submissions.

Private day therapy program

119. Catherine attended a weekly group therapy day program at a private clinic (**'the Clinic'**) from 2019 until the time of her passing.

120. Catherine's records indicate that she made disclosures suggestive of family violence over many sessions, including multiple references to her challenges in establishing and maintaining boundaries with a friend (who was sometimes nameless; sometimes referred to by Mr TT's nickname). Catherine discussed issues with Mr TT puncturing her car tyre, damaging her vehicle, stalking her, controlling and emotionally abusive behaviours, and disclosing her personal information to others. Catherine also stated that she wanted to be able to get away for a quiet week without being reported as a missing person by Mr TT.

121. Staff encouraged Catherine to report breaches of FVIOs to police and her GP, and engagement with her psychologist was noted in her records. It does not appear that the Clinic referred

Catherine to family violence services, however I note that the records only refer to the perpetrator as a 'friend'.

122. The Clinic contacted Catherine's psychiatrist shortly prior to her death to discuss concerns, including stalking.

Analysis

123. As a private mental health facility, clinicians at the Clinic are not prescribed under the Multi-Agency Risk Assessment and Management (**MARAM**) framework and therefore they may be less well-equipped to identify and respond to disclosures of family violence. This is discussed further below.

Procedural fairness response

124. The Court wrote to the Clinic to provide them with an opportunity to respond to the concerns identified about. The Clinic advised that it did not wish to provide any submissions in response.

General Practitioner

125. Catherine's GP provided a medical summary to the Court noting that Catherine had been her patient since 2010. There were no references to family violence in the summary, nor in the GP's referrals for mental health care plans (**MHCPs**).

126. The psychiatrist referenced behaviour indicative of family violence in multiple letters to the GP. However, the medical summary provided by the GP contained no evidence that she discussed family violence with Catherine.

127. The World Health Organization highlights primary care as a suitable setting for early intervention in family violence.[22] Primary care professionals are often the only clinicians seeing both women experiencing family violence and the perpetrators.[23] Women experiencing violence may use health services more frequently because of increased rates of emotional and physical health issues.

[22] Primary Care Pathways to Safety Kelsey Hegarty, Kitty Novy, Minerva Kyei-Onanjiri, Heather McKay Department of General Practice (2022) The University of Melbourne https://nwmphn.org.au/wp-content/uploads/2022/11/PrimaryCare-Pathways-to-Safety-NWMPHN-FINAL-REPORT-Oct-2022.pdf 3.
[23] Ibid.

128. I note that coroners have commented on GP responses to family violence in numerous investigations. For example, former State Coroner Judge John Cain recommended in his finding into the death of Fatima Batool:[24]

> *The National Federation Reform Council (**NFRC**) review the current registration standards required of medical practitioners with a view to updating CPD requirements for General Practitioners. A specific portion of CPD training undertaken by General Practitioners should be dedicated to family violence to reach an occupation-specific level of family violence understanding and referrals for further support where a patient is identified as experiencing or suspected to be experiencing family violence.*

129. Judge Cain made a similar recommendation in his Honour's finding into the death of Alicia Little.[25] In response, Prime Minister Anthony Albanese advised that he requested the Hon. Mark Butler, MP, Minister for Health and Aged Care, to work with the Health Ministerial Council in:

> *Developing options to enhance family, domestic and sexual violence training in the health workforce. These options are to include the recommendation of mandatory family violence CPD components for GPs, psychiatrists and psychologists, and noting that Governments share responsibility for CPD with the relevant medical and allied health colleges who deliver it, and reform will need to be collaborative.*

130. In 2023, Coroner Paul Lawrie recommended that the Commonwealth Government consider adding specific Medicare item numbers relating to family violence, to support the identification and management of family violence by GPs, as envisioned in the draft National Plan to End Violence Against Women and Children 2022-2023.[26] To date, no response has been received to this recommendation.

