IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003937

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Belinda Ann Jones
Date of birth:	10 January 1983
Date of death:	19 July 2023
Cause of death:	1(a) Streptococcal and staphylococcal meningitis, endocarditis and septicaemia Contributing factor(s) Osteomyelitis pubis
Place of death:	13 Porter Avenue Maryborough Victoria 3465
Keywords:	Meningitis; family violence; undiagnosed meningitis; rural urgent care centre; abandonment of family violence victim

INTRODUCTION

1. On 19 July 2023, Belinda Ann Jones was 40 years old when she was found deceased at her home in Maryborough, Victoria. Belinda lived with her de-facto partner, Michael Blyth, and was six to seven months pregnant to Mr Blyth when she passed.

Background – Belinda Jones

2. Belinda was born to parents Jeffrey Jones and Ann Maree Jones (**Ms Jones**) and was one of four siblings. When she was an adolescent, she "*met a boy who led her down the wrong path*". Belinda's mother noted that after this time, she started using illicit substances, experienced homelessness and worked in the sex industry. Many of her intimate relationships arose via her work in the sex industry.

3. Prior to her relationship with Mr Blyth, Belinda was in another long-term relationship with a man who perpetrated family violence against her.

4. Belinda had three children. Her eldest two children live with a former partner, while her third child (and first child with Mr Blyth) lives with her mother. Belinda and Mr Blyth were permitted to have supervised access with their child.

Background – Michael Blyth

5. Mr Blyth was 44 years old at the time of the fatal incident. He reportedly had four children prior to his relationship with Belinda. Some of these children were removed by Child Protection, while others lived with their mothers.

6. Mr Blyth was recorded as a perpetrator of family violence in relation to his father, a former partner and Belinda, and was accused of sexually assaulting a former partner's young child.

7. Mr Blyth has a significant criminal history which includes violent offending (unlawful assault, threats to inflict serious injury, recklessly causing serious injury, attempted rape). He was also convicted of family violence-related offences against Belinda, including contravening a Family Violence Intervention Order (**FVIO**), unlawful assault and recklessly causing injury.

8. Mr Blyth also has a history of illicit substance use including cannabis, ecstasy, heroin and methylamphetamine. The available records demonstrate differing accounts of mental health issues, including a possible diagnosis of schizophrenia.

Relationship between Belinda and Mr Blyth

9. Belinda and Mr Blyth commenced a relationship sometime between 2013 and 2016. Belinda told her mother that Mr Blyth was "*nasty*" and was very violent towards Belinda, including assaulting her. Belinda's reports to Victoria Police included allegations of Mr Blyth destroying her property, headbutting her in the face, threatening to "*smash her head in*", kicking and punching her, throwing items at her and stealing her property and her pet. Although Belinda engaged with Victoria Police on occasion, it is likely there were other incidents of violence that she did not report.

10. FVIOs were implemented against Mr Blyth to protect Belinda, as follows:

    a) Limited final FVIO on 15 December 2016 for 12 months, prohibiting family violence and property damage.

    b) On 12 April 2018, a new FVIO was varied by consent to include additional conditions prohibiting all contact or communication with Belinda if Mr Blyth was affected by illicit drugs/alcohol.

    c) On 28 May 2020, the FVIO was varied by consent to limited conditions, prohibiting family violence and property damage.

    d) On 8 December 2022, a final FVIO for two years, in limited conditions, prohibiting family violence and property damage.

11. Based on the Victoria Police records, it appears that whenever an incident occurred between Belinda and Mr Blyth, Mr Blyth left their home and stayed with his mother. His mother lived a few houses away from the couple, on the same street.

12. Mr Blyth was imprisoned for family violence offending against Belinda, including:

    a) Two weeks in November 2019 for contravening a final FVIO, unlawful assault and assault by kicking.

    b) From January to May 2020 for criminal damage, recklessly cause injury and contravening a final FVIO.

THE CORONIAL INVESTIGATION

13. Belinda'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.

14. 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.

15. 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.

16. Victoria Police assigned Detective Senior Constable Samuel Fary to be the Coronial Investigator for the investigation of Belinda's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

17. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to his retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

18. This finding draws on the totality of the coronial investigation into the death of Belinda Ann Jones including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

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

Identity of the deceased

19. On 26 July 2023, Coroner Leveasque Peterson made a formal determination identifying the deceased as Belinda Ann Jones, born 10 January 1983, via fingerprint identification.

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

Medical cause of death

21. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 20 July 2023 and provided a written report of her findings dated 28 December 2023.

22. The post-mortem examination revealed a widespread and severe bacterial (*Streptococcus* and *Staphylococcus*) meningitis, endocarditis and septicaemia.

23. The initial focus of this severe infectious process was unclear, although Dr Baber opined it was likely to have been from either the urinary tract or pubic symphysis abscess (osteomyelitis pubis). The presence of aortic valve endocarditis caused septic emboli to spread throughout the bloodstream leading to multiple foci of abscess formation in other organs, particularly prominent in the heart.

24. Histology confirmed the macroscopic findings and revealed the widespread nature of the infection into other organs that had not been identified with the naked eye, including in the placenta.

25. Vitreous electrolytes and glucose were within acceptable ranges for a post-mortem sample.

26. Toxicological analysis of post-mortem blood samples identified the presence of methylamphetamine and its metabolites amphetamine and 4-OH-methylaphetamine,[2] diazepam metabolite nordiazepam,[3] and olanzapine.[4] These results represented recent use, although did not have any bearing on the cause of death.

[2] Methylamphetamine is the N-methyl derivative of amphetamine and has no legitimate use in Australia.
[3] Diazepam is a benzodiazepine derivative indicted for anxiety, muscle relaxation and seizures.
[4] Olanzapine is an atypical antipsychotic drug with a similar structure to clozapine. It is also indicated for mood stabilization and as an anti-manic drug.

27. Toxicological analysis of hair samples identified the presence of methylamphetamine and its metabolite amphetamine, codeine,[5] diazepam and its metabolite nordiazepam, doxylamine,[6] buprenorphine and its metabolite norbuprenorphine,[7] and cannabis metabolite delta-9-tetrahydrocannabinol.[8] These results were indicative of previous use and/or environmental contamination.

28. Dr Baber provided an opinion that the medical cause of death was 1(a) Streptococcal and staphylococcal meningitis, endocarditis and septicaemia with a contributing factor of Osteomyelitis pubis. Dr Baber opined that the death was due to natural causes.

29. I accept Dr Baber's opinion as to the medical cause of death.

Circumstances in which the death occurred

30. In the weeks prior to her passing, Belinda experienced significant back pain and attended her general practitioner (**GP**) via telehealth for assistance. Belinda's GP advised her that it was her baby that was pressing on her spine and prescribed Panadeine Forte. On 14 July 2023, Belinda called paramedics in relation to her back pain. When paramedics attended, Belinda rated her pain at a nine out of ten. Her vital signs demonstrated a markedly elevated heart rate of 130bpm but no fever. Her blood pressure, respiratory rate, conscious state and oxygen saturation were all within normal limits. Paramedics administered methoxyflurane (the 'green whistle') to reduce pain. The paramedics' final set of observations documented slightly reduced pain, rated seven out of ten, and an elevated pulse rate at 120bpm.

31. Paramedics transported Belinda to Maryborough District Health Service (**MDHS**), arriving at 7.55pm. Belinda was triaged as Category 4 (to be seen within 60 minutes).

32. Belinda reported she had taken Panadeine Forte with minimal effect, and that the pain was in her lower back, radiating to her pelvis and knees. MDHS clinicians documented that she was "*really struggling ambulating*" and required encouragement and a wheelchair in order to use the toilet.

[5] Codeine is an opiate found in opium isolated from the plant *Papaver somniferum*. It is indicated as an effective antitussive and anti-diarrheal agent and can also appear as a minor contaminant in heroin.
[6] Doxylamine is an antihistamine agent and sleep-inducing agent.
[7] Buprenorphine is indicated for moderate to severe chronic pain and maintenance therapy in people with opioid use disorder.
[8] Delta-9-tetrahydrocannabinol is the active form of cannabis (marijuana).

