IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002596

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Ms KSQ [1]
Date of birth:	4 October 1983
Date of death:	Between 13 and 15 May 2023
Cause of death:	1(a) PLASTIC BAG ASPHYXIA
Place of death:	Marriott Waters Reserve Car Park, Lyndhurst, Victoria, 3975
Keywords:	Family violence; suicide; misidentification of the predominant aggressor

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased, and replace or redact the names of other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication'.

INTRODUCTION

1. On 15 May 2023, Ms KSQ was 39 years old when she was found deceased in circumstances suggestive of suicide. Ms KSQ is survived by her husband, Mr QDZ, and two daughters. Ms KSQ's friends and family described her as a compassionate, fun, sensitive and caring person who was devoted to her children and who loved to help others.

Background

2. Ms KSQ had a diagnosis of epilepsy and experienced seizures triggered by stress. She was also diagnosed with depression and borderline personality disorder (**BPD**). As a result of her mental health diagnoses, Ms KSQ experienced challenges with concentration and understanding and remembering information. She also attempted to end her own life on several occasions in the two years prior to her passing.

3. Ms KSQ met her husband, Mr QDZ, in 2005, and gave birth to their first child S[redacted] in 2007 and their second child [redacted] in 2009. Ms KSQ disclosed to friends, family and professionals that Mr QDZ was reportedly emotionally, financially and sexually abusive for several years prior to the fatal incident. She reported that Mr QDZ told her to "*go kill*" herself when they argued, put her down, raised his hand to hit her before walking away, made her feel useless and lazy, and sexually assaulted her while she was asleep. Evidence available to the Court suggests that this alleged behaviour had a significant impact on Ms KSQ's mental health.

4. In about October 2021, Ms KSQ and her husband separated. Ms KSQ initially moved into a separate room of the family home and continued cohabitating. In August 2022, Ms KSQ travelled to Western Australia for work, however returned to Melbourne a few weeks later and stayed with her mother. Ms KSQ reportedly agreed to move out of the family home on the condition that she could return home to visit her daughters, which Mr QDZ agreed to. However, Ms KSQ's mother, Ms NWA, reported that after Ms KSQ moved out of the family house, Mr QDZ took her house keys. Ms KSQ contacted her lawyer who reportedly advised her to change the locks.

THE CORONIAL INVESTIGATION

5. Ms KSQ'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.

6. 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.

7. 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.

8. Coroner Paul Lawrie initially held carriage of this investigation until it came under my purview in July 2023 for the purposes of finalising the investigation and making findings.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms KSQ'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.

10. This finding draws on the totality of the coronial investigation into the death of Ms KSQ 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.[2]

[2] 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

11. On 13 May 2023, Ms KSQ attended the family home to spend time with her daughters. She took them out during the day, before returning them to Mr QDZ. She told her daughters that she would return the next morning so that they could have Mother's Day breakfast together.

12. The next morning, Ms KSQ did not arrive at the family home to collect her daughters as expected. S[redacted] was very worried as Ms KSQ switched her phone off, and she rarely turned her phone off. Mr QDZ and his daughters called Ms KSQ's friends and roommate, to see if she had attended their homes. Ms KSQ's roommate advised that Ms KSQ had not returned home on the evening of 13 May 2023. Ms KSQ's friend Belinda called police to report Ms KSQ as missing.

13. On 15 May 2023, Ms KSQ's sisters located Ms KSQ's vehicle in the car park of the Marriot Waters Reserve in Lyndhurst. They observed Ms KSQ in the backseat of the car with a plastic bag over her head and called emergency services. When police attended, they gained entry to the car and confirmed that Ms KSQ was deceased. It was clear she had been deceased for some time and therefore resuscitation was not attempted. Police did not identify any suspicious circumstances or signs of third-party intervention in connection with Ms KSQ's passing.

Identity of the deceased

14. On 15 May 2023, Ms KSQ , born [redacted], was visually identified by her father.

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

Medical cause of death

16. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 17 May 2023 and provided a written report of her findings dated 18 May 2023.

