IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 004340

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	BQU
Date of birth:	2000
Date of death:	On or before 27 July 2025
Cause of death:	1(a) Acute ethanol toxicity in a woman with new onset seizures
Place of death:	Footscray, Victoria
Key words:	Ethanol toxicity, family violence, primary aggressor, mental ill health

INTRODUCTION

1. On 27 July 2025, BQU, was 24 years old when she was found unexpectedly deceased at home. At the time, BQU, lived alone in Footscray.

2. BQU grew up in Mullumbimby, New South Wales. Her parents separated when she was a child and her mother subsequently remarried, which resulted in two half-siblings for BQU. According to her mother, REU, her daughter was a gentle, loving, creative, artistic, sensitive, and intelligent person. However, she noted that BQU was vulnerable and picked on for being different.

3. REU stated that BQU started to exhibit symptoms of obsessive-compulsive disorder (**OCD**) and developed phobias when she was about 10 years of age. At the age of about 17 years, BQU began experiencing other mental health symptoms, including suicidal thoughts.

4. At about this time, BQU alleged her stepfather had sexually assaulted her as a child. He was subsequently investigated and prosecuted for charges related to sexual assault, but the charges were subsequently dismissed during the court process.[1] REU believed these events adversely impacted her daughter's mental health.

5. BQU did not go on to complete high school. She moved from New South Wales to Victoria for a new start. REU stated that her daughter was *"still very innocent"* at this age and felt she was vulnerable to manipulation by her friends.

6. BQU's father, OHD, stated that BQU received mental health treatment at about this time. She then went overseas for about two months. When she returned, she appeared to be in better mental health but began self-harming shortly thereafter.

7. In about 2020, BQU developed an eating disorder and received treatment at the Royal Melbourne Hospital. At the time, she was in a relationship which was said to have been supportive.

THE CORONIAL INVESTIGATION

8. BQU'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.

[1] Charge of indecent assault person under 16 years of age dismissed on 7 July 2020.

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. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of BQU'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.

12. This finding draws on the totality of the coronial investigation into BQU's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Identity of the deceased

13. On 27 July 2025, BQU, born in 2000, was visually identified by her partner, LZX, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

15. Forensic Pathology Registrar, Dr Daniel Hussey, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 31 July 2025 and provided a written report of his findings dated 13 October 2025.

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

16. The post-mortem examination revealed vomitus around her mouth and aspiration (inhalation) of food particles into the lungs which can impair respiration (breathing) leading to death.

17. BQU's history of seizures was noted. Examination of the brain did not identify an epileptogenic focus that could have caused seizures, but this does not preclude a seizure event having occurred. A seizure can also occur in the setting of acute alcohol intoxication. However, there are no autopsy findings that can confirm the occurrence of a seizure.

18. Routine toxicological analysis of post-mortem samples detected ethanol, levetiracetam,[3] and dothiepin.[4]

19. Ethanol (alcohol) was detected in the blood at 0.49 g/100 mL and in the vitreous humour at 0.59 g/100 mL. The effect of alcohol varies between individuals depending on tolerance and liver function. However, these levels were significantly elevated and above reported fatal alcohol concentrations.

20. Dr Hussey noted that both dothiepin and levetiracetam can cause sedation which can act synergistically with the central nervous system (**CNS**) depressant effects of alcohol and may have contributed to death.

21. Dr Hussey explained that ethanol toxicity depresses the CNS which supresses the cough reflex and increases the risk of aspiration.

22. Death in such cases is usually related to respiratory depression, but other complications of CNS depression may also be implicated. Alcohol decreases the seizure threshold which increases the risk of seizures. Alcohol can also affect the heart rhythm (QT-prolongation) which predisposes for potentially fatal cardiac arrhythmias.

23. The autopsy examination showed no evidence of any injuries that could have caused or contributed to death. Bruising seen at the right forearm and wrist may have been due to recent medical intervention during her hospital admission. There was focal haemorrhage in the neck muscles (no damage to the larynx) and the right temporalis muscle which may have been sustained in a terminal collapse. Bruising seen at the bony prominences may have been secondary to everyday occurrences. It is unclear how the healing mucosal injury to the upper lip frenulum occurred. It is noted that on 24 July 2025 in hospital multiple assessments of the

[3] Levetiracetam is an antiepileptic used for the control of partial onset seizures.
[4] Dothiepin (dosulepin) is a tricyclic antidepressant.

BQU's airway occurred when her consciousness deceased post-seizure. Injury to the frenulum during this medical intervention is one possible cause of this injury.

24. Dr Hussey provided an opinion that the medical cause of death was *"1(a) Acute ethanol toxicity in a woman with new onset seizures"*.