33. Belinda underwent urine and blood tests which revealed the presence of amphetamine and opioids. The clinical impression was a urinary tract infection (**UTI**) (although this was not documented in the medical records). Belinda received oxycodone for her pain and antibiotics for her UTI. She was discharged about two hours later with prescriptions for antibiotics and Panadeine Forte. MDHS staff also advised Belinda to follow-up with her regular GP and/or antenatal clinic and documented that Belinda was aware of the risks to her unborn child, in relation to her illicit substance use. Belinda's treatment at MDHS is discussed in further detail below.

34. On 17 July 2023, a friend attended Belinda's home and observed her on the bed, naked under a towel, moaning and reporting sore legs, which appeared swollen. Belinda told her friend that she was bedridden, lethargic and was unable to walk. Her friend encouraged her to seek medical attention, and Belinda advised that she had been to hospital, however they sent her home.

35. At about 7.30pm on 18 July 2023, a neighbour heard moaning "*like a female was in pain*" for about 20 minutes. This neighbour heard similar moaning the day before. Another neighbour reported hearing moaning shortly after midnight on 19 July 2023, which he believed was from Belinda.

36. On the afternoon of 19 July 2023, Mr Blyth called Triple Zero to report that Belinda was on the floor not breathing and cold to the touch. Ambulance Victoria (**AV**) paramedics arrived on scene at 12.30pm and located Belinda deceased on the floor of her bedroom.

37. Due to the circumstances of Belinda's death, Victoria Police commenced an investigation. Upon initial police attendance, Mr Blyth spoke to police advised that Belinda had a sore back the night before. He reported that at about 1.00am that morning (19 July 2023), he helped her to use the bathroom as she was unable to walk and needed help getting out of bed. Mr Blyth reported that while he was helping her, Belinda passed out and he assisted her onto the floor. He was unable to lift her up, and because her breathing was normal, he left her on the floor and went back to bed.

38. Mr Blyth explained that when he awoke at about 10.30am that morning, he noticed Belinda was still on the floor. She looked grey, was cold to touch and was not breathing. Mr Blyth stated that he "*sat around*" for two hours as he was unsure what to do.

39. Police arrested Mr Blyth and conveyed him to the Bendigo Police Station, where he participated in a recorded interview. During his recorded interview, Mr Blyth explained that on the evening of 18 July 2023, Belinda complained of back pain and the pair discussed calling an ambulance but decided against it as they called an ambulance a few days prior, only for her to be discharged quickly from hospital.

40. Mr Blyth explained that Belinda woke him up in the middle of the night (early hours of 19 July 2023) as she needed help mobilising to the toilet. While he was assisting her to the toilet, Belinda collapsed on the floor. Mr Blyth reported that he checked Belinda and as she was still breathing, he covered her with a shirt and went to bed. When he woke up later that morning, he observed Belinda was unresponsive on the floor and sat on the edge of his bed for two hours, thinking about what to do, as he did not have any friends or family, then he called an ambulance.

41. Mr Blyth noted that Belinda had collapsed on the floor several times throughout her pregnancy and on each occasion, he checked she was breathing before leaving her and on each of these occasions, she woke up in the morning without issue.

42. Police ultimately released Mr Blyth without charge and did not charge him with any offences in relation to Belinda's death.

FAMILY CONCERNS

43. Belinda's sister wrote to the Court and expressed concerns with the treatment Belinda received at MDHS and queried whether she received appropriate assessment and screening to exclude meningitis as a cause of her back pain.

CPU – MEDICAL REVIEW

44. As Belinda's death occurred following recent attendance at MDHS, this case was referred to the Health and Medical Investigations Team (**HMIT**) of the Coroner's Prevention Unit (**CPU**)[9]. The CPU reviewed the medical treatment Belinda received and considered whether there were any prevention opportunities arising from same.

[9] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

MDHS in-depth case review (IDCR)

45. When the Court originally wrote to MDHS in February 2025, MDHS advised that no investigation into Belinda's death was performed by the health service as they were unaware of her death. In follow-up correspondence from the Court to MDHS in May 2025, the Court queried whether Belinda's death had been reported to Safer Care Victoria (**SCV**). MDHS advised that it did not report Belinda's death to SCV at the time, however since made a Sentinel Event notification. MDHS advised that it completed an in-depth case review (**IDCR**), which was performed by a registered nurse.

46. The IDCR made the following findings and corresponding recommendations:

    a) Finding 1 – Low back pain red flags not recognised and insufficient explanation and exploration for cause of pain unresponsive to analgesia and concurrent intravenous drug use (**IVDU**) opiate use.

    b) Recommendation 1 – Update the low back pain guideline and include a clear flowchart which clearly defines red flags and actions required. Add yellow flags to guideline, to improve recognition and management of pain relief barriers.

    c) Finding 2 – No imaging for reduced ability to mobilise and no plan to image.

    d) Recommendation 2 –Update the low back pain guideline and clarify actions to take if imaging not available after hours. Consider time delay to imaging availability when establishing plans.

    e) Finding 3 – Consideration of admission for investigation not evident.

    f) Recommendation 3 – Include in the Admission Policy a procedure for recognising and admitting vulnerable patients for further investigation, including nurse-initiated admission for safety netting vulnerable patients.

    g) Finding 4 – Insufficiently developed plan – did not consider GP only open for two hours on the weekend and would be unlikely to have available bookings.

    h) Recommendation 4 – Provide all patients with a plan for when to return for further assessment and who to present to (i.e., if treatment not working, deterioration, etc.). Include actions to take if a GP or clinic is unavailable.

i) Finding 5 – Primary infection not recognised and treated, and risk of osteomyelitis pubis in IVDU not documented.

j) Recommendation 5 – Update sepsis guideline to include links to SCV maternal sepsis guideline. Update the sepsis pathway to reference maternal sepsis and include risk of infection for IVDU in sepsis guideline.

k) Finding 6 – Medical model of care relies on GP support and there is a lack of evidence locum GP staff are aware of hospital-based procedure (e.g., lower back pain, sepsis).

l) Recommendation 6 – Review medical model of support to ensure provision of timely medical support to urgent care centre and inpatients, that reflects understanding of urgent care centre assessment requirements and inpatient care needs. Ensure GP staff are aware of maternal sepsis and low back pain guidelines.

47. In March 2026, MDHS provided an update to the Court in relation to the status of the recommendations:

a) Recommendation 1 – MDHS advised that a review of the pain management document is in progress, which includes a review of the assessment and documentation of pain self-reporting and evaluating patient response to analgesia. MDHS advised that it will test the pain self-reporting document with patients for feedback. Further, MDHS advised the Adult Observation Chart is under review, and an additional audit will be developed to monitor compliance with the revised pain management process.

b) Recommendation 2 – A low back pain (**LBP**) guideline was implemented in 2023 and is currently being updated. MDHS also developed a decision-support flowchart, which is currently being converted into a clinical pathway.

c) Recommendation 3 – MDHS advised that their admission procedure has been updated to include enhanced risk factors and guidance on when to admit a patient, in particular, nurse-led admissions for patients that are considered unsafe for discharge home. The admission procedure includes recognition and escalation of undiagnosed patients who are unresponsive to treatment. All nurse-led admissions are reviewed by a GP the following morning.

d) Recommendation 4 – MDHS explained their updated admission document incorporates enhanced risk factors and an admission pathway flowchart, to assist in

the recognition of ‘at-risk’ patients. MDHS is due to commence a project to update the triage form to ensure there is better recognition of ‘at-risk’ patients and improved referral pathways.

e) Recommendation 5 – This recommendation is complete. MDHS implemented the maternity triage form in 2025 and will audit use of the form in 2026.

48. MDHS advised that it is undertaking additional actions as a result of this case:

a) A review of the sepsis documentation (in progress), to include an update to the sepsis guideline. This will highlight the risk of infection in IVDU patients and will provide links to other guidance as required. MDHS plan for the documentation to align with Grampians Health’s documentation.

b) A review of the medical model of support to ensure provision of timely medical support to inpatients, while supporting fatigue management amongst GPs. MDHS has proposed a business case for this review.

c) Updating the governance documentation (in progress) to clarify expectations of medical RUCC assessment requirements and inpatient care needs. MDHS will ensure that GPs are aware of maternal sepsis and LBP guidelines.

d) MDHS reviewed the presentation numbers and acuity in 2025 and will continue to monitor presentation numbers and acuity.

e) MDHS has joined the Grampians Local Health Service Network, which enables it to strengthen its relationship with Grampians Health, their primary referral hospital. This includes weekly meetings between the MDHS Director of Medical Services and the Grampians Health Chief Medical Officer. MDHS now participates in the Grampians Regional Morbidity and Mortality meetings and refers to Grampians Health documents/guidelines where appropriate.

f) As part of the ongoing MDHS quality review, MDHS implemented a robust death review process. All deaths are now notified to the Quality Unit for screening. If concerns are identified, then a case review is triggered.