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

18. Toxicological analysis of post-mortem samples identified the presence of clobazam,[3] duloxetine,[4] carbamazepine[5] and its metabolite, lamotrigine,[6] and topiramate.[7]

19. Dr Fronczek provided an opinion that the medical cause of death was *1(a) plastic bag asphyxia.*

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

FURTHER INVESTIGATIONS AND CORONERS PREVENTION UNIT REVIEW

21. For the purposes of the *Family Violence Protection Act 2008*, the available evidence suggests that Ms KSQ experienced '*family violence*'[8] in the years prior to the fatal incident. In light of this death occurring in connection with circumstances of family violence, it was requested that the Coroners Prevention Unit (**CPU**)[9] examine the circumstances of Ms KSQ's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[10]

22. I make observations concerning service engagement with Ms KSQ 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 Ms KSQ's death.

23. 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*".[11] I make observations about services that had contact with Ms KSQ to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

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[3] Clobazam is a benzodiazepine derivative used as a sedative, anticonvulsant and anxiolytic.
[4] Duloxetine is a serotonin and noradrenaline reuptake inhibitor indicated for major depression, generalised anxiety disorder, and diabetic neuropathic pain.
[5] Carbamazepine is an antiepileptic drug indicated for partial and tonic-clonic seizures, neuropathic pain and bipolar disorder.
[6] Lamotrigine is used as an anticonvulsant.
[7] Topiramate is an effective anticonvulsant.
[8] *Family Violence Protection Act 2008*, section 5.
[9] 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.
[10] 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.
[11] *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

24. As a matter of procedural fairness, the Court wrote to Mr QDZ to provide him with an opportunity to respond to the inclusion in the findings of the allegations of family violence and to make any other submissions about the case. One of the Court's Family Liaison Officers (**FLOs**) spoke to Mr QDZ before the letter was sent to him to explain the process. At that time, Mr QDZ told the FLO that he was aware of the allegations that Ms KSQ made, however he denied same. He further reported no interest to making negative remarks about Ms KSQ.

25. After sending the letter, Mr QDZ did not respond. As noted above, it is not my role to determine criminal or civil liability, and I make no comment regarding the allegations against Mr QDZ. I only note the issue as relevant to the broader circumstances unfolding in the lead-up to Ms KSQ's death, and which in turn underpin my discussion about police responses to family violence. It is to these circumstances that I now turn.

Police contact on 20 September 2022

26. On 20 September 2022, while Mr QDZ was at work, Ms KSQ and Ms NWA attended the family home with a locksmith and had the locks changed. Ms KSQ's children reportedly locked themselves in their bedrooms and S[redacted] sent text messages to Mr QDZ. She asked her father to come home and said, "*I'm scared she's getting a restraining order against you*". Ms NWA called police when she learned that S[redacted] had contacted her father.

27. When police arrived, they spoke to Ms KSQ and Mr QDZ separately. Both parties became tearful at times but were calm and cooperative with police. Both explained that they separated in October 2021 and that Ms KSQ had not been living with the family for about one month. Mr QDZ reported that Ms KSQ had moved out of the home willingly, while Ms KSQ reported that Mr QDZ "*kicked [her] out*".

28. Mr QDZ explained that he had asked for Ms KSQ's key back a few days prior as things had been going missing from the home. He reported that the children were scared when Ms KSQ changed the locks as "*she's a bit irrational*" and that Ms KSQ would throw furniture around the house during arguments. He noted that Ms KSQ had been calm throughout their interactions that day, however their daughter had been upset at one point, and cried and apologised for letting Ms KSQ into the house.

29. Mr QDZ's lawyer spoke to police via phone during this discussion and stated that "*nothing of concern*" had been disclosed to him, and that there had been "*no assault or anything along*

those lines". He stated that he suggested to Mr QDZ that he spend the night elsewhere, which Mr QDZ appeared to reluctantly accept.

30. Ms KSQ and her mother told police that S[redacted] had locked herself in her room because she had been smoking cannabis with a friend. Ms KSQ reported that Mr QDZ had been sexually and emotionally abusive towards her for about 12 years and that this had negatively impacted on her physical and mental health. She noted that Mr QDZ allegedly "*said that my body is his body*" and that she did not know that she could report the sexual abuse to police. She reported frequent, ongoing instances of sexual coercion and rape.