131. I note that there is currently a program called the 'Primary Care Pathways to Safety' that provides professional support and service navigation to engaged health care providers in the North Western Melbourne Primary Health Network (**NWMPHN**) region. This is an expansion of a successful pilot program in the region. Activities of this program include:

[24] Finding into death without inquest – Fatima Batool.
[25] Finding into death with inquest – Alicia Little.
[26] Finding into death without inquest – Loris O'Meara.

(a) Service navigation, with workers from local family violence services commissioned to provide professional support and service navigation to engaged health care providers in the NWMPHN region.

(b) Workplace capability building by the Safer Families Program at the University of Melbourne who will deliver the Pathways to Safety training program to general practices in the NWMPHN region. Training will cover a range of topics focused on identifying, responding, and referring for family violence.

(c) Implementation of training into practice with primary health care providers including GPs, nurses, general practice teams, allied health, mental health workers, social workers and those from the family violence sector invited to community of practice sessions to increase integration and collaboration of primary health care providers locally.

(d) Building understanding of the systematic barriers to provide best practice family violence care in primary care.

(e) Evaluation.

132. The model aims to:

(a) Increase primary health care provider skills, confidence, and knowledge in identifying, assessing, and referral patients who experience family violence.

(b) Establish practice systems using a whole-of-practice approach to embed training into general practices.

(c) Improve confidence of primary health care providers to connect with family violence services and support systems.

(d) Increase integration and collaboration of local primary health care providers locally.

133. I am of the view that this program has the potential to significantly improve the ability of GPs to identify and respond to disclosures of family violence, and to provide a more holistic response to patients experiencing family violence. I support this program and hope that it can be expanded to other areas of Victoria. I will direct a copy of this finding be provided to the Safer Families Program and the Royal Australian College of General Practitioners.

Systemic issues – suicide in the context of family violence

Background

134. Based on the available evidence, it appears that the gender-based violence Catherine experienced was a significant contributor in her decision to take her life. This includes, but is not limited to, the controlling relationships she experienced in the eight years prior to her death. These issues featured heavily in her discussions with mental health clinicians, and her diary indicates that Mr TT may have encouraged her to take her own life.

Analysis

135. In my finding into the death of Ms HRZ,[27] I commented on the link between family violence and suicide. I made similar comments in my finding into the death of Ms BCJ,[28] while other coroners have made similar comments.[29] Since my finding into Mr HRZ's death was published, the report on the Parliamentary Inquiry into the Data on the Profile and Volume of Perpetrators of Family Violence in Victoria has been published, and it recommended:

> *The Victorian Government support the Coroners Court of Victoria to better investigate and analyse the circumstances of all family violence-related deaths to build a more complete picture of the patterns of family violence perpetration and the context in which family violence related deaths occur (including the link between suicide and family violence) and code, analyse and disseminate associated data to relevant stakeholders for research.*[30]

I also strongly support this recommendation.

Systemic issues – coercive control

136. Coercive control "*is a course of conduct aimed at dominating and controlling another (usually an intimate partner, but can be other family members) and is almost exclusively perpetrated by men against women*".[31] Coercive control may not always be accompanied by physical violence, but can undermine an individual's sense of autonomy, liberty and equality in a

[27] Finding into death without inquest – Ms HRZ.
[28] Finding into death without inquest – Ms BCJ.
[29] See, e.g., Finding into death without inquest – Thi Nguyen; Finding into death without inquest – CM.
[30] Recommendation 60, Legislative Assembly Legal and Social Issues Committee, Building the evidence base Inquiry into capturing data on people who use family violence in Victoria.
[31] Australia's National Research Organisation for Women's Safety. (2021). *Defining and responding to coercive control: Policy brief* (ANROWS Insights, 01/2021). Sydney: ANROWS.

relationship, resulting in traumatic and pervasive immediate and long-term impacts for victim-survivors, their families and communities.[32]

137. The evidence available to the Court supports that Mr TT perpetrated coercive control against Catherine, including:

    (a) Mr TT contacted Catherine's friends and health professionals to disclose private health information without her consent, while referencing his professional knowledge and focusing on her inabilities or challenges. Mr TT described Catherine's ABI and mental health issues to police.

