



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2023 002887**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Monique Anita Lezsak
Date of birth:	30 August 1983
Date of death:	30 May 2023
Cause of death:	1(a) Multiple stab wounds
Place of death:	9 Kassan Gardens, Endeavour Hills, Victoria, 3802
Keywords:	Homicide; intimate partner violence; coercive control; recent separation

## INTRODUCTION

1. On 30 May 2023, Monique Anita Lezsak was 39 years old when she was fatally attacked by her partner and died at her home in Endeavour Hills, Victoria. Monique is survived by her young twins and her parents.
2. Monique was described as a passionate bodybuilder who was dedicated to maintaining her fitness. Monique first encountered her partner, Sven Lindemann, in about 2014 or 2015 when she purchased clothing from his online gym apparel store. Monique and Sven did not communicate for several years, however commenced a relationship in about 2018. Sven was living in South Australia at the time with his wife and two children. After pursuing a relationship with Monique in 2018, Sven decided to move to Melbourne and commenced living with Monique, her children and her parents in about 2019.
3. As Monique and Sven's relationship progressed, friends observed that Sven exhibited some concerning and controlling behaviour. Monique was very popular in the fitness industry and was active on social media, however Sven became concerned when males spoke to her via Facebook or Instagram. Saturdays became 'Sven's day', requiring Monique to walk on 'egg shells' around him to ensure that her children did not disturb Sven. Monique was reportedly required to prepare meals for Sven which he ate in his room (rather than in the kitchen with the rest of the family). Monique and Sven went out together, however never in the company of Monique's children. Sven reportedly ignored the children or forced them to apologise for making noise. Sven threatened suicide if Monique tried to leave him, and their friends attempted to manage his behaviour, for example, preventing males from approaching Monique when the couple were at the gym together.
4. By mid-2022, conflict was regularly occurring between Sven and Monique, regarding the parenting of her two children. Sven was reportedly critical of Monique's parenting and expressed anger "*because of the children*". One of her children had been diagnosed with autism and Sven believed the other child had undiagnosed obsessive compulsive disorder.
5. Sven and Monique decided to purchase a house and land package in another suburb of Melbourne. The home was to be purchased in Sven's name only, and Monique transferred over \$100,000 of her savings into Sven's bank account to bolster his loan application. While Monique was initially comfortable with this approach, she later became uneasy as her relationship with Sven deteriorated.

6. In April 2023, Monique, her two children, her parents and close friend, Jacqueline Schwarcz, travelled to Queensland for a family holiday. While in Queensland, Monique and Jacqueline exercised at a local gym and posted about it on social media. This drew the attention of a man named Jona, who was a patron of that gym. Monique and Jona started conversing with one another online and decided to meet in person.
7. Upon Monique's arrival home, and prior to Sven's departure for a solo trip to Germany to visit family, he made a concerted effort with her children, however Monique's lack of feelings for him remained unchanged. Sven left Australia on 1 May 2023 for Germany. While he was away, Monique travelled to Queensland to meet with Jona and returned Melbourne on 21 May 2023.

## THE CORONIAL INVESTIGATION

8. Monique's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
11. Victoria Police assigned Detective Senior Constable David Martin-Alcaide to be the Coronial Investigator for the investigation of Monique's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, friends, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence.
12. This finding draws on the totality of the coronial investigation into the death of Monique Anita Lezsak 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.<sup>1</sup>

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

### **Identity of the deceased**

13. On 2 June 2023, Monique Anita Lezsak, born 30 August 1983, was visually identified by her cousin, Alana Peril.
14. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

15. Forensic Pathologist Dr Chong Zhou, from the Victorian Institute of Forensic Medicine (VIFM) conducted an autopsy and provided a written report of her findings dated 1 August 2023.
16. The post-mortem examination revealed 17 sharp force injuries about the head, neck, chest, back, and left arm. This included seven stab wounds and ten incised injuries. Additionally, some linear abrasions were present which may also represent superficial injuries sustained from the tip/edge of a sharp implement.
17. Sharp force injuries refer to wounds caused by implements with a sharp tip and/or edge. A stab wound is a type of sharp force injury in which the depth of penetration into the body is greater than the length of injury on the skin surface. An incised injury (also known as a ‘cut’ or a ‘slash’) is a type of sharp force injury in which the length of the wound on the skin’s surface is greater than the depth of penetration into the body.
18. The most immediately life-threatening injuries included the stab wounds to the neck and right chest which could cause death via blood loss and respiratory compromise. However, all of the stab wounds likely contributed towards death by way of combined blood loss (an estimated ~2L was reported by paramedics at the scene).
  - a) The stab wound to the neck cut into the trachea (windpipe), completely transected the right common carotid artery, went into the right chest cavity and penetrated the apex

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<sup>1</sup> 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.

of the right lung. The transected artery would have caused significant blood loss, and the injury to the trachea would have caused significant respiratory impairment and inhalation of blood.