Serious Adverse Patient Safety Event (SAPSE) report

49. Following conversations between MDHS and the Court, MDHS consulted with Safer Care Victoria (**SCV**) regarding whether this incident should be classified as a sentinel event. MDHS subsequently commenced a Sentinel Event review in July 2025 and submitted the SAPSE report in September 2025.

50. The SAPSE review panel made the following findings:

a) There was no clear connection identified between the RUCC presentation and subsequent collapse four days later. Two years had elapsed since the incident, and the panel could not identify any specific performance issues.

b) The escalation processes for the nurse-led, GP-supported model of care were appropriately utilised. An on-call GP reviewed Belinda in person. Staff notified the on-call midwife, and the GP/Obstetrician attended the assessment.

c) The on-call GP used an appropriate approach to rapid review of the presenting problem.

d) Staffing was limited on the shift and at that time, there were limited postgraduate qualified nursing staff working at the RUCC.

e) There was an inadequate explanation for the cause of pain. Some guidelines were not available (LBP), considered or adequately followed. Imaging was not available and pathology was not utilised.

f) There was inadequate evidence of controlling pain. There was no evidence available that Belinda's pain was assessed post-administration of analgesia, despite Belinda receiving a strong opioid. This was compounded by the inadequate explanation for the cause of pain in the presence of difficulty mobilising.

g) Drug-seeking was ruled out, as Belinda received Endone and had appropriate pain-scoring. The evidence suggested that her pain was considered genuine.

h) Belinda did not meet the criteria for admission or transfer. There was no short stay unit (which is still the case in 2026). Belinda was unable to be considered for an overnight admission (in the absence of a short stay unit) to permit review the following morning. MDHS availability to perform further investigations was (and still is) limited on weekends.

i) The discharge safety net was incomplete and did not offer the opportunity for a timely review of Belinda's response to the analgesia provided. There was no evidence that Belinda was considered for an overnight admission to permit review in the morning (noting MDHS did not and still do not have imaging on weekends). There was no evidence that Belinda was advised to return to the RUCC if her symptoms deteriorated. There was no evidence that she was assessed for appropriate referrals, which could have been sent to ensure she was connected with antenatal care, physiotherapy and drug/alcohol services.

j) Sepsis was not apparent when the patient presented and there were no findings which would have triggered commencement of a sepsis pathway.

51. The CPU disagreed with some of the findings of the SAPSE report, namely:

a) That there was no clear connection between the RUCC presentation and collapse.

b) That the escalation process was utilised appropriately and that the GP used an appropriate rapid review approach.

c) That Belinda did not meet the criteria for an admission or transfer.

d) While the SAPSE reported that MDHS did not have an LBP standard in 2023, the CPU noted that the ACSQHC's *Low Back Pain Clinical Standard* was released in September 2022 and was therefore available in the present case.

Department of Health oversight of RUCCs

52. The Court obtained further information from the Department of Health (**the Department**), with respect to its oversight and monitoring of Urgent Care Centres (**UCCs**) and Rural Urgent Care Centres (**RUCCs**) in Victoria. In particular, the Department was asked to explain what data it collects from RUCCs, and if this data is input into a minimum data set.

RUCC attendance data collection

53. The Department advised that all UCCs, including RUCCs, are required collect and submit a minimum aggregate set of data. UCCs/RUCCs are not required to report patient-level data to the Department. The required data is submitted monthly via the Agency Information Management System (**AIMS**). This data is fed into an AIMS reporting tool and is accessible

by designated Departmental staff. RUCC data is also reported to the Independent Health and Aged Care Pricing Authority.

54. RUCCs receive funding in accordance with their aggregate reported data, categorised by the funding source for each patient presentation. For example, Medicare Benefits Schedule patients, public patients, Transport Accident Commission patients, and self-funded patients. The aggregate data set reported to AIMS includes the number of presentations, the visit type, the triage category, departure status and selected payment categories. The Department explained that this standardised core set of information is an aggregate minimum data set. Health services are mandated to submit this data to the Department. The data set is used for funding decisions.

Compliance with data collection requirements

55. The Department advised that their Data Collections team monitors compliance with data collection. The Department contacts non-compliant UCCs/RUCCs who have not submitted their monthly data, to ensure that it is submitted.

56. In February 2026, 66 of the 70 UCCs were compliant with the monthly data collection requirements. The Department contacted the four non-compliant services. The Department noted that MDHS is one of the services that submits its monthly data and is compliant with the data collection requirement.

Collection of patient-level data

57. In 2024, the Department conducted an assessment to consider whether UCCs/RUCCs should collect patient level data, rather than categorised aggregate data using the Victorian Emergency Management Dataset (**VEMD**). The assessment determined that the VEMD was not the appropriate mechanism for data collection due to the cost of introducing the required information technology systems to support this level of data collection, and the administrative burden it would place on smaller centres such as RUCCs.

58. From March to September 2024, the Department piloted a program in the Grampians region for UCCs to collect a patient-level minimum dataset. While pilot program demonstrated that the collection of patient-level data for UCCs was viable, there is no current plan for broader implementation.

Safer Care Victoria support to RUCCs

59. The Court also obtained information from the Department, specifically SCV, about the support it provides to UCCs/RUCCs, and how that support differs from the support provided to metropolitan health services.

60. The Department advised that SCV provides materials, guidance, services, support and clinical governance assistance to all Victorian health services. Every Victorian health service receives the necessary support and clinical governance, regardless of its size or location. There is no difference in the support provided based on size, resources, or geographical location. The Department explained that any bespoke support or clinical governance assistance for an individual UCC/RUCC is the responsibility of the relevant health service.

61. The Department further explained that SCV ensures every health service has the necessary support and clinical governance assistance through the implementation of a discrete set of best practice guidelines. SCV does not prescribe clinical guidelines and practices to individual healthcare services, as each service has their own needs.

62. SCV provides a range of support, best practice guidelines and clinical governance assistance on its website. This material is accessible to all Victorian health services and includes:

    a) The Victorian Clinical Governance Framework.

    b) The Clinical Governance Toolkit.

    c) A variety of clinical governance capability offerings to Victoria health service leaders.

    d) The Clinical Governance Leadership Health Check.

63. In addition to its clinical governance role, the Department explained that SCV leads statewide improvement initiatives, including:

    a) The Victorian Sepsis Program, with over 40 participating health services.

    b) The Maternal Sepsis Guideline, which was published in 2025.

    c) The original Think Sepsis, Act Fast collaborative, which was delivered in 2017-2018.

    d) The Safer Together Program.

    e) An online Framework and Toolkit to promote a structured review process for Morbidity and Mortality meetings at Victorian health services.

EXPERT OPINION – ASSOCIATE PROFESSOR TIMOTHY BAKER, EMERGENCY PHYSICIAN

64. The Court obtained an independent expert opinion, from Associate Professor Timothy Baker (**A/Prof Baker**), who has more than 30 years' experience working in emergency medicine, including in metropolitan, regional, remote and small rural hospitals. A/Prof Baker was asked a series of questions in relation to Belinda's treatment at MDHS, to assist with responding to the concerns submitted by Belinda's family, and to determine if there are any prevention opportunities arising in this matter.