    (b) Mr TT called police or mental health services for welfare checks, followed Catherine, or made noise out the front of her house when Catherine did not respond to him.

    (c) Mr TT threatened to suicide if Catherine left the relationship.

138. Coercive control within family violence has been a topic of significant attention in recent years, with robust debates as to the merits and risks of introducing it as a specific criminal offence. In Victoria, coercive control becomes a criminal offence when the behaviour continues after a FVIO has been implemented that prohibits the use of family violence. Mr TT was charged with a FVIO breach shortly before Catherine's death; however, the charge was withdrawn after her passing.

139. Prevailing community attitudes toward family violence and gender roles fundamentally inform the service sector's response to coercive control and affect victim-survivors' capacity to access support.[33] Findings from the 2021 National Community Attitudes towards Violence Against Women Survey (**NCAS**) reveal that a significant proportion of Australians continue to hold dated views about women and their roles in society.[34]

140. NCAS results also highlighted a concerning gap in public understanding of coercive control, with many Australians failing to recognise such behaviours as forms of family violence.[35] For example, only 66% of respondents identified that repeated criticism intended to undermine a

[32] Australian Government, Attorney generals' Department, Coercive control https://www.ag.gov.au/families-and-marriage/families/family-violence/coercive-control.
[33] Australia's National Research Organisation for Women's Safety. (2021*). Defining and responding to coercive control: Policy brief* (ANROWS Insights, 01/2021). Sydney: ANROWS; Respect Victoria, 'Coercive control and the primary prevention of family violence' (position paper, September 2021).
[34] Australia's National Research Organisation for Women's Safety. (2023). *Quick Guide to the 2021 National Community Attitudes towards Violence against Women Survey (NCAS)* [Fact sheet]. ANROWS
[35] Ibid.

partner's self-worth, 'always' constituted family violence, while 19% agreed "*that women prefer men to take control in relationships*".[36]

141. Addressing the material and social conditions that drive the formation of belief systems that underpin the use of coercive and controlling behaviours is critical to ending this form of violence. For this reason, Respect Victoria advocates for a focus on primary prevention in any effort to address coercive control, and family violence more broadly.[37]

142. Primary prevention aims "*to change the underlying social conditions that produce and drive violence against women*" to prevent it from occurring in the first place.[38] This involves working on actions to address the gendered drivers of violence against women to create generational, cultural and attitudinal change.[39] These drivers include:

    (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.[40]

143. Primary prevention also involves addressing other factors which play a role in influencing the occurrence or dynamics of men's violence against women, including:

    (a) The condoning of violence in general.

    (b) Experience of, and exposure to, violence.

    (c) Factors that weaken pro-social behaviour, such as neighbourhood-level poverty, disadvantage and isolation, and substance misuse.

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[36] Ibid.
[37] Respect Victoria, 'Coercive control and the primary prevention of family violence' (position paper, September 2021).
[38] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 12.
[39] Victorian Government, Free from Violence: Victoria's Strategy to Prevent Family Violence and all Forms of Violence Against Women - Second Action 2022-2025 (December 2021) 4 https://content.vic.gov.au/sites/default/files/2021-12/Free-from-violence-second-action-plan-2022-2025.pdf.
[40] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 36.

(d) Backlash and resistance to prevention and gender equality.[41]

144. In my finding into the death of Ms HRZ, I recommended:

> *That the Commonwealth Government commit to long-term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch in Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia. These include:*
>
> *a. Our Watch (to provide independent national leadership on primary prevention)*
>
> *b. Australia's National Research Organisation for Women's Safety (ANROWS) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)*
>
> *c. Australian Bureau of Statistics (to deliver the Personal Safety Survey)*
>
> *d. Workplace Gender Equality Agency.*[42]

145. In his Honour's finding into the death of Thi Nguyen, former State Coroner, Judge Cain, recommended that:

> *The Victorian Government urgently increase the total quantum of primary prevention funding, and prioritise longer term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria.*[43]

146. In response to the recommendation in the Thi Nguyen finding, DFFH and the Department of Prime Minister and Cabinet responded by explaining the current state and federal government investment in primary prevention. While having such initiatives is positive, it is my view that