31. Ms KSQ and her mother explained to police that Ms KSQ wanted to move back into the family home with the children, as they had been calling her and asking her for things, including food. Ms KSQ reported that Mr QDZ and his family put her down in front of the children and she felt like the children hated her. Ms KSQ also reported that Mr QDZ would only permit her to see the children on Wednesdays and every second weekend, despite there being no formal childcare arrangement in place. Ms KSQ's mother asked police if Ms KSQ should get an intervention order against Mr QDZ, and they explained that she could do so at court.

32. The attending police consulted with the Sexual Offences and Child Abuse Investigation Team (**SOCIT**) about Ms KSQ's allegations and arranged for them to contact her.

33. While police spoke to Ms KSQ and Mr QDZ, their children waited in their uncle's car. Their uncle (Mr QDZ's brother) told police that when he arrived, the children were crying. One of the police officers briefly spoke to the children in the presence of their uncle and aunt, and confirmed they were happy to leave with their uncle. The Body Worn Camera (**BWC**) footage only captures one child clearly, and they were not expressing distress during this time.

34. The attending members were unsure how to proceed and called a supervisor for assistance. The supervisor advised them to take out a Family Violence Safety Notice (**FVSN**) in protection of Mr QDZ and the children, to exclude Ms KSQ from the family home. The members completed a family violence risk assessment (**FVR L17**), naming Mr QDZ as the

affected family member (**AFM**) and Ms KSQ as the predominant aggressor. The rationale for assigning the parties these roles was as follows:

a) Mr QDZ and his brother reported that the children were "*distressed*" by Ms KSQ changing the locks.

b) Mr QDZ reported that the children were content to continue living in the family home with him.

c) The supervisor believed an order needed to be in place to prevent similar additional incidents from occurring in the short term.

d) Ms KSQ had made serious allegations of sexual assault against Mr QDZ, and an order with conditions excluding her from the family home was needed to protect her.

35. The attending members appeared reluctant to pursue this course of action. One queried, "*she's going to be the respondent because she got sexually assaulted?*" The supervisor stated that they did not have enough information about Ms KSQ's allegations of sexual assault to take further action and explained "*we just have to deal with what's happened today*". The supervisor further noted that "*there'll be criticism about this but just say you spoke to me. We're doing what's best for the kids*".

36. Mr QDZ completed a short statement with one of the police members, however appeared reluctant to accept that police were seeking a FVSN against Ms KSQ. He expressed concern about police preventing the children from having contact with Ms KSQ.

37. Police explained to Ms KSQ that a FVSN would be put in place, in part to protect her from further abuse. She noted she was unhappy with this course of action but reluctantly agreed to go to the police station to cooperate with the process. Police then issued the FVSN and applied for a Family Violence Intervention Order (**FVIO**) against Ms KSQ. Police did not identify any criminal offending and therefore did not pursue a criminal investigation.

38. On 29 September 2022, at the Dandenong Magistrates' Court, a final 12-month FVIO was issued in protection of Mr QDZ and the children. The order had several conditions, including preventing Ms KSQ from committing family violence and approaching or remaining within five metres of Mr QDZ or 200 metres of the family home. The order permitted Ms KSQ to negotiate childcare arrangements in writing. Following issuance of the FVIO, Ms KSQ continued to have contact with Mr QDZ and the children.

39. Evidence available to the Court suggests that Ms KSQ was unhappy with the police intervention in September 2022 and felt that police did not listen to her. She reported that this had a negative impact on her mental health prior to the fatal incident.

Review of police response on 20 September 2022

40. Based on the information available to the Coroners Court, it appears that Ms KSQ may have been misidentified as the predominant aggressor during this interaction with police. The term 'predominant aggressor' is at times substituted for the term 'primary aggressor', and:

> *Seeks to assist in identifying the actual perpetrator in the relationship, by distinguishing the history and pattern of coercion, power and controlling behaviour, from a victim survivor who may have used force for the purpose of self-defence or violent resistance in an incident or series of incidents. The predominant aggressor is the perpetrator who is using violence and coercive control to dominate, intimate or cause fear in their partner or family member, and for whom, once they have been violent, particularly use of physical or sexual violence, all of their other actions take on the threat of violence.*[12]

41. The *Victoria Police Manual – Family Violence* (**VPM FV**) in place in September 2022 provided the following guidance to members when attempting to identify the predominant aggressor:

    a) Respective injuries

    b) Likelihood or capacity of each party to inflict future injury

    c) Whether either party has defensive injuries

    d) Which party is more fearful

    e) In predicting or anticipating violence, whether it is likely that one party acted with violent resistance

    f) Patterns of coercion, intimidation and/or violence by either party.