- b) The stab wound to the right chest caused a through-and-through injury to the right lung and was associated with approximately 150mL of blood and a moderate amount of air within the right chest cavity.
  - c) A stab wound to the abdomen cut into part of the small bowel and inferior vena cava. Venous bleeding is slower than arterial bleeding and only about 50mL of blood was located within the abdomen. The injury to the small bowel was not immediately life-threatening.
  - d) The three stab wounds to the back went into the muscle and one of them superficially cut into the back of the lumbar vertebra. None of these injuries penetrated into the chest cavity.
19. There were sharp force injuries about the left forearm (including a through-and-through stab wound), left wrist, and left hand, which were consistent with defence-type injuries. There were also multiple incised injuries about the lip, neck, right breast, lower right chest/abdomen, and back. These injuries were mostly superficial penetrating into the dermis or subcutis only. Therefore, their relative contribution towards blood loss was likely to have been minimal.
20. There were also a few small abrasions and contusions about the right forehead, just above the right eye, and about the left jaw indicative of blunt force trauma to these regions. Blunt force injuries occur when a blunt object strikes the body, or the body impacts a blunt object or surface. None of these injuries were patterned and there was no associated intracranial haemorrhage or skull/facial fractures.
21. Incidental microscopic findings in the subcarinal lymph node and lungs raised the possibility of sarcoidosis. This did not cause or contribute to the death.
22. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.
23. Dr Zhou provided an opinion that the medical cause of death was *1(a) multiple stab wounds*.
24. I accept Dr Zhou's opinion.

## Circumstances in which the death occurred

25. On 27 May 2023 after Sven had returned from Germany, Sven and Monique checked into the Mantra Hotel on Russell Street, Melbourne for a weekend getaway. This was planned by Sven, however Monique continued conversing with Jona during this time. Following their weekend getaway, Sven and Monique “*seemed okay when they came home, but not loving towards each other*”.
26. On the morning of 29 May 2023, Monique called Sven and ended their relationship. She then attended her local gym and worked out with her friend, Jacqueline. Monique told Jacqueline about the end of her relationship and said she was not worried as Sven had said he was ‘ok’. Monique expressed concerns, however, about the money that she had transferred to Sven for the house and land package that they purchased together.
27. Jacqueline remained concerned about Monique as she observed Monique distracted and on her phone during their workout. She noted that Sven reportedly had to be driven home from work after being told of the breakup as he was so distraught. Monique sent two messages to her friend, Alistair Mundy-Castle, in which she explained that she had ended her relationship with Sven and was nervous about returning home. She admitted to Alistair that she was concerned about Sven doing “*something stupid*”. Monique later called Alistair and explained that Sven was leaving work early so that the pair could discuss their breakup.
28. Monique arrived home in the early afternoon, where Sven was waiting for her. At 2.18pm, Sven called Alistair, whom he was also friends with, and explained that Monique had ended their relationship, and he felt like “*necking himself*”. Alistair responded by telling Sven “*not to be silly*”. Sven suggested that he would “*put a spell on her*” (in the context of recently exploring ‘witchcraft’), which Alistair “*shut down immediately*”.
29. When Monique’s father returned home from work at about 4.30pm, he overheard Sven and Monique talking about Jona. Sven discovered Jona’s identity and sent a series of messages to Jona via Instagram. At 7.52pm, Monique left home in her car and drove to a nearby high school where she called Jona. She told him that she had ended the relationship with Sven, who was initially accepting of the decision, but later changed his mind and wanted to undertake couples counselling.
30. At 8.01pm, Sven called Alistair and told him of his disbelief about the end of his relationship. Alistair could hear Monique’s daughter crying in the background as Sven told her that she had

a new stepfather who was 26 years old. Alistair encouraged Sven to be kind and loving towards Monique's daughter.