[41] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 48, 51; Shaoling Zhong, Ronggin Yu, and Seena Fazel, 'Drug Use Disorders and Violence: Associations with Individual Drug Categories' (2020) 42(1) Epidemiologic Reviews.
[42] Finding into death without inquest – Ms HRZ.
[43] Finding into death without inquest – Thi Nguyen.

the current approach still falls short of what is required by the sector to meaningfully undertake primary prevention strategies in Victoria. As identified in this case (and others), meaningful and widespread primary prevention strategies in Victoria are critical if we want to address the pervasive nature of coercive control.

Systemic issues – private mental health clinicians/services

147. I note the current *Mental Health and Wellbeing Act 2022* (Vic) recognises that:

> *People receiving mental health and wellbeing services may have specific safety needs or concerns based on their gender. Consideration is therefore to be given to these needs and concerns and access is to be provided to services that:*
>
> *(a) are safe; and*
> *(b) are responsive to any current experience of family violence and trauma or any history of family violence and trauma; and*
> *(c) recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery; and*
> *(d) recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage.*[44]

148. However, this section only applies to state-funded mental health providers.[45]

149. Sadly, this is not the first case in which private psychologists, psychiatrists and/or GPs have not responded outside of therapeutic sessions (e.g. to make appropriate referrals) based on indicators and disclosures of family violence.[46]

150. I am concerned that Catherine's GP, psychiatrist, psychologist and group therapy day program all held information (albeit incomplete and, in her interactions with her psychiatrist, at times difficult to decipher) relating to her experience of family violence. Clinicians are mandated to maintain their client's confidentiality, except in certain circumstances, for example, if they are at imminent risk of serious harm. It is not apparent that this threshold was met in this case. However, as some of the clinicians involved with Catherine did not identify the family violence she was experiencing, there was no opportunity to explore this with her further, offer

[44] Section 26 *Mental Health and Wellbeing Act 2022* (Vic).
[45] See Designated Mental Health Services, Terms and definitions | health.vic.gov.au
[46] See, e.g., Finding into death without inquest – William Heddergott; Finding into death without inquest – Samantha Fraser.

referrals to support services or seek her consent to share these concerns with her other treating clinicians. I cannot determine that Catherine would have accepted a referral to a family violence service if one was offered (noting she declined offers in the past). However, her experience may have differed if she experienced consistent messaging and support related to Mr TT's alleged violence, particularly with improved professional understanding of the known impacts of family violence on mental health.

151. Catherine's treating clinicians 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 any psychologists or psychiatrists in Victoria.

152. 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 viewed family violence as beyond the scope of their role. Given the increasing evidence linking family violence and suicide risk (to victims), mental health and medical practitioners' roles are increasingly important in this space.

153. In his Honour's finding into the death of Samantha Fraser, former State Coroner Judge Cain 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.*[47]

154. In response, the APS advised that "*it is not in the purview of the APS to mandate CPD requirements*" but that it supports the provision of family violence CPD training to psychologists. The APS further noted that it "*consistently produces CPD education on the topic of intimate partner violence*" and that it has a series of webinars in development on this topic for 2025.

[47] Finding into death without inquest – Samantha Fraser.

155. The RANZCP response noted that they implemented this recommendation "*as feasibly possible within the RANZCP structures*" after it was made in another coronial finding. RANZCP advised that all RANZCP members can access their Family and Domestic Violence Learning Path online, which includes a non-mandatory module on family violence.

156. While it is a positive step to include non-mandatory family violence training, I am concerned that only RANZCP members who are interested or want to undertake this training will pursue same. Members who are not interested in this training therefore may not review it. I therefore intend to recommend that the RANZCP introduce mandatory family violence training into their fellowship training for new psychiatrists.