42. The VPM FV also explains that if members are unsure about how to assign the predominant aggressor, they should consider which person appears to be the most fearful and who is most

[12] Family Safety Victoria, *MARAM Practice Guides: Foundation Knowledge Guides* (February 2021), 124.

in need of protection. The VPM FV also requires police responding to family violence incidents to take other actions which assist in identifying the predominant aggressor, such as:

a) Completing an FVR-L17 and using this to "*help identify the history of violence in the relationship and any patterns of harmful behaviour, taking into consideration AFM and other party relationship*"

b) Where possible, speaking to all parties privately to determine what has occurred

c) Independently assessing the level of risk to the children to ensure their safety.

43. It appears that there were some instances of deviation from the VPM FV in the police response on 20 September 2022. It also appears that attending police (and the supervisor contacted via phone) took an incident-based approach, as evidenced by the statements made on the day including:

a) "*I reckon in relation to today she's the respondent. The kids are scared shitless and they want to go*".

b) "*I think we just have to deal with what's happened today…and that's – the kids have had to call dad because mum's changing the locks*".

c) *"So I reckon she goes as the respondent in my opinion…Disregard the historical stuff cause we're just doing L17s*".

44. I note that police did not speak to the children to confirm whether they were scared of Ms KSQ and did not speak to them privately to determine what had occurred. This may have assisted in determining whether the FVSN against Ms KSQ was required, noting that a deciding factor in implementing a FVSN was the perceived protective impact it would have on the children.

45. Incident-based policing is inappropriate in the context of family violence and is counter to police guidance on identifying the predominant aggressor. If the police response on 20 September 2022 was oriented towards identifying the predominant aggressor and patterns of coercion, intimidation and violence, it may have constituted a more appropriate and thorough response.

46. The above observations are not intended as a criticism of the individual members involved with the response on 20 September 2022, or of the decision-making that followed. I note the

challenges faced by police in attending any family violence incident and of determining the appropriate and safest course of action in the circumstances. I accept it is never an easy endeavour.

47. I also make no implication that a different response would have prevented the final outcome.

48. However, in my view, this situation shows that specialist further support and guidance would be of deep assistance to Victoria Police members in providing immediate responses to complex family violence callouts. In this case, upon police arrival, all parties were calm and cooperative, and police required resort to their sergeant for advice about what to do next due to the uncertainty they faced in the circumstances. Their sergeant was aware that the course of action adopted would be '*criticised*'. Trauma-informed responders with a specialisation in family violence may have been able to more holistically assess risk, engage with the children, and formulate a plan with the family. Alternative programs which incorporate specialist family violence services into functions currently carried out by police are discussed further below.

Response by Victoria Police

49. In response to my proposed comments on this issue, Victoria Police submitted:

    a) The available evidence does not support a conclusion that the events of 20 September 2022 are sufficiently proximate and causative of the death to provide a jurisdictional basis to include any proposed adverse comment in the finding; and

    b) Alternatively, if I remain satisfied that I am empowered to make comments regarding the 20 September 2022 attendance, an evidentiary basis to make the comments as proposed does not exist.

50. I will address both issues in turn.

Jurisdictional power to make comment

51. Victoria Police submitted that while section 102W(d) of the Act provides a broad scope to "*identify trends and patterns in response to family violence*", it should be considered within the scope of the Act and authorities such as *Harmsworth v The State Coroner*.[13] In those circumstances, Victoria Police submitted that the attendance on 20 September 2022 is not

[13] [1989] VR 989, 996.

sufficiently proximate and causative to the death and therefore should not be referenced by way of any adverse comment or finding.

52. Section 102W(d) of the Act is indeed broad and I accept that the coronial jurisdiction is not limitless. I also accept, as I have already stated, that the police attendance on 20 September 2022 was not proximate to nor causative of the death.

53. However, it is a well-established principle that a coroner may make comments and recommendations even if the subject-matter of the comment or recommendation is not causally related to the death.[14] Where I consider that police attendance on 20 September 2022 is relevant to the broader circumstances in the lead-up to Ms KSQ's death, following which her mental health deteriorated and she exhibited increased suicidality, I consider that the issue may be permissibly canvassed in the present finding and, as appropriate, be the subject of comments or recommendations.