Outline of treatment and assessment at MDHS

65. As noted above, Belinda arrived at MDHS at 7.55pm and was triaged as a Category 4 patient. Her vital signs were identical to those recorded by paramedics (i.e., elevated heart rate). Belinda was noted to be accompanied by Mr Blyth. Her treatment proceeded as follows:

    a) 8.14pm – pulse rate 114bpm, respiratory rate 19 breaths per minute, oxygen saturation 98%, blood pressure 111/73mmHg, temperature 36.7°C and Belinda rated her pain as seven out of ten. This was the only set of observations taken during Belinda's treatment.

    b) 8.55pm – urine testing demonstrated signs of possible urinary infection due to the presence of nitrites (which are produced by bacteria) as well as trace amounts of blood and protein. Testing was also positive for amphetamines and opiates. These results indicated recent use of amphetamines and opiates, however, did not confirm whether Belinda was intoxicated/affected by these drugs at the time of her presentation. A/Prof Baker noted that codeine (which Belinda was previously prescribed) is an opiate and may cause a false positive test result. Belinda's urine pregnancy test was also positive.

    c) 9.20pm – the evening nursing staff handed over to the night nursing staff. A midwife was contacted; however, they stated that they were happy for the doctor to review the patient.

    d) 9.25pm – the nursing assessment and the urine assessment were documented. The medical records note that some details had been communicated to an off-site private telehealth provider ('My Emergency Doctor'), then a local GP arrived on site and agreed to review Belinda.

e) 9.32pm – the GP documented his assessment of Belinda. He noted that he assessed Belinda while she was sitting in a chair. He recorded cardiovascular, respiratory and gastrointestinal examinations, as well as the patient's reporting complaint, a review of urinary symptoms and foetal movements, vital signs and urine test results. The reason for visit was documented as 'back pain'; however, no diagnosis or clinical reasoning was recorded. The GP provided Belinda with a prescription for Panadeine Forte and antibiotics and warned her of the risks of drug use to her unborn child.

f) 9.46pm – nursing staff administered oral amoxycillin 500mg and oxycodone 5mg.

g) 9.58pm – Belinda left MDHS. The nursing notes recorded that Belinda could follow up with her GP or antenatal clinic. No discharge vital signs or pain score were recorded.

h) MDHS' IDCR noted that the maximum time taken by the GP to assess Belinda was eight minutes.

Patient assessment

66. A/Prof Baker noted that Belinda's records included assessments by two paramedic crews (Carrisbrook and Avoca), three or four notes, and the GP. Multiple clinicians recorded severe back pain radiating to the groin and legs, however there was no working diagnosis provided for the cause of this pain.

67. Despite recording that Belinda was walking, she was documented as walking slowly and with significant encouragement. She required transfer to the toilet with a wheelchair. The GP documented "*no neurology on limited exam*", however a detailed assessment of lower limb neurological assessment of strength, sensation, coordination or reflexes was not recorded.

68. The paramedic, nursing and medical notes all indicate that there were no urinary or bowel symptoms (which could indicate cauda equina syndrome; a cause of back pain that compresses the nerves to the bladder or bowel). Urine testing suggested a UTI, as noted above.

69. Paramedics documented that Belinda did not report a fever or sweating, however there is no record of MDHS staff asking her the same questions. Her temperature was not elevated when taken by paramedics and MDHS nursing staff. Her pulse was found to be strong, and her skin was warm. The only abnormal vital sign was a persistently fast heart rate between 114 and

130bpm. No clinicians documented the signs of recent skin punctures (indicative of IVDU) that were documented at autopsy.

Cause of presenting symptom

70. A/Prof Baker noted that no cause was found for Belinda's back pain after the autopsy, however he opined that an infection of the spinal column was a likely (but not certain) cause. His reasoning for this opinion was as follows:

    a) Spinal column infections (such as epidural abscesses) are known to cause severe back pain in IVDUs. Bacteria are thought to enter the bloodstream through unsterile injections.

    b) Spinal infections often involve multiple separate sites in the spine and elsewhere. The pubic symphysis, where an abscess was found at autopsy, has a structure similar to that of intervertebral joints.

    c) Spinal column infections are often invisible on CT scanning and require MRI scanning for diagnosis. A spinal epidural abscess may be missed on post-mortem CT scanning, even when it is the cause of death.

    d) No formal examination of the spinal column was performed at autopsy to exclude this diagnosis.

71. Other possible causes of back pain include:

    a) Osteomyelitis pubis, causing pain to radiate around the pelvis from the site of infection at the front of the pelvis to the lower back.

    b) Coincidental musculoskeletal back pain. Pregnancy can exacerbate lower back pain, and an x-ray early in the year showed signs of osteoarthritis. However, osteoarthritis changes become common as patients age.

    c) Pyelonephritis (infection of the kidney). Pyelonephritis causes flank or loin pain. In A/Prof Baker's opinion, this was unlikely to have been the primary site of infection in this case, as the bacteria identified at autopsy were not those typically associated with a urinary tract source, suggesting the renal involvement was secondary to infection elsewhere.

Whether care provided on 14 July 2023 was appropriate

72. A/Prof Baker stated that given research shows that this diagnosis is more often missed than correctly diagnosed in any emergency setting, and that no practical low back pain guidelines were available at the time, he opined that this diagnosis would have been missed by many clinicians working in RUCC settings. However, he considered that the care provided to Belinda nevertheless fell below what should be accepted as appropriate. He observed the following deficiencies:

    a) Insufficient consideration was given to the possibility of blood-borne infection due to IVDU.

    b) Insufficient consideration was given to the severe ongoing back pain and difficulty walking, although noted that assessing patients with a history of illicit opiate use can be difficult.

    c) Insufficient consideration was given to determining the cause of Belinda's persistent tachycardia.

73. A/Prof Baker opined that because these factors were not considered, the clinicians involved did not recognise Belinda to be in a high-risk category. In his view, this led to the following deficits in care required when managing high-risk back pain:

    a) An adequate history was not taken. No questions were asked about infective symptoms.

    b) An adequate examination was not performed. Examination in a chair does not permit a thorough assessment. Specifically, there were no findings documented about midline spinal tenderness (a sign of spinal column infection), and there was no documentation of a detailed lower limb neurological assessment. An abdominal examination while the patient was lying flat would have increased the likelihood of detecting tenderness and swelling from an infection near the pubic bone.

    c) Vital signs were not repeated. A/Prof Baker noted that a heart rate can be elevated due to many factors, including pain, amphetamine use, anxiety, or the changes associated with pregnancy. However, underlying illnesses such as infection should be considered. He also noted that body temperature can vary over time.

    d) Appropriate investigations were not arranged.

e) The documentation did not include a working diagnosis or clinical reasoning.

f) A safe discharge plan was not arranged.

What steps/investigations would constitute reasonable care

74. On recognising Belinda to be a high-risk back pain patient, A/Prof Baker opined the following steps would have been reasonable:

a) Providing stronger analgesia to allow Belinda to change into a hospital gown and be assessed on a trolley (not in a chair).

b) Repeating assessment of vital signs after adequate analgesia.

c) Sending urine for culture, to ensure that the bacteria in the urine were sensitive to the prescribed antibiotics.

d) Taking blood for full blood examination including C-reactive protein, lactate, blood sugar and blood cultures.

e) Consulting the medical staff at a regional emergency department. Although a case could be made for undertaking an MRI, based on Belinda's presenting symptoms alone, the results of the blood tests would help decide whether an immediate transfer to an emergency department (**ED**) should be arranged, and how urgently an MRI needed to be scheduled. Appropriate antibiotics to cover potential IVDU-associated infections could be discussed.

75. A/Prof Baker made two notes/amendments to the above steps:

a) Note 1 – Depending on the repeat vital signs and local protocols, pathology staff could be called in that night, the patient kept overnight until the blood tests could be processed (which would involve calling pathology staff on a Saturday), or the patient discharged when pain improved and a secure plan was in place for follow-up of the blood test results.

b) Note 2 – If the blood tests revealed an abnormal white cell count or raised lactate and tachycardia persisted, Belinda would have met the criteria for sepsis and required intravenous fluids and antibiotics.