157. The Psychology Board of Australia (**PBA**), the national body responsible for the registration of psychologists, supported by the Ahpra, also provided a response to the recommendation made in relation to the death of Samantha Fraser. They stated that changes to the 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 support 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.*

158. In my view, these proposed amendments are positive. However, as outlined in the MARAM practice guides, family violence is prevalent in all parts of our community.[48] In those circumstances, family violence needs to be considered as a potential factor in *any* client presentation. The current wording of Competency Five may well have the unintended consequence of maintaining the status quo; that is, that psychologists who are currently unaware of the potential for their client to be experiencing family violence will not identify a

[48] Family Safety Victoria, MARAM practice guides: Responsibility 2: Identification of family violence risk: Working with adult people using family violence, 25.

learning need and therefore may not seek out a CPD program that would enhance their skills in identifying and assessing family violence.

159. I further note that family violence is not explicitly mentioned anywhere in the new Professional Competencies for Psychologists, including in Competency Five, or in the definition of 'risk' within the document.

160. I therefore intend to recommend that the PBA explicitly recognise in 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 are competent in family violence identification, assessment and management.

161. I further note that the Australian Government Department of Health, Disability and Ageing has recently tasked the PBA with providing recommendations for redesigning the training pathways for psychologists.[49] The PBA is currently reviewing the training pathway and is projected to finalise recommendations for redesign in November 2026.[50] This redesign provides an opportunity for family violence education for psychologists to be embedded in the curriculum for updated training pathways. I therefore intend to recommend that the PBA consider this finding as part of their review and redesign of the training pathway and include family violence education as part of that redesign.

[49] Psychology Board of Australia, Training pathway review to boost access to psychologists (web page, 31 March 2025).
[50] Redesigning the higher education pathway (web page, 21 July 2025).

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Catherine Alison Lynch, born 6 August 1980;

    (b) the death occurred on 4 July 2022 at 66 Clarke Drive, Gladstone Park, Victoria 3043, from 1(a) Mixed drug toxicity (alprazolam, clonazepam, diazepam, methadone, metoclopramide, mirtazapine, morphine, nitrazepam, ondansetron, oxycodone, tramadol); and

    (c) the death occurred in the circumstances described above.

163. Having considered all of the circumstances, I am satisfied that Catherine ingested medications with the intention of taking her own life. In having made such a finding, I note the excessive prescription medication consumed and the deterioration in Catherine's mental health prior to her death.

164. While there was a constellation of factors involved, I find that the significant family violence that Catherine experienced and resisted for many years, including in the period immediately prior to death, underpinned and propelled the decision she made to end her own life.

165. While I consider that the clinical care provided to Catherine by her mental health treaters was, for the most part, considered, caring and competent, my investigation has identified ways in which responses to her disclosures of family violence could have been improved. While this does not and cannot lead to any conclusion that Catherine's death could have been prevented had such responses been optimised, it does in my view demonstrate the need for greater education and enhanced training on family violence identification, assessment and management in the private mental health sector.

RECOMMENDATIONS

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

1. That the **Royal Australian and New Zealand College of Psychiatrists** introduce mandatory family violence training into their fellowship training for new psychiatrists.

2. That the **Psychology Board of Australia** explicitly recognise in 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 are competent in family violence identification, assessment and management.

3. That the **Psychology Board of Australia** consider this finding and include mandatory education on family violence identification, assessment and management in their recommendations to the Department of Health, Disability and Ageing on the redesign of the psychology higher education pathway.

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

ORDER AND DIRECTIONS

Pursuant to section 73(1A) of the Act, I order that this partially de-identified 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:

Senior Next of Kin (identified version)

Australian Health Practitioner Regulation Agency (identified version)

Department of Families, Fairness and Housing (partially de-identified version)

Detective Sergeant Christopher Couacaud, Professional Standards Command Oversight Investigator (identified version)

Safer Families Program (partially de-identified version)

Department of Health, Disability and Ageing (partially de-identified version)

Royal Australian and New Zealand College of Psychiatrists (partially de-identified version)

Royal Australian College of General Practitioners (partially de-identified version)

Psychology Board of Australia (partially de-identified version)

Mr TT (identified version)

Detective Senior Constable Joshua Heymanson, Coronial Investigator (identified version)

Signature:

INGRID GILES

CORONER

Date: 19 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.