Evidentiary basis

54. Victoria Police submitted that the attending members on 20 September 2022 were faced with a particularly challenging situation due to the following factors:

    a) It was the first police attendance in relation to Ms KSQ and her husband. There were no parenting orders in place for the children and no FVIOs in place between Ms KSQ and her husband.

    b) The children were present, including a friend of one of the children.

    c) Divorce proceedings were imminent, and legal advice was being provided in relation to the incident to Mr QDZ.

    d) Victoria Police understood that Ms KSQ presented at the family home in order to change the locks on advice from her husband. The lawyer also advised her to take out an FVIO against Mr QDZ.

55. I agree with the submissions made on behalf of Victoria Police that such circumstances would have presented a challenge to attending members, particularly in the oft-vexed task of identifying the predominant aggressor. However, it is not uncommon for Victoria Police to attend family violence incidents where there are overlapping family law/divorce proceedings,

[14] *Thales Australia Limited v Coroners Court of Victoria* [2011] VSC 133.

children are present, and parties had their own lawyers involved. They also attend family violence incidents where one or more parties are substance affected, have serious mental health conditions, a weapon was involved, amongst many other issues. I accept that the attending members were unsure how to proceed, as evidenced by their decision to call a supervisor, which I consider was appropriate in the circumstances. However, this incident was not dissimilar to many other family violence incidents that are routinely reviewed by this Court.

56. In the Court's correspondence to Victoria Police, it noted some of the quotes from attending members on 20 September 2022:

    a) *"I reckon in relation to today she's the respondent. The kids are scared shitless and they want to go*".

    b) *"So I reckon she goes as the respondent in my opinion…Disregard the historical stuff cause we're just doing L17s*".

    c) "*I think we just have to deal with what's happened today…and that's – the kids have had to call dad because mum's changing the locks*".

57. It submitted that as I do not have statements from the members involved, "*the available evidence provides a basis for comments arising from the above and no further*". I consider that these quotes give an example of some of the difficulties police faced in responding to this incident. In my view, they also clearly demonstrate that police were only considering the incident for which they were responding (the changing of the locks). Even when considered within the relevant context and in chronological order, the member's direction to "*disregard the historical stuff*" clearly depicts that members had decided to proceed by ignoring the reported historical sexual abuse (in relation to which Ms KSQ was the victim-survivor) and were only considering the present incident.

58. I accept that I do not have statements from the attending members and obtaining those nearly three years after the incident would be of limited evidentiary benefit. The State Coroner, Judge Cain, noted a similar difficulty in his finding into the death of FCP.[15] His Honour recommended:

[15] Finding into death without inquest – FCP (COR 2020 1981).

That Victoria Police update their policies and documents to require members to document the reason for their decision to assign the roles of AFM and respondent and document the conversation(s) held with the respective parties/other witnesses when attending family violence incidents where the roles of AFM and respondent are not clear.

59. Victoria Police's response to this recommendation indicated that they were supportive of same and that they are presently developing the Family Violence Predominant Aggressor Practice Guide (**'the Practice Guide'**) which will direct members to include information in their FVR L17 regarding their determination of the predominant aggressor and AFM in incidents of family violence. The Practice Guide will also guide members to document any uncertainty regarding their identification of the predominant aggressor in the FVR L17, and to document any conversations with parties, including witnesses.

60. This guidance would have been beneficial for the members attending on 20 September 2022 and I support Victoria Police's work to include this guidance in their new Practice Guide.

61. In circumstances where I do not have statements from the attending members and only the conversations captured on BWC, I cannot take this issue any further.

Misidentification of the predominant aggressor

62. Research indicates that when women use violence in heterosexual intimate relationships, the violence tends to be a consequence of their own victimisation and as a violent resistance to a pattern of controlling, coercive and violent behaviour used against them.[16] It is important therefore that the primary aggressor is selected by police on the basis of a pattern of coercive and controlling behaviour, rather than on the basis of an incident-based approach to investigation which does not take patterns of coercion and control into account.[17]

63. Since Ms KSQ's death, Victoria Police have undertaken work to address the issue of police misidentification of the predominant aggressor. They have updated and improved guidance on identifying the predominant aggressor in line with Victoria's family violence risk

[16] Women's Legal Service Victoria, *"Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family violence incidents in Victoria* (Policy Paper One, July 2018), 2-3; Family Safety Victoria, *MARAM Practice Guides, Foundation Knowledge Guide: Guidance for Professionals Working with Child or Adult Victim Survivors, and Adults Using Family Violence* (2021) 112.