25. I accept Dr Hussey's opinion.

Circumstances in which the death occurred

Family violence history

26. In about late-2022, BQU commenced an intimate relationship with LZX who she met through an online dating app. BQU's parents described the relationship with LZX as volatile and believed it was instrumental to the self-destructive behaviours (such as drug and alcohol use) and mental ill health symptoms that BQU subsequently demonstrated, and which led to her eventual death.

27. According to LZX, he took on a 'carer's role' for BQU, taking her to medical appointments and managing her medications, and trying to manage her mental health episodes. He noted that their relationship had become 'on and off' due to BQU's fluctuating mental health. During the periods when they were on a 'break', BQU often made threats.

28. In August 2023, BQU moved into LZX's house in Maribyrnong.

29. In mid-2024, her father purchased an apartment for her in Footscray. However, LZX stated that she was reluctant to move into the property *"properly"* by taking her furniture and belongings there and she spent her time between the two residences.

30. Senior Constable Gregory Martin, Coronial Investigator, noted the following reported family violence incidents between the couple.

31. On the evening of 30 March 2024, LZX contacted emergency services stating that BQU was suicidal and had a knife. Shortly after that, BQU also contacted emergency services stating that LZX was controlling her. When police attended, BQU was not in possession of a knife nor had any signs of self-harm. LZX reported that BQU had been escalating her suicidal ideation and tapped her wrist with a knife to simulate self-harm. He expressed to police that he was at his breaking point due to the stress of caring for her. Both BQU and LZX had been

drinking alcohol on this occasion. LZX was listed as the Respondent in this incident due to police deeming BQU to be the more vulnerable party in the long-term.

32. On the evening of 9 April 2024, LZX contacted emergency services to report that BQU was trying to break into his bedroom and was threatening suicide. Both were reported to have been drinking prior to the incident which resulted in a verbal argument. BQU admitted to police that she was struggling with her mental health and had an appointment the following Friday at the Saltwater Clinic, Footscray. It was recorded that LZX appeared keen for BQU to be taken to hospital for mental health treatment. Police recorded LZX as the Respondent and BQU was the Affected Family Member in this matter.

33. On the evening of 10 April 2024, BQU and LZX had a verbal argument over BQU's mental health and LZX hiding her mobile phone somewhere in the house. The argument spilled out on to the street and was observed by witnesses and police. LZX reported that BQU had been cutting herself with glass on the neck and wrists in an apparent suicide attempt. LZX subsequently left the scene. Police recorded him as the Respondent during this incident.

34. On the evening of 29 May 2024, Ambulance Victoria were called in response to BQU having a mental health episode at LZX's home. With Ambulance Victoria unavailable at the time, police attended in their place. Both BQU and LZX had been drinking. BQU accused LZX of withholding her medication and alcohol. LZX explained his role in managing her medication and BQU confirmed she had tried to overdose on medication in the past. LZX was again recorded as the Respondent during this incident.

35. On 21 August 2024, police issued a Family Violence Safety Notice naming BQU as the Respondent and LZX as the Affected Family Member in response to an argument. BQU stated that she found evidence of LZX cheating on his mobile phone and BQU kicked a mirror out of anger, causing a cut to her foot. LZX left the address and when he returned, BQU held a shard of the broken mirror to her own throat telling LZX that she would kill herself if he left. LZX contacted emergency services as he was concerned for BQU's wellbeing.

36. In the early hours of 7 September 2024, BQU attended LZX's house in breach of the active Family Violence Safety Notice. She was reported to have banged on the front door demanding to be let in but he refused to let her enter. BQU then turned the power off to the house and began banging on LZX's bedroom window, smashing the glass in the window. LZX called emergency services, but BQU left the premises prior to police attendance. About two hours later, police receive a call from LifeLine to attend and speak to BQU who was expressing

suicidal ideation at the tram stop near LZX's house. BQU's father attended and took BQU into his care. BQU was charged with contravening the family violence order on 28 December 2024, which was later dismissed under section 76 of the *Sentencing Act 1991* on 7 February 2025. This single criminal charge is the only charge ever laid by police.[5]

37. On 27 September 2024, LZX contacted emergency services to report that BQU was at her home address and was heavily intoxicated and threatening suicide. LZX was at his own home and was allegedly missing medication which he believed BQU had taken. Police attended BQU's apartment at which time she denied all allegations of suicidal ideations and taking the medication belonging to LZX. BQU told police that her comments to LZX were in relation to a breakup not in relation to taking her own life. When police spoke to LZX, he stated BQU had taken his Ritalin medication in front of him but refused to make a statement. Once again, LZX was listed as the Respondent and BQU was listed as the Affected Family Member.