Describe the escalation pathways available for a GP reviewing a patient at MDHS on a Friday evening

76. A/Prof Baker detailed the following possible escalation pathways, however noted that there were no formal referral pathways between RUCCs and other services at the time of Belinda's presentation and therefore Belinda still may not have received the appropriate help she required.

    a) Discussion with senior staff at either Bendigo or Ballarat EDs. At this time of night, a specialist emergency physician would likely have been available to offer the help described above.

    b) Discussion with the neurosurgery registrar at a metropolitan hospital. However, their advice may have involved obtaining blood tests and an MRI, then call back with results.

    c) Discussion with a telehealth service. The MDHS notes references 'My Emergency Doctor', a private telehealth service. These services usually provide advice to nursing staff, but they have contracts for different types of support at different health services. They may have provided an emergency physician for advice. The publicly funded Victorian Virtual Emergency Department (**VVED**) service commenced during COVID-19 and was being used by some RUCCs at that time. Typically, the VVED provides guidance to nursing staff managing low acuity patients (triage categories four or five). They may have provided advice to the treating GP.

    d) Discussion with Adult Retrieval Victoria (**ARV**). ARV provides advice to doctors and nurses with critically ill patients (including neurosurgical patients) requiring transport to larger centres. As Belinda was clinically stable without a defined pathology, her case would normally be considered out of scope for ARV.

    e) Discussion with medical staff caring for MDHS inpatients. A/Prof Baker stated that he was unsure whether MDHS had other senior medical staff on-call to care for inpatients and noted that some RUCCs do have this capability. If such capability existed, he noted that they may have been available to assist or provide guidance.

Guidelines for low back pain and sepsis

77. A/Prof Baker explained that low back pain is challenging to assess because most cases are non-specific and self-limiting, yet among them lies a small subset of patients with serious underlying disease. Infections of the spinal column or pelvis, as occurred in this case, represent one of the most important and difficult of these to identify. A/Prof Baker noted that up to 75% of patients ultimately diagnosed with spinal infection had that diagnosis missed at their initial assessment. The classic triad of back pain, fever, and neurological deficit is present in only 10 to 15% of cases, and about 50% of patients have a normal temperature at first presentation.

78. At the time of Belinda's presentation to hospital, A/Prof Baker noted the Australian Commission on Safety and Quality in Health Care (**ACSQHC**)'s Low Back Pain Clinical Care Standard (September 2022) was available. This national standard sought to reduce unnecessary investigation and treatment of non-specific back pain. It emphasised assessment for "*specific or serious pathology*" but otherwise advised that imaging is not indicated for most patients because it rarely alters management and may cause harm through over-diagnosis or anxiety.

79. As noted in the ACSQHC's standard (full document of 62 pages), a history of IVDU is a risk factor for spinal infection, warranting further assessment. However, the shorter derivative guides produced for GPs and EDs does not explicitly mention IVDU, potentially reducing clinician awareness of that particular risk group.

80. A second relevant document at the time of Belinda's presentation was the Royal Australian and New Zealand College of Radiologists (**RANZCR**)'s Choosing Wisely Australia: Acute Low Back Pain guideline (2015). This document also discouraged routine imaging for non-specific acute back pain, but it specifically listed IVDU as a risk factor and indicates that an MRI should be performed to exclude spinal infection. Infection-related changes are not visible on plain radiography and are frequently missed on CT scans. MRI is not available MDHS.

81. To A/Prof Baker's knowledge, SCV does not have a guideline for assessing acute back pain in an ED or a RUCC.

82. At the time of Belinda's presentation, SCV had a clinical pathway for sepsis, designed for use in both EDs and RUCCs. Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. A/Prof Baker opined that sepsis likely contributed to Belinda's death in this case.

83. The SCV guideline lists physiological abnormalities that, when occurring in a patient with suspected infection, may indicate possible sepsis. These include:

a) Temperature greater than 38°C or less than 36°C.

b) Heart rate greater than 90bpm.

c) Respiratory rate greater than 20 breaths per minute.

d) White cell count less than 4 x 109/L or greater than 12 x 109/L.

84. Under the SCV guideline, two or more of these features existing in the presence of suspected sepsis meets the definition of possible sepsis and should trigger early intervention and treatment. In Belinda's case, the only abnormality present when she was assessed at MDHS was an elevated heart rate. A/Prof Baker noted that a blood test to assess Belinda's white cell count *could* have been performed, however he believed that this would have necessitated pathology staff being recalled from home. A/Prof Baker noted that an elevated blood lactate (greater than 2 mmol/L) indicates reduced tissue perfusion and is used to identify severe sepsis, requiring immediate escalation. Most RUCCs have equipment for nurses to quickly assess lactate levels on a blood sample, however A/Prof Baker was unsure whether MDHS had this capacity at the time of Belinda's presentation in 2023.

85. A/Prof Baker further noted that a Maternal Sepsis Guideline was not produced by SCV until 2024 and was therefore not available to clinicians at the time of Belinda's presentation. The maternal guideline applies the same principles, however it adjusts for normal pregnancy physiology, for example, setting a higher threshold for tachycardia (heart rate over 110bpm) before sepsis is considered.

Rural Urgent Care Centres

86. A/Prof Baker explained that the emergency care facilities that are attached to small rural hospitals in Victoria are known as RUCCs. This designation is unique to Victoria and arose in response to then-Coroner Stuthridge's finding into the death of Veronica Campbell.[10] The terminology signals an intention that these facilities should primarily manage minor injuries and illnesses. In practice, however, these centres do manage complex and life-threatening presentations at times, because the seriousness of a patient's condition is not always apparent

[10] Finding into death without inquest – Veronica Campbell.

at first assessment. For example, back pain is usually benign, but may occasionally reflect serious underlying pathology, as demonstrated in this case.

87. RUCCs differ substantially from standalone UCCs in metropolitan and regional centres, which are typically located close to larger EDs that can readily accept complex and critically ill patients. In contrast, RUCCs are often the first point of contact for ambulance arrivals and acutely unwell patients in their community.

88. There is no single statewide model of care across Victoria's approximately 70 RUCCs, which vary widely in size and activity – from a few hundred to over 10,000 presentations per year. Some centres are staffed by ward nurses who attend the unit when a patient arrives and seek advice via telehealth (e.g., VVED). Others have dedicated on-site nurses and doctors (usually GPs) rostered to the emergency area.

89. The Australasian College for Emergency Medicine, the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners all support GPs providing emergency care in these settings.

90. However, each College provides additional training and certification – typically around 12 months in duration – for GPs undertaking regular emergency work. This is similar in concept to the additional training undertaken by GPs providing rural obstetric care. However, unlike obstetrics, this training is not mandated before providing urgent care, and remuneration is generally not differentiated. A/Prof Baker noted with concern that increasing training requirements may further reduce the availability of doctors willing or able to staff these services.

Outline the main strengths, weakness and threats related to the RUCC model, specifically relating to MDHS

91. In A/Prof Baker's opinion, the principal strength of the RUCC model is that it provides local access to the state's acute care system for people living in small and often geographically isolated communities. Timely access to emergency care strongly influences health outcomes; patients are known to delay presentation when they are required to travel long distances for assessment. Many are particularly reluctant to be transported by ambulance to a distant ED, as this can leave them far from home with no practical way to return. Similarly, ambulance crews may be reluctant to transfer non-critical patients long distances, because it temporarily

removes local ambulance coverage. RUCCs therefore act as an essential local entry point for urgent assessment, triage and stabilisation.

92. A/Prof Baker noted it was difficult to quantify how many emergency presentations are managed through Victoria's (approximately) 70 RUCCs, however nationwide, about 8% of emergency presentations in Australia occur at similar-sized facilities. Therefore, RUCCs play a critical role in preventing a corresponding increase in presentations to already overstretched regional and metropolitan EDs.

93. For moderate-size rural towns such as Maryborough, which also face higher levels of socio-economic disadvantage and health risks, the local RUCC provides a safety net that supports timely access to acute care and stabilisation prior to transfer when required.

94. The main threat to quality and safety at RUCCs is their lack of economies of scale. Compared with larger EDs, they have fewer diagnostic resources, including limited on-site pathology and radiology. They also have reduced capacity to employ medical and nursing staff with specific emergency training. Furthermore, smaller health services have fewer support staff and educators to maintain local clinical protocols. The main threat to the sustainability of RUCCs is the ability to recruit a suitably trained workforce.

Potential or possible changes following MDHS' merger with the Grampians Local Health Service

95. MDHS joined the Grampians Local Health Service Network from 1 July 2025. A/Prof Baker noted that it was unclear what changes might arise from MDHS joining this network. However, he hoped that it would result in shared protocols, improved access to education and clearer pathways for consultation and patient transfers, without a significant reduction in services provided in Maryborough.