31. Over the course of that evening, Monique's mother, Magali Peril, observed Sven becoming increasingly angry. Magali observed Sven verbally abusing Monique over the course of the evening. Monique left home at about 8.50pm and again called Jona. She expressed concerns that Sven was manipulating her daughter into believing that Sven could offer them a better future than she could.
32. Later that evening, Sven sent a series of text and audio messages to Jona via Instagram and Facebook messenger in which he blamed Jona for destroying his family and suggested Jona was lucky that he was living in another state.
33. Monique spent the night sleeping in her daughter's room, while Sven spent the night in the couple's bedroom. At about midnight on 30 May 2023, Sven entered the bedroom Monique was sleeping in, and the pair had a heated discussion.
34. At about 6.15am, Monique's father, Zoltan Lezsak, was in the kitchen getting ready for work when Sven walked in. Sven commented that Monique was "*crazy*" and that he would move his belongings out of the house. Zoltan left for work at about 6.35am and noted that while Sven was still upset about the end of his relationship, he appeared calm.
35. Magali awoke at about 7.00am and entered the kitchen, where she was joined by Sven. Magali observed that Sven looked angry, and she offered to make him a coffee, which he declined. At about 7.30am, Monique sent some audio messages to Jona in which she detailed her daughter's distress at the end of her relationship. Her daughter reportedly tried to convince Monique to reconsider her decision. Monique's final text messages to Jona were sent between 7.30am and 7.32am. She advised Jona that her daughter had chosen Sven over her and that both children would not be attending school that day.
36. After Monique sent the final message, Sven commenced an attack on Monique in their bedroom. Her screams were so loud that they were captured on their neighbour's CCTV recording. Monique's daughter overheard her mother's screams and ran to the bedroom where she observed Sven stabbing Monique with such force that he broke the knife. Sven punched and strangled Monique, then dragged her out of the room, through the house and into the kitchen.

37. Monique's daughter screamed as Sven dragged Monique into the kitchen, and she tried to intervene to stop the attack. Sven obtained another knife from the knife block, then repeatedly stabbed Monique. Monique's daughter and her mother bravely tried to intervene by kicking Sven and wrestling the knife off him, throwing it onto the floor. Sven obtained a third knife and continued stabbing Monique. This knife also broke due to the force Sven was using.
38. Sven grabbed a fourth knife and resumed the attack. Monique's daughter again attempted to wrestle the knife from him. Sven then obtained a fifth knife and dragged Monique into the dining room where he continued the assault on Monique. Her daughter continued her brave efforts to save Monique, and in the process received knife injuries to her hands, elbow and shoulder. Sven eventually left Monique fatally injured on the floor and retreated to the bedroom.
39. Monique's daughter called 000 and reported her mother's boyfriend had stabbed and killed her mother because she was trying to break up with him, while also trying to comfort her mother.
40. Meanwhile, Sven transferred about \$71,000 from one of his bank accounts to another account and then tried to call his former wife, however, was unable to reach her. At some point after entering the bedroom, Sven inflicted several stab wounds to himself.
41. Emergency services arrived on scene quickly and attempted to revive Monique, however she succumbed to her injuries and died at the scene. Monique's daughter was transferred to hospital where she received treatment for her five lacerations. Sven was admitted to the Alfred Hospital where he underwent emergency surgery for his self-inflicted wounds. He was discharged into custody on 12 June 2023.
42. Sven pleaded guilty to the charge of murder and recklessly causing injury to Monique's daughter and was sentenced to 31 years' imprisonment, with a non-parole period of 25 years.

## **FINDINGS AND CONCLUSION**

43. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
  - a) the identity of the deceased was Monique Anita Lezsak, born 30 August 1983;
  - b) the death occurred on 30 May 2023 at 9 Kassan Gardens, Endeavour Hills, Victoria, 3802, from *1(a) multiple stab wounds*; and



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

## COMMENTS

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

### Coercive and controlling behaviour

44. I am deeply troubled by the circumstances of this matter but note that unfortunately it is not unique. The court has investigated a numbers of cases that follow a similar pattern. I have recently commented on this my finding into the death of in Michelle Darragh<sup>2</sup> where the victim was murdered with a knife in the context of separation and controlling behaviours, and her partner then turned the knife on himself.
45. This is also recognised in the ANROWS report *Pathways to intimate partner homicide project: Key stages and events in male-perpetrated intimate partner homicide in Australia*, one of the three pathways identified were of the ‘fixated threat’ offender, who is characterised by primarily coercive controlling behaviours and non-physical forms abuse throughout a relationship, and prior to the fatal incident.
46. The research indicates these perpetrators are typically employed or running their own business, and middle class with minor or no prior involvement with the justice system. It also identifies that the period of acute escalation for many of these offenders, that coincided with their loss of control of the victim preceding the fatal incident, is typically very short, creating challenges for disruption or intervention. Over 50% of these offenders use a knife in the fatal incident, and in 75% of cases, the offender was older than the victim, by an average of 8.4 years. This case sadly aligns to all of these previously identified factors.
47. It is well recognised in literature, and indeed in the Victorian Multi-Agency Risk Assessment and Management framework (**MARAM**) that controlling behaviours and obsessive jealousy are risk factors of a victim being killed or almost killed. Separation is also a risk factor for fatality included in the MARAM and observed in the ANROWS research above.
48. The challenge we continue to face as a community, is that there is a specific kind of family violence perpetrator, such as in this matter, who does not come to the attention of services of authorities nor family violence service providers, often until the fatal incident. While a victim, family and friends, may notice controlling behaviours, with good intentions they often seek