38. On 11 October 2024, BQU and LZX went out to celebrate her birthday. BQU became intoxicated which led to an argument between them, and they subsequently left the venue separately. Later that evening, LZX contacted emergency services stating he received a text from BQU saying she was at his address, threatening to kill herself. Police found BQU at LZX's home with multiple superficial cuts to her left wrist and she was taken to Footscray Hospital.

39. On 30 October 2024, LZX contacted emergency services stating BQU was kicking his car and front door and screaming. When police arrived, BQU was crying and hyperventilating and was subsequently taken to Footscray Hospital. BQU was not charged for contravening the family violence order due to insufficient evidence.

40. On 11 December 2024, LZX invited BQU to his home. LZX then informed BQU that he was sleeping with another woman. This led to BQU threatening to harm herself using the tram tracks across the road from his house. Both were intoxicated on this occasion, and BQU was taken to Footscray Hospital.

41. On 21 December 2024, OHD contacted police requesting a welfare check on BQU at his house. When police arrived, BQU was found heavily intoxicated inside the house and was

[5] Section 76 provides that a court, on being satisfied that a person is guilty of an offence, may (without recording a conviction) dismiss the charge.

taken to Footscray Hospital for medical assessment. Police officers documented that LZX was not supportive of the family violence order condition prohibiting BQU from being at his home.

42. On 28 December 2024, BQU was reported to be running on the tram tracks near LZX's home and threatening suicide. When spoken to by police, BQU appeared highly emotional and intoxicated. She was transported to Footscray Hospital.

43. On 5 February 2025, the Sunshine Magistrates' Court issued a Family Violence Interim Intervention Order (**FVIVO**) identifying BQU as the Respondent and LZX and his son as the Affected Family Members. The only condition on this order was to not commit family violence.

44. On 5 July 2025, BQU and LZX returned home from dinner at which BQU consumed alcohol. LZX accused BQU of cheating on him and a verbal argument ensued. Police reported that when they attended, LZX exhibited concern for BQU's wellbeing stating that this incident was out of character for her. LZX was recorded as the Affected Family Member and BQU as the Respondent.

45. On 9 July 2025, LZX became verbally abusive towards BQU calling her 'ugly' and saying he was going to cheat on her. BQU became extremely upset by this and began crying loudly causing a passerby to call emergency services. Upon police attending, BQU reported that LZX was very controlling in the relationship and regularly belittled her. LZX was recorded as the Respondent and BQU as the Affected Family Member.

46. At the time of BQU's death, she was listed as the Respondent in a FVIVO whereby LZX and his son were listed as the Affected Family Members. This application was initiated by the incident reported on 20 August 2024. At this time, there were no FVIVO in which LZX was named as the Respondent and BQU as the Affected Family Member.

Mental health and medical history

47. BQU had received mental health treatment from public mental health services intermittently since 2018. She had received diagnoses of borderline personality disorder, complex post-traumatic stress disorder (**PTSD**) on a background of significant childhood sexual abuse, anxiety, depression, OCD, eating disorder (atypical anorexia nervosa), and alcohol use disorder. LZX stated that BQU also engaged in illicit substance use (including cocaine, Xanax, MDMA, and speed).

48. From February 2024 to 26 May 2025, she received mental health treatment and support from Mercy Mental Health.

49. On 25 February 2024, BQU presented to Werribee Mercy Emergency Department via ambulance in the context of erratic behaviour, alcohol use, and possible overdose of dothiepin. Following a period of observation and referred to Alcohol and Other Drug (**AOD**) services, she was discharged the following day.

50. On 1 March 2024, Victoria Police recorded an incident in which BQU held on to tram tracks saying she wanted to die after running from an Uber. LZX and OHD were both able to calm BQU down and return her home. Police had to attend twice on the same day to assist both ODH and LZX support BQU. They both agreed that BQU should not be transported to hospital on this occasion.

51. On 14 May 2024, BQU attended the Footscray Hospital via ambulance after an overdose. In the Emergency Department, BQU experienced her first generalised tonic clonic seizure episode and was admitted to the Intensive Care Unit (**ICU**) as she required intubation. BQU's partner reported that she had a history of seizures which appeared more like panic attacks and for which she reportedly previously received treatment for from her general practitioner.

52. During her admission, BQU was reviewed by Consultant Liaison Psychiatry. BQU reported that the overdose was impulsive and she had recently experienced psychosocial stressors. BQU engaged well with the psychiatrist and was remorseful about the overdose. She denied current suicidal ideation, was able to engage in safety planning, and was happy to follow up with community mental health services. She was discharged on 16 May 2024 and referred to Western Health's outpatient First Seizure Clinic but failed to attend the outpatient appointment for an electroencephalogram (**EEG**).