The most important area(s) for MDHS to focus on, to continue to safely service clinical demand

96. A/Prof Baker noted that like most RUCCs, MDHS needs to establish a sustainable model of care in an environment where clinical workforce recruitment is a challenge. He suggested that a detailed analysis of patient acuity within the MDHS emergency service would be warranted. Based on A/Prof Baker's understanding of current presentation numbers and acuity, it would appear unlikely that a safe model of care could be maintained using only local nursing staff, supported by telehealth. He noted that it is plausible that both the volume and acuity of

MDHS' presentations now align more closely with those seen in rural EDs and opined that consideration of established ED models of care would be appropriate.

97. A/Prof Baker suggested that MDHS should focus on the strengths and risks arising from its integration with the broader Grampians Health network. This integration provides an important opportunity to share and adapt clinical protocols, access network-wide education and training, and obtain specialist opinions for complex or high-risk patients. It also enables the development of formalised patient transfer pathways to ensure timely escalation of care to higher-acuity facilities when required.

The role of Safer Care Victoria

98. A/Prof Baker explained that SCV is Victoria's lead agency for clinical quality and safety improvement, operating as an administrative office within the Department of Health. Its functions include supporting health services to conduct adverse event reviews, providing advice on sentinel and serious adverse patient safety events, and disseminating the lessons learnt. It also has a role in developing guidelines and tools and delivering education.

99. These functions are particularly important in the context of RUCCs and small rural hospitals, which often have limited governance infrastructure. Rural health services have fewer dedicated quality improvement staff to conduct detailed adverse event reviews, insufficient resources to develop local clinical guidelines, and limited access to specialist educators. As RUCCs generally interact most closely with their nearest larger regional hospital (rather than with other similar-size services), the statewide sharing of lessons learnt from adverse event reviews can be challenging. A/Prof Baker opined that SCV's continued support is therefore essential to ensure consistent learning and quality improvement across these smaller services.

The role of telehealth, in particular, the Victorian Virtual Emergency Department (VVED)

100. Telehealth provides an opportunity to bring clinical expertise to the patient, rather than requiring the patient to travel to a larger hospital where that expertise is located. It is one of a range of statewide support and advisory services available to Victorian clinicians, for example, Adult Retrieval Victoria, the Victorian Stroke Telehealth Network and the Poisons Information Service. Medical colleges and telehealth services both see telehealth as a way to support rural clinical staff, rather than replace them.

101. The VVED offers expert emergency medicine advice via telehealth, either directly to patients or to clinicians treating patients in smaller health services. In RUCCs, the VVED's role is

primarily to support nursing staff to manage low acuity presentations. This arrangement assists with the sustainability of on-call medical rosters, allowing on-call doctors to be called in for higher acuity or complex cases, rather than for minor conditions after hours.

102. As currently configured, the VVED does not provide direct expert consultation to GPs managing complex presentations within RUCCs. However, the VVED is actively assessing how telehealth can better support RUCCs.

In-depth case review by MDHS

103. A/Prof Baker noted that MDHS initially completed an IDCR, rather than a Serious Adverse Patient Safety Event (**SAPSE**) review, which requires a larger team and involves external and consumer representatives. MDHS noted the serious limitations to the IDCR as the death occurred outside the hospital and took place two years after the event itself.

104. A/Prof Baker agreed with the documented clinical information, timeline, cause and effect diagram and causal statement. He agreed with the review findings that red flags were not recognised, the primary infection was not recognised (although, from the clinical information provided, he would not have considered the specific diagnosis of osteomyelitis pubis), and that a better-developed follow-up plan was needed. The IDCR stated that consideration should have been given to medical imaging and a local hospital admission. In A/Prof Baker's view, these were not unreasonable suggestions, however he would have recommended local pathology testing and outside consultation instead.

105. Finding Six and the associated recommendation refer to the model of care that relies on GPs to provide care. The reviewer suggested that the knowledge of GPs is "*misaligned with ED/internal medicine skill set*". A review of the medical model was recommended. A/Prof Baker disagreed with this finding, specifically that the GP skill set is misaligned with the needs of RUCCs. However, he noted that a review of GP rostering, their education and accreditation at MDHS was a sensible recommendation.

Whether death was preventable

106. In A/Prof Baker's opinion, Belinda's death could have been prevented if appropriate antibiotics had been administered early. The earlier the administration, the more likely they would have been effective. Furthermore, the abscess found in the pubic area could have been drained by surgeons, as could any spinal abscess.

107. However, A/Prof noted that even if the reasonable care suggested above was provided, Belinda may have still passed away. The early stages of osteomyelitis pubis and spinal column infections do not always cause abnormal blood test results. Furthermore, an MRI focused on the spine may have missed the osteomyelitis at the front of the pelvis.

MDHS' procedural fairness response to A/Prof Baker's report

108. As a matter of procedural fairness, the Court provided a copy of A/Prof Baker's report to MDHS and provided an opportunity to respond to A/Prof Baker's comments and conclusions.

109. MDHS advised that they "*essentially agree[d] with the summary finding of the independent expert report, that the death may have been preventable*". MDHS further agreed that there was insufficient recognition of the patient's high-risk characteristics, which affected the assessment of the possible cause of her back pain. MDHS noted that this was compounded by a short observation period in the RUCC and that a longer period of observation may have revealed a fever. This would have provided an opportunity to explore the ongoing pain, which was unresponsive to the analgesia provided.

110. MDHS noted that calling in the pathology service to perform additional investigations may have revealed illness that was not apparent on presentation (if pathology was abnormal). Abnormal pathology may have triggered a transfer for imaging, which was unavailable after business hours at MDHS at the time (and is still unavailable in 2026). Belinda would have had to transfer to Ballarat or Bendigo to undergo this imaging.

111. Finally, MDHS noted that assessing the cause of Belinda's tachycardia was confounded by Belinda's pregnancy, pain and amphetamine use.

GP's procedural fairness response to A/Prof Baker's report

112. As a matter of procedural fairness, the Court also wrote to the GP who was involved in Belinda's care. His role was akin to that of a Visiting Medical Officer, rather than MDHS employee, and therefore it was unclear what role (if any) he had in the IDCR.

113. The GP noted that this was a difficult presentation. He stated that he thought about sepsis, however it was not at the top of his list for a diagnosis. He noted the high heart rate, however acknowledged that this could be due to pain and/or anxiety.

114. The GP recalled that he examined her with "*key important exam points*" to rule out acute neurology and he was satisfied with his examination. Although not documented, the GP noted

that he strongly recommended Belinda see her routine GP/obstetrician or other antenatal clinician if her condition did not improve.

115. The GP otherwise fully support my proposed recommendations and advised that he would take this case into consideration in his clinical practice in future.

116. Given the willingness of the GP to learn from this case and adopt any changes/recommendations at MDHS I am satisfied I do not need to make any specific recommendations about the GP.

CPU – FAMILY VIOLENCE REVIEW

117. While Belinda's death was due to natural causes, as it occurred in circumstances where she was experiencing family violence in the lead-up to her passing, this case was also examined by the CPU as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[11]

118. I make observations concerning service engagement with Belinda and Mr Blyth 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 Belinda's death.

119. 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*".[12] I make observations about services that had contact with Belinda and Mr Blyth to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

120. I further note that as a matter of procedural fairness, the Court wrote to Mr Blyth to advise him that the finding would include details of their relationship, his criminal record and the allegations of family violence against Belinda. Mr Blyth did not respond to the correspondence.

[11] 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.

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

L17 referrals – The Orange Door

Summary of engagement

121. Victoria Police submitted six L17 family violence reports for Belinda and Mr Blyth from 2016 to 2022, with Belinda recorded as the affected family member (**AFM**) and Mr Blyth recorded as the respondent on each occasion. A review of the referral outcomes indicates:

122. Mr Blyth never engaged with men's family violence services, either due to insufficient information being provided (such as contact details), not receiving consent for the referral, being in custody, time constraints of services, or not responding to contact attempts.

123. The only time Belinda engaged with a service via an L17 referral was in January 2020 when she was contacted by the Centre for Non-Violence and an intake appointment was booked. On the available evidence, it is unclear whether Belinda continued to engage with this service.

124. An 'information pack' was sent to Belinda via text message in relation to all the other L17s submitted, and The Orange Door (**TOD**) only attempted to contact her in relation to one incident.