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<sup>2</sup> Finding into death without inquest – Michelle Darragh (COR 2021 5393).

to manage them, and are unaware of the significant risks these men pose, due to the lack of physical violence.

49. I also note that in the matter of Samantha Fraser COR 2018 003600, I recommended that Family Safety Victoria consider the available evidence and consider re-partnering by the victim as a risk factor to be considered in the MARAM. The response from DFFH indicated that the 2023 review of the MARAM did not identify this as a risk factor to be added and they committed to exploring how the findings from the Coroner's recommendation could strengthen practice guidance for existing risk factors. Given the circumstances in this case again illustrating re-partnering as a potential risk, I will be directing that a copy of this finding is provided to FSV to inform their ongoing work.

### **Children bereaved by family violence homicide**

50. I turn now to Monique's children. It is increasingly recognised that children are victims of family violence in their own right and should be responded to as such. There is nothing that brings this to light more starkly than children bereaved by a family violence homicide.
51. I cannot imagine the terror felt by Monique's children, faced with a man their mother had loved and welcomed into her home, attacking her in a violent rage, where the entire family had the right to feel safe. Not only has their mother been murdered, but they now have unimaginable scars from the violence they have been exposed to and experienced. I commend the immense courage of Monique's daughter Ivy, who so bravely and persistently intervened to try to save her mother in the face of such horrendous violence.
52. I have commented previously on the importance of specific services for children bereaved by homicide, noting recent studies on and by children of parents who have died from intimate partner homicide, and reporting by the Commission for Children and Young People (CCYP) that children in families bereaved by domestic homicide remain invisible and lack comprehensive support through the service system. We are yet again seeing children not only bereaved by family violence but deliberately exposed by a family violence perpetrator to a final, terrifying, fatal, act of violence. Until we are able to prevent these acts, we must certainly do everything in our power to support children who experience them.
53. Whilst it is important to emphasize that not all children bereaved by homicide will have the same experience, the impact of a family violence homicide can have long-term effects on a child's development and wellbeing. Studies have found that children exposed to fatal family

violence can experience substantial mental health and developmental difficulties, with concerns that some children may also be at greater risk of perpetrating family violence in the future. In an Australian study which interviewed 70 children from Australia, the United Kingdom and Ireland who have been bereaved by intimate partner homicide, researchers found that surviving children often carried a pervasive sense of being ‘different’ from their peers, impacting on their social life and capacity to relate to their peers.<sup>3</sup> Surviving children spoke of those around them failing to acknowledge the family violence as causing the death, viewing them as ‘damaged’ and in some cases, blaming of their deceased parent.<sup>4</sup>

54. Upon a review of the available services, study participants noted that supports were hard to find or non-existent and that when support *was* available, it was not specialised to appropriately respond to the types of traumas experienced by these children.<sup>5</sup>
55. Several support services for children affected by homicide exist internationally and in other Australian jurisdictions. In the United States, the Arizona Child and Adolescent Survivors Initiative providers wraparound services to children bereaved by homicide including personal advocacy, mental health care, peer support, referrals to legal assistance, ongoing case management and mentoring.<sup>6</sup> In Australia, the Homicide Victims Support Group, in collaboration with the New South Wales Government, established Grace’s Place in 2022. Grace’s Place is the “*world’s first residential trauma recovery centre providing tailored support for children impacted by violent crime*”.<sup>7</sup>
56. Victoria does not have a similar program targeted at children bereaved by homicide. Children can access:
  - a) Victims of Crime - a generic service aimed at providing advice on victim entitlements and the criminal justice program.
  - b) Victims Assistance Program – a generalist victim support service provided by community services

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<sup>3</sup> Alisic, E, Barrett, A., Conroy, R., Devaney, J., Eastwood, O., Frederick, J., Houghton, C., Humphreys, C., Joy, K., Kurdi, Z., Marinkovic Chávez, K., Morrice, H., Sakthiakumaran, A., & Vasileva, M. (2023) ‘Children and young people bereaved by domestic homicide: A focus on Australia’, University of Melbourne and University of Edinburgh.