53. Between 25 May 2024 and 29 December 2024, BQU had multiple attendances to hospital emergency departments related to self-harm, suicidal ideation, and intoxication.[6] At many of these presentations, BQU requested discharge and declined care for her mental health and alcohol use.

[6] 25 May 2024, 2 September 2024, 12 October 2024, 27 October 2024, 30 October 2024, 11 December 2024, 21 December 2024, 28 December 2024.

54. Between September 2024 and 15 May 2025, BQU received assistance from the Eastern Health Spectrum Service for psychological treatments such as managing anxiety, distress management, emotional regulation, and interpersonal relationships.

55. According to Dr Mithira Nithianandan, Acting Executive Clinical Director at Spectrum, BQU was assessed by Spectrum on 28 September 2024 and received primary diagnoses of complex-PTSD and borderline personality disorder, as well as a background of binge alcohol use. Core issues included emotion dysregulation, impulsivity, interpersonal difficulties, abandonment fears, non-suicidal self-injury, and chronic suicidal thoughts. There was a history of non-suicidal self-injury by cutting (last in June 2024). She reported two overdoses with prescription medication in 2023 and an incident of lying on train tracks in 2024. Dr Nithianandan noted that BQU had identified a pattern of alcohol use and relationship conflict leading to suicidal behaviours. Her pattern of suicidal behaviours suggested that these behaviours were impulsive and could be understood as a coping mechanism – suicidal behaviours functioned as a method of escaping emotional pain. BQU's alcohol use was associated with higher levels of impulsivity and disinhibition, leading to an increased risk of BQU acting on non-suicidal self-injury and suicidal thoughts. At the time of assessment, it was noted that BQU had struggled to sustain engagement with clinicians/therapists/services over the years which posed a barrier to receiving adequate treatment.

56. Following assessment, BQU was offered a place in Spectrum's Acceptance and Commitment Therapy Program – an evidence-based psychotherapy treatment for BPD and complex-trauma. She was also offered weekly group psychotherapy sessions. The treatment program offered was for a period of one year. Spectrum's primary role in BQU's care was psychotherapy treatment.

57. Once she commenced treatment at Spectrum, BQU did not attend any of the group psychotherapy sessions and attendance at individual therapy was limited. She largely attended via telehealth despite her therapist's recommendation for face-to-face sessions to improve the effectiveness of treatment.[7]

58. On 7 November 2024, BQU presented to Werribee Mercy Emergency Department via ambulance in the context of increased paranoia and significant alcohol use. She subsequently was transferred to the Werribee Inpatient Psychiatric Unit where it was noted BQU was experiencing paranoia, auditory hallucinations (hearing voices), limiting food intake, and

[7] Over a period of seven months, BQU attended 10 sessions. Throughout treatment there was regular liaison between Spectrum and the local area mental health service (Saltwater Clinic).

engaging in self-harming behaviour (scratching and cutting) while drinking two litres of alcohol a day. She was provided treatment for acute alcohol withdrawal and was discharged with regular medication (mirtazapine 30 mg daily, thiamine 100 mg daily). Follow up care was to be provided by the Crisis Assessment Team (**CATT**), drug and alcohol services, and Saltwater Community Mental Health Team (**Saltwater**).

59. After hospital discharge, BQU engaged with the CATT and the drug and alcohol team for a limited period. She was sober for a while and then lapsed into drinking two litres of wine per day. BQU was encouraged to re-engage with drug and alcohol services, but she refused. She reported that she had been drinking since the age of 17 years and did not want further support. However, she agreed to take regular thiamine tablets to minimise the side effects of thiamine deficiency.

60. Following the voluntary hospital admission in November 2024, BQU was case managed by Saltwater. Dr Thinzar Phyo, consultant psychiatrist at Saltwater, stated he last reviewed BQU in January 2025 at which time she reported chronic emotional dysregulation with dissociation and depressive symptoms, contributed by chronic alcohol use and psychosocial stressors such as relationship, finance, and past trauma. She suffered from chronic auditory hallucinations (hearing voices) and paranoid ideation, possibly related to chronic alcohol use. Dr Phyo prescribed aripiprazole (an antipsychotic medication) and mirtazapine (an anti-depressant medication).

61. In February 2025, BQU was noted to have a stable mental state. She reported that she had not used alcohol for about two weeks. Whilst she still had suicidal ideation when distressed, she denied any acute risks to act on those thoughts.

62. BQU then failed to attend follow-up medical and case-management reviews in March and May 2025. Given that BQU had not attended the last five scheduled reviews and she had been stable for about four months, it was decided that BQU's care could be transferred to her general practitioner.