[17] Heather Nancarrow et al, 'Accurately Identifying the "Person Most in Need of Protection" in Domestic and Family Violence Law' (Research Report Issue 23, ANROWS, November 2020), 27; Women's Legal Service Victoria, *"Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family violence incidents in Victoria* (Policy Paper One, July 2018) 4.

assessment and management framework, the Multi-Agency Risk Assessment and Management framework (**MARAM**).[18] Victoria Police also carried out the Predominant Aggressor Identification Trial (**the Trial**) in the Northwest Metro Division Five between October and December 2022. The aim of the Trial was to examine police risk assessment decisions and to identify opportunities for interventions or practice changes that support early recognition and rectification where misidentification has occurred. The Trial encouraged consultation and review at different points in the police process when police members identified a female respondent in the context of a heterosexual relationship. It also involved the provision of a MARAM-aligned tool to assist supervisors with reviewing these cases.

64. The findings from the Trial were discussed in detail in Coroner Despot's finding into the death of EDH.[19] In summary, the Trial identified ongoing problems associated with police misidentification of the predominant aggressor:

a) Supervisory support prior to submission of the FVR L17 was uncommon, possibly due to resourcing issues, meaning police members rarely received support with identifying the predominant aggressor prior to committing their assessment to LEAP and taking further actions, such as making family violence referrals and applying for FVIOs.

b) Supervisor case reviews were completed after the completion of FVR L17s in 38.4% of the cases where a female was identified as the predominant aggressor (56 of the 146 instances) but were wholly ineffective in identifying cases of misidentification.

c) There were no documented instances of information sharing with relevant agencies to improve accurate identification of the predominant aggressor. Even uncertainty about the predominant aggressor did not prompt information sharing by police, and the Trial concluded that '*information sharing continues to be under-utilised at the frontline and across the broader systems into Victoria Police*'.

d) Following the Trial, a review of the police records relating to the 146 instances where police identified a female predominant aggressor found likely cases of misidentification which were not identified at any stage of the trial. This is particularly concerning given the additional mechanisms in place for improving accurate identification of the predominant aggressor during the Trial.

[18] Victoria Police, *Victoria Police Manual – Family Violence* (April 2022) 10-1; Family Safety Victoria, MARAM Foundation Knowledge Guide (2021), 113.
[19] Finding into death without inquest – EDH (COR 2021 000204).

e) The Trial found that police continue to take an incident-based approach to assessing predominant aggressors, and to '*equate criminal offending with the predominant aggressor at a family violence incident*', and that this has led to instances of misidentification of the predominant aggressor.

f) Which party contacted the police influenced the subsequent direction taken by police - when a male using systems abuse contacted police to make a report about their partner, misidentification was more likely to occur.

65. During the Trial, the only point of review which was effective in identifying instances of misidentification was review by a Family Violence Court Liaison Officer (**FVCLO**). Of the 16 cases subject to a review by a FVCLO, six were confirmed as misidentified, and three others were identified as suspected misidentification. These included cases which had previously been reviewed by a supervisor at a police station. The Trial report suggests that one reason for the discrepancy in different types of reviews' efficacy in picking up on misidentification may be the differing priorities between police members working in different contexts whereby '*the station focuses on criminality and immediate safety in contrast to the pre-court space, where there is a civil and justice focus*.'

66. Following the Trial, Victoria Police have continued their work on addressing misidentification of the predominant aggressor through their Predominant Aggressor Program of Work, which started in December 2022 after the Trial ended. This work includes improving training and guidance and considering amendments to record keeping systems which promote correct initial identification of the predominant aggressor.

Expansion of Victoria's co-responder program

67. Co-responder programs involve the presence of a family violence specialist worker during police attendance at family violence incidents to provide a collaborative response. Research has identified key benefits to co-responder programs, including higher satisfaction of victims with police, increased willingness of victims to contact police in future, more information sharing and coordination of services for victims, greater understanding of family violence by police, and a perceived increase in the accountability taken by police in responding to family violence.[20] Further, co-responder programs are a popular option for reducing rates of misidentification of the predominant aggressor amongst researchers, police, and people with

[20] VSRFVD, Multidisciplinary responses to Family Violence (2023), 4, 6.

lived experience of family violence.[21] Victoria Police, Family Safety Victoria (**FSV**) and ANROWS also agree that co-responder models have the potential to reduce rates of misidentification of the predominant aggressor.