<sup>4</sup> Ibid, 6-7.

<sup>5</sup> Ibid, 13-14.

<sup>6</sup> Ibid, 15.

<sup>7</sup> New South Wales Government, ‘\$5 million towards safe have for children’, (media release 30 September 2023), <<https://www.nsw.gov.au/media-releases/safe-haven-for-children>>.

- c) Generalist family violence or trauma-informed counselling through services such as Take Two.

- 57. While these services offer critical assistance in the absence of specialist support, these agencies experience resource limitations which challenge their ability to work with all children needing their support. Research undertaken by the University of Melbourne in collaboration with the University of Edinburgh highlighted the need to introduce specific services that are equipped to offer comprehensive support in response to the uniqueness and complexity of this form of trauma and grief.<sup>8</sup> Researchers have repeated calls for specialist support for children and families bereaved by homicide, noting the urgency in developing this infrastructure in Victoria, with families bereaved by homicide currently accessing specialist services interstate as they have no other option.<sup>9</sup>
- 58. Recognition for the need for specialist support for families bereaved by homicide was also highlighted by the Centre for Innovative Justice's (CIJ) *Strengthening Victoria's Victim Support System: Victim Services Review*. In their final report, the CIJ recommended the introduction of a "*Specialist Service for Bereaved Families*" to provide long-term, highly specialised support and case management for those bereaved by family violence.<sup>10</sup>
- 59. In the Commission for Children and Young People's 2022-2023 annual report, it noted that DFFH advised that they would "*examine current service responses and identify any gaps and opportunities for service improvement*" and "*progress*" best practice guidelines for Child Protection practitioners working with children bereaved by homicide. As of February 2025, there do not appear to be any relevant practice guides within the Child Protection manual.
- 60. The introduction of protocols for responding to children bereaved by homicide would indeed help to guide practitioners, however, without dedicated funding and targeted specialist programs, the capacity of workers to meet the needs of this population may be compromised within an already stretched workforce. I therefore intend to make a recommendation to the Victorian Government to provide funding for a service designed to support children and young people (and their carers) who are bereaved by homicide.

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<sup>8</sup> Alisic, E, Barrett, A., Conroy, R., Devaney, J., Eastwood, O., Frederick, J., Houghton, C., Humphreys, C., Joy, K., Kurdi, Z., Marinkovic Chávez, K., Morrice, H., Sakthiakumaran, A., & Vasileva, M. (2023) 'Children and young people bereaved by domestic homicide: A focus on Australia', University of Melbourne and University of Edinburgh.

<sup>9</sup> Outcomes Practice Evidence Network, 'You Should Ask That: Continuing the conversation with the children of women killed by men' (video, 10 December 2024), <[https://youtu.be/qAoYo3LaqgM?si=Jp5ac\\_TyHX3jEhpo](https://youtu.be/qAoYo3LaqgM?si=Jp5ac_TyHX3jEhpo)>.

<sup>10</sup> Centre for Innovative Justice, 'Strengthening Victoria's Victim Support System: Victim Services Review – Final Report', (2020).

## RECOMMENDATIONS

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

- (i) That the **Department of Families, Fairness and Housing** and **Family Safety Victoria** work with and resource bodies such as Respect Victoria and Safe and Equal to deliver a public campaign to resource the broader community, beyond service providers, to better understand the risks that perpetrators of family violence pose, including in the absence of physical violence. This campaign should consider how to reach the broadest possible audience including through education, health, local community, sports and faith groups. The campaign should enhance awareness of fatality risks posed by those who use coercive and controlling behaviour, factors that may increase risk (such as in the context of separation) - and should include clear information to victims, friends, family and bystanders as to services available to help keep them safe.
- (ii) That the **Minster for Prevention of Family Violence** provide funding for a service designed to provide support to children and young people (and their carers) bereaved by homicide.

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

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

**Zolton Lezsak and Magali Peril, Senior Next of Kin (C/- Hymans Solicitors)**

**Commission for Children and Young People**

**Department of Families, Fairness and Housing**

**Family Safety Victoria**

**The Hon. Natalie Hutchins MP, Minister for Prevention of Family Violence**

**Detective Senior Constable David Martin-Alcaide, Coronial Investigator**

Signature:



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Judge John Cain  
State Coroner  
Date: 12 June 2025

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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.

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