63. From about March 2025, BQU's engagement with Spectrum also became sporadic and she failed to respond to the Spectrum's attempts to contact her. Spectrum also discharged BQU from their service in May 2025 after missing four consecutive individual sessions and not returning contact. Reengagement with the service in future was offered at the time of discharge. During her treatment, it was noted that BQU displayed a pattern of avoidance to cope with uncomfortable emotions. Her pattern of emotional crisis included contact with

services and disclosures of suicidal thoughts was precipitated by conflict with LZX and associated alcohol use. Alcohol use was understood as a barrier to engagement in treatment and change. BQU also identified that alcohol use increased her suicidal thoughts and thus she made a commitment to avoid drinking.

64. On 19 June 2025, BQU had a further hospital presentation.

Days leading to BQU's death

65. BQU stayed with LZX on the evening of 23 July 2025 despite LZX stating he was trying to end his relationship with her.

66. The following morning, 24 July 2025, she experienced a seizure in bed and LZX contacted emergency services. BQU subsequently presented to the Footscray Hospital Emergency Department via ambulance. She had reportedly consumed approximately 700ml of spirits the night before. She had two further seizures in the Emergency Department before being transferred to the General Medicine Unit where she was commenced on anti-epileptic medication Keppra (levetiracetam) 500 mg twice daily. No additional seizure activity was observed. She was discharged at 1.35pm on 26 July 2025 with a referral for an outpatient EEG at the First Seizure Clinic.

67. BQU's father, OHD, stated he last spoke to his daughter at about lunchtime that day. She informed him of her hospital admission. OHD described BQU as sounding like she was *"in an ok mood",* however noted that LZX had been contacting her in *"jealous rages".*

68. BQU later text messaged her father after discharge ask for money, which he sent to her. He again text message her that evening, to which BQU did not reply.

69. Following discharge from hospital, BQU returned to her apartment in Footscray and maintained phone contact with LZX. During this time, BQU requested some of her belongings, but LZX stated that he could not deliver them to her as he was taking his son to the zoo. He left a bag of belongings at his house, which BQU subsequently collected after which she returned to her apartment. LZX stated that he then received multiple erratic text messages and voicemails from BQU, which signalled to him that she was intoxicated.

70. BQU's last in communication with LZX was via text message at 3.32pm on 26 July 2025. She expressed that she was not afraid to kill herself. LZX told her to stop drinking and try and work on herself. She pleaded with LZX, saying all she wanted was him.

71. BQU's call log shows her first missed call was at 7.25pm that evening.

72. LZX stated he sent her a text at about 11.00pm that evening and did not receive a response. He assumed that BQU had passed out by that stage and so he went to bed.

73. The next morning, 27 July 2025, LZX noted that he had not heard from BQU overnight. He sent her a text again but did not receive a response. He then called her, but her phone was switched off. This was unusual, so he made his way to BQU's apartment with his son.

74. He arrived at her apartment at about 11.48am and used a spare key to unlock the door, but there was a latch on the door which only allowed the door to be opened a small amount. He looked through the ajar door and saw BQU lying on the ground in the hallway and called out to her. When BQU failed to respond, he tried to get in by smashing the glass door via the front courtyard. However, due to the plastic panels on the door, he was unable to get inside.

75. LZX called emergency services at 11.52am. Victoria Police members arrived a few minutes later, finding LZX still at the scene. The police members used force to gain entry into the apartment at which time they assessed BQU to be deceased.

76. Ambulance Victoria paramedics also attended the scene and formally verified death at 12.04pm.

77. Senior Constable Martin noted there was an Uber Eats bag with a receipt for 'loaded fries' stating it was delivered at 2.03pm on 26 July 2025 on the floor of the loungeroom. The barely touched fries were on the kitchen bench.

78. Apart from the smashed glass in the door out to the courtyard caused by LZX and the broken plastic caused by police gaining entry, there were no other signs of forced entry to the unit.

79. There was a single open bottle of Captain Morgan Rum located on the kitchen bench next to a liquor style brown paper bag with 'BQU' written on it. There was approximately one sixth of the bottle of rum remaining. There was another single empty bottle of Captain Morgan Rum in a rubbish bag on the floor of the kitchen.

80. Senior Constable Martin later interrogated BQU's mobile phone, which revealed messages between BQU and LZX depicting what he described as a dysfunctional relationship full of distrust and cheating allegations usually aimed toward BQU.

FURTHER INVESTIGATION

81. As part of my investigation, I obtained advice from the Coroners Prevention Unit[8] (**CPU**) about the mental health care and family violence aspects of BQU's death.

Mental health care

82. The CPU considered that Saltwater Clinic and Spectrum's decisions to discharge BQU in May 2025 appeared reasonable at the time. At each service, BQU had failed to attend multiple consecutive appointments despite reminders and there were no grounds to utilise more restrictive actions to compel ongoing treatment.