125. It does not appear TOD contacted Belinda in relation to the November 2022 incident, and there was no record of a referral being made within the L17 portal for her. Victoria Police addressed this by determining that she had not received a call and provided her with TOD's contact details.

Analysis

126. Belinda and Mr Blyth's lack of engagement with support services is consistent with published data about TOD, detailing that:

    a) Only 28% of L17 referrals had their needs met by TOD or engaged with the service system.

    b) 54% of all AFMs had their needs met by TOD or engaged with the service system.

c) 40% of referrals for people using family violence were closed because they were unable to be contacted, with only 18% either having had their needs met by TOD or having engaged with the service system.[13]

127. I note that workforce shortages are likely to impact both TOD and the family violence service sector more broadly, and that these shortages may be more acutely felt in rural and regional areas of Victoria. This may impact a practitioner's efforts to engage people using or experiencing family violence.

128. I further note that I and multiple other coroners have made recommendations and/or commentary in support of co-responder programs,[14] which may help overcome these issues. A core component of these models is the presence of a family violence specialist worker during police attendance at family violence incidents to provide AFMs and respondents with a collaborative response. Such programs often target couples where there have been multiple reports of family violence, but limited service interaction.

129. The most recent evaluation of the Alexis Family Violence Response Model (**'Alexis'**), which embeds specialist family violence practitioners alongside police to support both AFMs and respondents, reported improved client engagement. This evaluation found:

a) While 52% of AFMs engaged with the program had their cases closed as 'needs met', a further 21% were referred onto other services, suggesting enhanced success in engaging victims with ongoing support.

b) In 83% of cases, the program successfully contacted the respondent, with assertive outreach used in 85% of cases.

c) 36% of respondent cases were closed as having their 'needs met'.[15]

130. In October 2025, the Victorian Government announced an expansion of the Alexis model into two additional regions. Currently, Alexis operates in Prahran, Bayside, Morwell and Wonthaggi, with two additional locations to be determined. While this expansion is positive, the service is not accessible to all Victorians, regardless of their location. It is also currently available to people in Belinda's location of Maryborough. I therefore intend to recommend

[13] The Orange Door Annual Service Delivery Report, Case Closure results, <https://www.vic.gov.au/orange-door-annual-service-delivery-report-2022-23/case-closure-results>.
[14] See, for example, Noeline Dalzell, Ms KSQ, Narelle Simmons, ZSQ, Carolyn James, EDH, Jessica Geddes, CM, FCP.
[15] Updated Evaluation of the Alexis Family Violence Response Model, RMIT Social Equity Research Centre

that the Department of Families, Fairness and Housing resources an expansion of Alexis across the entire state.

Victoria Police

131. Victoria Police had contact with both Belinda and Mr Blyth prior to and during their relationship for various reasons, including (but not limited to) family violence. The couple's most recent interaction with police occurred in November 2022. Following this contact, police applied for a safe contact FVIO to protect Belinda and followed up with her to ensure she received offers of support.

132. I have not identified any concerns in relation to police contact with Belinda or Mr Blyth.

Department of Justice and Community Safety

133. Mr Blyth had a lengthy history of engagement with the Department of Justice and Community Safety (**DJCS**) business units including Corrections Victoria and Community Correctional Services (**CCS**).

134. In 2009, Mr Blyth participated in a Sex Offenders Program, after being convicted of attempted rape. Mr Blyth described that this program:

> *…taught [him] a lot about life skills and stated that one of the biggest things that stuck in [his] head was how to treat women; instead of using force, getting to know them first*

135. However, in 2016, a Corrections file review documented:

> *According to the Risk Assessment-LS/RNR and the Victoria Police Outcomes Report, Mr Blyth presented with extensive criminal history and criminal attitudes evidenced by the minimisation of the need for maintaining law and order in society, repeatedly trying to find ways to circumvent laws or established rules, justifying and rationalising antisocial behaviours, or refusing to accept responsibility for his actions.*

136. There are multiple references to Mr Blyth being referred to a Men's Behaviour Change Program (**MBCP**) in his Corrections records, including between 2017 and 2019. However, it is not clear on the records whether he ever completed one.

137. Mr Blyth's most recent engagement with DJCS was for family violence-related offending in 2020, when he was sentenced to four months' imprisonment for criminal damage, recklessly causing injury and contravening a FVIO. DJCS records indicate that he was a 'straight release' and had not participated in all recommended treatment programs, due to the length of his sentence. I note that Mr Blyth's imprisonment on this occasion was in the context of the COVID-19 pandemic and restrictions, which may have impacted his engagement.

Analysis

138. As noted above, it remains unclear whether Mr Blyth ever completed a MBCP, despite multiple periods of imprisonment relating to his use of family violence. Critically, when he was imprisoned for four months in 2020 for family violence offences, it was noted that he could not participate in all recommended programs due to the length of his sentence. I am not critical of DJCS for this, as the length of a person's sentence is not within their control. I only raise it as a systemic issue seen here and in other cases before this Court.

139. Former State Coroner, Judge Cain, commented on the issue of short sentences for FVIO breaches in his Honour's finding into the passing of Noeline Dalzell. In that case, eligibility criteria and length of sentence impacted the offender's ability to access appropriate interventions.[16]

140. In the period 1 July 2020 to 30 June 2023, 710 charges of contravening FVIOs resulted in terms of imprisonment, however almost 80% of those sentences were for periods of less than three months.[17] The Australian Law Reform Commission (**ALRC**) canvassed issues with short prison terms in their report *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples.*[18] The ALRC found that while short prison sentences can provide a brief period of safety for victims of family violence,[19] they do not deter offenders, and may increase the likelihood of recidivism. The ALRC commented that prisoners serving short sentences are less likely to be able to access programs which might assist them to desist from offending and are generally released into the community without supervision or supports.[20]

[16] Finding into passing of Noeline Dalzell with inquest, 92.
[17] Sentencing Advisory Council, https://www.sacstat.vic.gov.au/mc-vic/contravene-family-violence-intervention-order-08- 52-123-2-mc.html>.
[18] ALRC, Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (Final Report No 133, 2017).
[19] Ibid, 271-2.
[20] Ibid, 268.

141. The ALRC did not recommend the abolition of short sentences, given the dearth of community-based sentencing options, supports and programs available to replace them. It did, however, recommend an expansion of community programs aimed at addressing the underlying causes of crime, and therefore of community-based sentencing options.[21]

142. This issue highlights the importance of a systemic approach to family violence offenders. Preventing family violence requires a web of accountability and intervention, in which each actor, service and system works in collaboration with one another to create opportunities for the perpetrator to work towards responsibility and accountability.[22]

143. In Victoria, the government has committed to this model of response and highlighted its importance in the *Family Violence Reform Rolling Action Plan 2020-2023,*[23] *2023-2025*[24] and *2025-2027.*[25] These plans frame a 'web of accountability' as a core vision, aiming to ensure that whenever a person using violence interacts with the service system, there is potential for behaviour change. The 2025 to 2027 Rolling Action Plan acknowledges current challenges to the creation of a whole of system response to family violence, including shortages of qualified practitioners and lack of role clarity across the sector,[26] and commits to a series of actions aimed at addressing these challenges and working towards a system that is equipped to respond to victims ad perpetrators of family violence.[27]

144. As Mr Blyth's most recent engagement with DJCS (prior to Belinda's death) was a short period of remand in February 2021 for non-family violence offending, I have not identified any deficiencies or opportunities for recommendation.

Systemic issues – abandonment of family violence victim

145. Sadly, Belinda's case is not the first case before the Court where a previously identified perpetrator of family violence has failed to act to assist a previously identified victim of family violence in need of urgent medical assistance.[28]

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[21] Ibid, 271-2.
[22] Rodney Vlais, 'What does it mean to support victim-survivor led, community-held and service system scaffolded accountability for adults who perpetrate domestic, family and sexual violence harm?', (March 2025), 5.
[23] Victorian Government, 'Family Violence Reform Rolling Action Plan 2020-2023', https://www.vic.gov.au/family-violence-reform-rolling-action-plan-2020-2023/building-victorias-family-violence-system.
[24] Victorian Government, 'Second rolling action plan 2023 to 2026', (August 2024), < https://www.vic.gov.au/sites/default/files/2024-08/Framing-the-Future-Second-RAP-2023-26.pdf>.
[25] Victorian Government, 'Third rolling action plan to end family and sexual violence 2025 to 2027', (September 2025), https://www.vic.gov.au/family-violence-reform-rolling-action-plan-2025-2027.
[26] Ibid.
[27] Ibid.
[28] See, for example, Narelle Simmons and HCG.