68. Specialist family violence services are currently unable to successfully engage with a large proportion of the AFMs referred to them under the current system, whereby police make referrals after attending family violence incidents. Diverting resources from the current referral pathway and into the co-responder programs may effectively engage more AFMs whilst also reducing police misidentification of the predominant aggressor and introducing all of the other benefits to co-responder programs discussed above.

69. The Alexis Family Violence Response Model is a co-responder model which operates across Prahran, Bayside and Sommerville Family Violence Units. Evaluations of the program have found many positive effects, including a reduction in family violence recidivism by 85 per cent,[22] increased reporting,[23] and transfer of skills and knowledge between police and specialist family violence workers.[24] In a December 2024 review of the Alexis Family Violence Response Model, RMIT University in conjunction with The Salvation Army noted:

> *Overall, the Alexis-FVRM provided a range of support to a diverse pool of respondents and victim-survivors in several police divisions across Victoria. Taken together, the two stages of the evaluation results are largely positive regarding the efficacy of the Alexis-FVRM. The evaluation results indicate that the Alexis-FVRM helped to reduce the risk of family violence for many of the respondents and affected family members, and that the victim-survivor survey participants generally felt safer and supported following the coordinated police and social services response.*

70. I note in his Honour's recent finding into the passing of Noeline Dalzell, State Coroner Judge Cain, in particular, recommendation 5:

> *Victoria Police and The Orange Door in two regions as a pilot collaborate to embed advanced family violence practitioners within each FVIU [Family Violence Investigation Unit] to assess, jointly respond to and manage repat and/or high-risk*

[21] Nancarrow, H., Thomas, K., Ringland, V., & Modini, T., Accurately identifying the "person most in need of protection" in domestic and family violence law (No. ANROWS Research Report 23, 2020) 21, 96.
[22] Dr Lisa Harris, Dr Anastasia Powell and Dr Gemma Hamilton, Alexis – Family Violence Response Model (Evaluation Report, 2017) 28.
[23] Hamilton, G., Harris, L., & Powell, A., 'Policing Repeat and High-Risk Family Violence: Police and Service-Sector Perceptions of a Coordinated Model' (2021) 22(3) *Police Practice and Research*, 145.
[24] Ibid, 145-152.

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 and provided with supervision by a specialist family violence service.

An independent evaluation of the pilot program should be completed within two years of commencing operation in each of the two regions selected.[25]

71. Judge Cain also noted the potential benefits of co-responder programs in the finding into the death of Carolyn James.[26]

72. I cannot determine now that if a co-responder program was available in Ms KSQ's area at the time of her interaction with police, that her death would have been prevented. However, it would have likely provided Ms KSQ with an alternative pathway to engage with specialist family violence services and receive support. I intend to make a recommendation regarding the expansion of co-responder programs in Victoria.

Specialist family violence sector reviews of Victoria Police Family Violence Reports

73. The Family Violence Reform Implementation Monitor's (**FVRIM**) report *Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor* (**FVRIM report**) made recommendations in relation to improving accurate police identification of the predominant aggressor, and all were endorsed by State Coroner Judge Cain in the finding into the death of Michael Power.[27] Victoria Police are undertaking a program of work designed to address "*the intent of all [FVRIM] recommendations*", however, this does not appear to include FVRIM recommendation five, namely, that Victoria Police:

Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possibly for other targeted cohorts) before it is committed to Victoria Police's LEAP database.[28]

[25] CCoV, Finding into passing following inquest – Noeline Dalzell (COR 2020 000670), 79-80.
[26] CCoV, Finding into death following inquest – Carolyn James (COR 2022 1604), 13-14.
[27] CCoV, Finding into the death of Michael Power 2016 5556, 24.
[28] FVRIM, Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor (Report, December 2021), 6.