83. Additionally, Saltwater Clinic encouraged BQU to re-engage with drug and alcohol services while under their case management.

84. In any event, BQU's discharge from these services was not sufficiently proximal to the fatal incident which occurred on 26 July 2025. The CPU did not identify prevention opportunities proximate to her passing.

Family violence

85. Regarding family violence, the CPU noted the following:

    (a) there were 14 recorded family violence incidents between BQU and LZX in 2024 and 2025 – with one on 9 July 2025;

    (b) both BQU and LZX were identified at different times as Affected Family Member and Respondent;

    (c) each incident would have resulted in referral to the Orange Door. Spectrum also advised that they had liaised with Orange Door in March 2025; and

    (d) the (alleged) sexual abuse from BQU's stepfather also constituted family violence.

[8] 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.

86. I acknowledge the concerns raised by BQU's family that LZX perpetrated family violence against BQU and that the nature of their relationship contributed to her mental health and substance abuse issues.

87. Having reviewed the available evidence, it is difficult to make definitive comment about the adequacy of the police response to the reported family violence incidents. Both BQU and LZX were named as Respondents and Affected Family Members in the multiple incidents of family violence reported to Victoria Police and there is no doubt their relationship was turbulent, and even 'toxic'. A complicating factor was that BQU experienced and exhibited what were, at times, significant mental health symptoms and it appears that many of the family violence incidents occurred in this context. BQU also experienced alcohol misuse and the family violence reports refer to both parties consuming alcohol at various times. Only BQU was recorded as a Respondent in a FVIVO.

88. Police members are not qualified mental health practitioners. I acknowledge that in practice, it can be difficult to differentiate between behaviour that may be a result of family violence and behaviour that may be due to mental illness. In many cases, there is an overlap and no clear distinguishing line.

89. I also note that in March 2025, BQU's case managers from Spectrum and Saltwater Clinic held a case conference with Orange Door during which they discussed concerns regarding the complex interpersonal patterns in the relationship between BQU and LZX – in particular a pattern of abandonment triggers leading to BQU reacting with acute emotion dysregulation and impulsivity. It was identified that BQU had a tendency to self-blame and struggled to identify when others' behaviour was unacceptable or implement appropriate boundaries. Despite the difficulties in her relationship, BQU maintained that LZX was an important support for her. It was noted that Orange Door advocated for BQU in relation to matters where police became involved in her relationship conflict with LZX.

Misidentification of primary aggressor

90. I make no finding or comment about whether BQU was appropriately labelled as the Respondent in several of the reported family violence incidents with LZX. However, I note the following.

91. The Victoria Police *Code of Practice for the Investigation of Family Violence* (**the Code of Practice**) provides guidance on identifying the predominant aggressor,[9] listing several indicators for police to consider, including:[10]

(a) how fearful each person is;

(b) any historical pattern of coercion, intimidation and/or violence;

(c) the nature of any injuries;

(d) the capacity to inflict injury;

(e) the need for protection; and

(f) any information from other agencies.

92. The Code of Practice also cautions against police members making assumptions regarding the role of either party and notes that members should be alert to:[11]

(a) attempts to influence, the presence of power imbalance and/or possible manipulation by the predominant aggressor;

(b) the predominant aggressor can appear calm and reasonable, whereas the victim may appear agitated or potentially violent;

(c) the predominant aggressor using the incident to minimise their actions and create doubt about the victim's version of events, and thereby would be using the justice system to carry out family violence; and

(d) violence may be normalised so the victim may appear to 'choose' to remain in a violent relationship.

[9] The term predominant or primary aggressor is at times substituted for the term primary aggressor, and "seeks to assist in identifying the actual perpetrator in the relationship, by distinguishing their history and pattern of coercion, power and controlling behaviour, from a victim survivor who may have used force for the purpose of self-defense or violent resistance in an incident or series of incidents. The predominant aggressor is the perpetrator who is using violence and coercive control to dominate, intimidate or cause fear in their partner or family member, and for whom, once they have been violent, particularly use of physical or sexual violence, all of their other actions take on the threat of violence": Family Safety Victoria, MARAM Practice Guides: Foundation Knowledge Guides (February 2021), 124.
[10] Victoria Police, Code of Practice for the Investigation of Family Violence (2022) 4th Edition, Version 2, 18.
[11] Victoria Police, Code of Practice for the Investigation of Family Violence (2019) 4th Edition, Version 33, 18.