146. These deaths have occurred in circumstances where a duty of care exists in a familial relationship, and where a reasonable person would be expected to seek medical assistance. In these cases, the victim of family violence has subsequently died. The evidence varies as to whether the victim would have survived if medical attention had been sought immediately, and in some cases the length of time that passed between the death and discovery of the body makes it difficult to identify prevention opportunities.

147. In the identified cases, the perpetrator of family violence faced either no criminal charges for their inaction or was only charged with summary offences.

148. In the present case, Mr Blyth left Belinda collapsed on the floor overnight while she was six to seven months pregnant, and once he discovered her unresponsive on the floor, did not call emergency services for an additional two hours.

149. While Mr Blyth told police that he and Belinda discussed calling an ambulance the night before she passed, this conversation occurred *before* she collapsed and thus *before* she was unable to call an ambulance for herself. Mr Blyth told police that he did not call an ambulance for two hours after discovering her unresponsive, as he did not have any family or friends and he did not know what to do. I note that his mother lived a few houses away from the couple, on the same street, and Mr Blyth often attended his mother's home following a family violence incident.

150. In my view, the act of abandoning a victim of family violence requiring medical attention is an act of family violence, that instils fear in the victim and affirms a perpetrator's control over the victim. This behaviour aligns with the definition in the *Family Violence Protection Act 2008*, which defines family violence as a behaviour by a person towards a family member that controls or dominates that family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person.[29]

151. In my recent finding into the death of Narelle Simmons, I recommended:

> *That the Attorney-General consider making a referral to the Victorian Law Reform Commission to:*
>
> *a. consider the creation of a new offence (abandoning a victim in medical need); and/or*

[29] Section 5(1)(vi) *Family Violence Protection Act 2008* (Vic).

b. *amending the Family Violence Protection Act 2008 (Vic) to include abandonment of a victim in medical need as an example of family violence; and*

c. *to consider how family violence perpetrators can be held to account in circumstances where a charge of criminal negligence is not available.*[30]

152. In his Honour's finding into the death of HCG, Coroner McGregor endorsed the above recommendations.[31]

153. Noting that Narelle, Belinda and HCG are not the only cases before this Court where the issue of abandonment has arisen, I intend to make the same recommendation again.

Systemic issues – primary prevention

154. As noted above, Belinda experienced gendered and family violence from at least two long-term intimate partners.

155. In Australia, violence against women is "*staggeringly common*", and is overwhelmingly perpetrated by men.[32] Although attitudes regarding violence against women are slowly improving, problematic attitudes in relation to gender equality and violence against women, including attitudes which reinforce rigid gender roles, persist for a concerning minority of Australians.[33] To address gender-based violence, more must be done to challenge dominant forms of masculinity, and the harm they do to people of all genders at an individual, group and societal level.[34]

156. 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.[35] This involves

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[30] Finding into death without inquest - Narelle Simmons

[31] Finding into death without inquest – HCG.

[32] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 12; Australian Bureau of Statistics, Personal Safety Survey – Physical Violence (2023) < Physical violence, 2021-22 financial year | Australian Bureau of Statistics (abs.gov.au)>; Australian Bureau of Statistics, Personal Safety Survey – Partner Violence (2023) https://www.abs.gov.au/statistics/people/crime-and-justice/partner-violence/2021-22.

[33] Christine Coumarelos et al, ANROWS, *Attitudes Matter: The 2021 National Community Attitudes Towards Violence against Women Survey (NCAS) Findings for Australia* (Report, 2023) 22-4.

[34] Respect Victoria, Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three Yearly Report to Parliament (Report, September 2022) https://www.respectvictoria.vic.gov.au/sites/default/files/documents/202209/Three-Yearly%20Report%20-%20Respect%20Victoria%20-%202022.PDF.

[35] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 12.

working on actions to address the gendered drivers of violence against women to create generational, cultural and attitudinal change.[36] 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.[37]

157. 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 prosocial behaviour (such as neighbourhood-level poverty, disadvantage and isolation, and substance misuse).

d) Backlash and resistance to prevention and gender equality.[38]

158. Primary prevention uses a range of mutually reinforcing strategies across a wide range of settings/areas including education, workplaces, sports clubs, health and community services and the media industry.[39] As it takes a whole of population approach, primary prevention can play a role in positively shifting the attitudes not just of those who use and experience family violence in the community, but of professionals who respond to it.

159. In recent years, Victoria has made progress in building an effective primary prevention system. Respect Victoria was established in 2018 in response to a recommendation by the

[36] 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.

[37] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 36.

[38] Ibid, 48, 51; Shaoling Zhong, Ronggin Yu, and Seena Fazel, 'Drug Use Disorders and Violence: Associations with Individual Drug Categories' (2020) 42(1) Epidemiologic Reviews.

[39] Respect Victoria, *Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three Yearly Report to Parliament* (Report, September 2022) 6, 114.

Royal Commission into Family Violence, becoming the first agency dedicated to the primary prevention of family violence and all forms against women in Victoria.[40] Under Victoria's *Free from Violence* strategy, several primary prevention initiatives have been funded and rolled out across education, public sector workplaces, local government and sport settings.[41] One prominent example of a primary prevention initiative is Respectful Relationships Education (**RRE**) in Victorian schools, which has had positive outcomes thus far, but requires stronger, ongoing investment to sustain and embed it within schools over the long-term.[42] Further examples include initiatives focused on the primary prevention of sexual violence, which is currently a priority area for Respect Victoria, including consent education in schools.[43]

160. Achieving lasting change of the underlying social conditions which produce and drive family violence through primary prevention will require large-scale, persistent efforts over an extended period. Current state and federal funding for primary prevention is not sufficient to meet this goal and has predominantly been for relatively short-term activity, targeting fairly small cohorts.[44]

161. It is critical that primary prevention *and* effective intervention mechanisms be adequately resourced to end family violence-related deaths.

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 Belinda Ann Jones, born 10 January 1983;

b) the death occurred on 19 July 2023 at 13 Porter Avenue Maryborough Victoria 3465, from streptococcal and staphylococcal meningitis, endocarditis and septicaemia, with a contributing factor of osteomyelitis pubis; and

c) the death occurred in the circumstances described above.

[40] Ibid, 4.
[41] Ibid, iii.
[42] Ibid, 52-53.
[43] Ibid, 28.
[44] Ibid, 16; Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 109; FVRIM, *Monitoring Victoria's family violence reforms Primary prevention system architecture* (Report, 2022) 38-40.

163. Having considered all the circumstances, I am satisfied that Belinda's death could have been prevented if she received appropriate antibiotics at an earlier stage, ideally, when she presented to MDHS. I note, however, that even with appropriate care, Belinda still may have died as the early stages of osteomyelitis pubis and spinal column infections do not always cause abnormal blood test results.[45]

164. I cannot determine whether Belinda would have survived if her partner had called for medical assistance when she first collapsed in the early hours of 19 July 2023. However, I note that receiving prompt medical attention at that time (i.e., if an ambulance was called at the time) would have maximised her chances of survival.

RECOMMENDATIONS

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

(i) That the **Department of Families, Fairness and Housing** resources an expansion of Alexis across the entire state.

(ii) That the **Attorney-General of Victoria** consider making a referral to the Victorian Law Reform Commission to:

a. consider the creation of a new offence (abandoning a victim in medical need); and/or
b. amending the Family Violence Protection Act 2008 (Vic) to include abandonment of a victim in medical need as an example of family violence; and
c. to consider how family violence perpetrators can be held to account in circumstances where a charge of criminal negligence is not available.

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

[45] Pursuant to A/Prof Baker's report.

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:

Michael Blyth, Senior Next of Kin

Danielle Jones

Department of Families, Fairness and Housing

The Hon. Sonya Kilkenny MP, Attorney-General of Victoria

Maryborough District Health Service

Detective Senior Constable Samuel Fary, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 11 August 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.