74. This recommendation was made based on recurring suggestions to the FVRIM during their consultation with government agency staff, community organisations and victim survivor groups.[29]

75. Implementation of this recommendation has the potential to significantly reduce rates of misidentification of the predominant aggressor by:

    a) Drawing on the expertise of the family violence sector in assessing predominant aggressors

    b) Facilitating skills and knowledge transfer from the family violence sector to police

    c) Reducing issues related to the focus on criminality in the police station context identified in the Victoria Police Identification of the Predominant Aggressor Trial, by involving specialist family violence workers outside of the station environment and broader police culture

    d) Promoting information sharing between Victoria Police and the family violence sector

    e) Ensuring appropriately thorough consideration of the information available to police, including past LEAP records, when determining the predominant aggressor

    f) Ensuring all of the above is done before the L17 is committed to LEAP, triggering harmful actions such as applications for FVIOs in protection of family violence perpetrators and family violence referrals which misidentify victims as perpetrators.

76. The same issues were canvassed in Coroner Despot's finding into the death of EDH. In that matter, the Court wrote to Victoria Police to seek their views on a potential recommendation:

    That Victoria Police and Safe and Equal collaborate to implement recommendation five of the FVRIM, by trialling a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent before it is committed to Victoria Police's LEAP database.

77. In that matter, Victoria Police responded and suggested that it supported recommendation 5 of the FVRIM, however noted the complexity of making such a recommendation in circumstances where there are many stakeholders who may have differing views. It also

[29] Ibid.

stressed that any proposed reform should be driven as a whole of government approach, rather than with Victoria Police and Safe and Equal only.

78. State Coroner Judge Cain made a similar recommendation in his finding into the death of FCP,[30] namely:

> *That Victoria Police fully implement recommendation 5 of the FVRIM December 2021 report, Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor, specifically to "Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possible for other targeted cohorts) before it is committed to Victoria Police's LEAP database." The review of Family Violence Reports should occur by police and members of the specialist family violence sector together.*

79. In response to the FCP finding, Victoria Police noted that it "*has significant concerns regarding the operability of the proposed review process, as recommended by the [FVRIM]. Specifically, Victoria Police is concerned with the potential safety risks associated with any delays in information being committed to the LEAP database, noting resourcing constraints across the sector which may impact the timely review of FVRs/L17s.*"

80. Victoria Police further submitted that "*it is not desirable to commit to trialling a solution which has not been developed within the sector and in conjunction with the relevant stakeholders*". These submissions were repeated by Victoria Police in response to the Court's correspondence in this matter regarding a potential recommendation.

81. I note that FVRIM Recommendation 5 was made based on recurring suggestions to the FVRIM during their consultation with government agency staff, community organisations and victim survivor groups. Victoria Police's submission the trial was not developed within the sector and in conjunction with the relevant stakeholders is therefore, in my view, without proper basis. It was formulated based on direct feedback from relevant stakeholders. Furthermore, it is merely a trial and if it were trialled and found to be unsuccessful, then appropriate lessons could be learnt and taken from same.

[30] CCoV, Finding into death without inquest – FCP (COR 2020 1981).

FINDINGS AND CONCLUSION

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

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

    b) the death occurred between 13 and 15 May 2023 at Marriott Waters Reserve car park, Lyndhurst, Victoria, 3975, from 1(a) PLASTIC BAG ASPHYXIA; and

    c) the death occurred in the circumstances described above.

83. Having considered all of the circumstances, I am satisfied that Ms KSQ intentionally took her own life. In having made such a finding, I note the lethality of means chosen and Ms KSQ's rapid deterioration in mental health, and increase in suicidality, prior to her death.

RECOMMENDATIONS

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

(i) 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.

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

ORDERS AND DIRECTIONS

Pursuant to section 73(1A) of the Act, I order that this finding be published in a de-identified manner 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:

Mr QDZ, Senior Next of Kin

Department of Families, Fairness and Housing

Family Safety Victoria

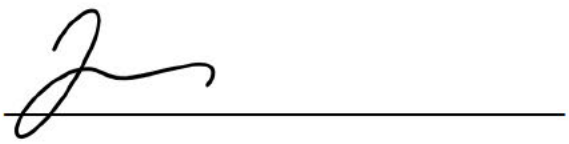
Ms NWA

Monash Health

Victoria Police

Senior Constable Sebastian Krivohlavy, Coronial Investigator

Signature:



INGRID GILES

CORONER

Date: 28 July 2025

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