93. I note that police misidentification of women as primary aggressors has been an issue in Victoria and other Australian jurisdictions and has serious repercussions for victims.[12]

94. Research indicates that when women use violence in heterosexual intimate relationships, the violence tends to be a consequence of their own victimisation and as a violent resistance to a pattern of controlling, coercive, and violent behaviour used against them.[13] It is important therefore that the primary aggressor is selected by police on the basis of a pattern of coercive and controlling behaviour, rather than on the basis of an incident-based approach to investigation which does not take patterns of coercion and control into account.[14]

95. Misidentification of victims as primary aggressors in family violence incidents can have profound and lasting consequences. When a victim is wrongly labelled as the perpetrator, this mischaracterisation can reinforce harmful narratives in future police responses, leading authorities to view the victim with unwarranted suspicion and undermining their credibility. This, in turn, can significantly limit the victim's access to justice, safety, and protective interventions.

96. Moreover, misidentification can impact upon a victim's self-perception, causing them to internalise blame or question the legitimacy of their own experiences. This may reduce their confidence in seeking help or leaving the relationship and may increase the perpetrator's control over them.

97. On a practical level, being wrongly labelled as the predominant aggressor can restrict access to critical support services, including therapeutic programs, housing, and recovery pathways that are typically reserved for victims.

98. Misidentification of women as primary aggressors is often driven by racialised, classed, and gendered stereotypes of ideal victims, and women in general, as being submissive to authority,

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[12] Women's Legal Service Victoria, 'Snapshot of Police Family Violence Intervention Order Applications' (2018), 1; Women's Legal Service Victoria, "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family violence incidents in Victoria (Policy Paper One, July 2018), 1; No To Violence, Predominant Aggressor Identification and Victim Misidentification (Discussion Paper, November 2019), 6; FVRIM, Monitoring Victoria's family violence reforms Primary prevention system architecture (Report, 2022) 10-1; Parliament of Victoria Legislative Council, Legal and Social Issues Committee Inquiry into Victoria's Criminal Justice System Volume 1 (March 2022), 243.

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

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

downtrodden, passive, and dependent.[15] Women who engage in violent resistance may not fit these stereotypes, and this in turn may influence police decision-making in favour of the perpetrator.[16]

99. In recent years, Victoria Police have undertaken work to address the issue of police misidentification of the predominant aggressor. Victoria Police have updated guidance on identifying the predominant aggressor in line with Victoria's family violence risk assessment and management framework, the Multi-Agency Risk Assessment and Management Framework (**MARAM**).[17]

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

101. Following the Trial, Victoria Police continued their work on addressing misidentification of the predominant aggressor through the Predominant Aggressor Program of Work, which started in December 2022 after the Trial ended.

102. Victoria Police have developed a Practice Guide, *Family violence – Predominant aggressor*, July 2025, to help support police members to accurately identify the predominant aggressor and affected family member, and to review and rectify these labels when needed.

103. Victoria Police are also part of the Predominant Aggressor Working Group (**PAWG**) co-chaired by Family Safety Victoria and the Department of Justice and Community Safety Victoria.

104. In statements provided to the Court in other coronial investigations, Victoria Police acknowledged the ongoing challenge of accurately identifying the predominant aggressor

[15] Heather Nancarrow et al, 'Accurately Identifying the "Person Most in Need of Protection" in Domestic and Family Violence Law' (Research Report Issue 23, ANROWS, November 2020), 3; Heather Nancarrow et al (n 246) 26; No To Violence, 'Predominant Aggressor Identification and Victim Misidentification' (Discussion Paper, November 2019)12.
[16] Heather Nancarrow et al, 'Accurately Identifying the "Person Most in Need of Protection" in Domestic and Family Violence Law' (Research Report Issue 23, ANROWS, November 2020) 96.
[17] Victoria Police, Victoria Police Manual - Family Violence (2022), 10-1; Family Safety Victoria, MARAM Foundation Knowledge Guide (2021), 113.

especially in the cases of heightened and emergency situations or where there are complex relationship dynamics and/or a history of mental health and/or substance misuse issues in respect of one or both parties.

105. Recent legislative changes aim to address misidentification. In February 2026, Royal Assent was provided for the *Justice Legislation Amendment (Family Violence, Stalking and Other Matters) Bill 2025*, which added into the *Family Violence Protection Act 2008*[18] a requirement for both police and courts to consider when issuing Family Violence Safety Notice or an interim or final FVIVO if the respondent has been misidentified, with reference to:

(a) the nature of the incident involving family violence in the context of the entire relationship between the affected family member and the respondent; and

(b) any history of family violence between the affected family member and the respondent; and

(c) whether any of the family violence may have been committed by the respondent in self-protection or to protect another person; and

(d) whether the respondent has any characteristics that tend to increase the risk of being misidentified, including the following—

(i) age;

(ii) race;

(iii) sex;

(iv) sexual orientation;

(v) gender identity;

(vi) disability;

(vii) being Aboriginal or Torres Strait Islander.

[18] Subdivision 3—Misidentification and consideration of age or impairment.

Expansion of Victoria's co-responder program

106. Co-responder programs involve the presence of a family violence specialist worker during police attendance at family violence incidents to provide a collaborative response.

107. Research has identified key benefits to co-responder programs, including higher satisfaction of victims with police, increased willingness of victims to contact police in future, more information sharing and coordination of services for victims, greater understanding of family violence by police, and a perceived increase in the accountability taken by police in responding to family violence.[19] Further, co-responder programs are a popular option for reducing rates of misidentification of the predominant aggressor amongst researchers, police, and people with lived experience of family violence.[20] These views are shared by ANROWS,[21] and by Family Safety Victoria and Victoria Police.[22]

108. The Alexis Family Violence Response Model is a co-responder model which operates across Prahran, Bayside, Morwell, and Wonthaggi. Under this model, two senior specialist family violence practitioners are allocated to each Victoria Police Family Violence Investigation Units and accompany police in responding to victims and perpetrators of family violence in the immediate aftermath of a high-risk incident.

109. In 2024 an evaluation of this program found that most victim-survivors engaged with the program felt supported by the Alexis team. Seventy-eight per cent of victim-survivors who took part in the evaluation also reported that family violence had reduced in their relationship, with no victim-survivors reporting an increase in violence. Risk levels were also noted to reduce, with 66 per cent of respondents assessed as exhibiting lower risk levels at case closure when compared to their initial risk rating.[23] Whilst engaging respondents with support is notoriously challenging, findings of the Alexis model indicate that practitioners had successful contact with 83 per cent of respondents, with assertive outreach being a key feature of this success.[24]

110. In October 2025, the Allan movement announced expansion to two new sites.

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[19] VSRFVD, Multidisciplinary responses to Family Violence (2023), 4, 6.
[20] Nancarrow, H., Thomas, K., Ringland, V., & Modini, T. (2020). Accurately identifying the "person most in need of protection" in domestic and family violence law (No. ANROWS Research Report 23) 21, 96.
[21] VSRFVD, Multidisciplinary responses to Family Violence (2023), 3.
[22] Ibid 10.
[23] Hamilton, G., Gerryts, D., Chesser, B., & Ridgway A. (2024). *Updated Evaluation of the Alexis Family Violence Response Model*. RMIT University, Melbourne.
[24] Hamilton, G., Gerryts, D., Chesser, B., & Ridgway A. (2024). *Updated Evaluation of the Alexis Family Violence Response Model*. RMIT University, Melbourne.

111. I note my fellow coroners have made recommendations and comments in support of expansion of co-responder models in Victoria in recent findings.[25]

112. In the finding into the passing of Noeline Dalzell, then State Coroner, Judge Cain, explored the benefits of co-responder programs and made the following recommendation:

> *Recommendation 5: Victoria Police and The Orange Door in two regions as a pilot collaborate to embed advanced family violence practitioners within each FVIU to assess, jointly respond to and manage repeat and/or high-risk family violence matters and improve proactive victim/AFM engagement. I note the complexity of placing a Family Violence 79 Practitioner within the structure of a statutory organisation such as Victoria Police and acknowledge that this will need to be a senior worker with extensive experience and provided with supervision by a specialist family violence service. An independent evaluation of the pilot program should be completed within two years of commencing operation in each of the two regions selected*.

113. In response to the recommendation, both Victoria Police and the Department of Families, Fairness and Housing noted that they had consulted with each other, but the implementation of the recommendation was subject to funding decisions.

114. It is unclear in this case whether BQU would have engaged differently with police had a co-responder program been available in her area.

Child sexual abuse

115. In addition to family violence, I also noted that BQU reportedly experienced child sexual abuse, which is associated with substance misuse and mental health issues later in life.

116. The Royal Commission into Institutional Responses to Child Sexual Abuse (**the Commission**) was a five-year inquiry that investigated how organisations handled allegations of child abuse, amongst many other issues regarding child sexual abuse. The Commission's final report included detailed information on the impacts of child sexual abuse on survivors,

[25] Finding into the death of Carolyn James with Inquest, published 23 April 2024; Finding into the death of Noeline Dalzell with Inquest, published 15 November 2024; Finding into the death of CM without Inquest, published 9 January 2025; Finding into the death of EDH without Inquest, published 11 April 2025; Finding into death of Jessica Geddes without Inquest, published 24 June 2025; Finding into the death of KSQ without Inquest, published 28 July 2025; Finding into the death of Tracey Knowles without Inquest, published 25 August 2025; Finding into the death of ZSQ without Inquest, published 11 Septemebr 2025; and Finding into the death of Narelle Simmons without Inquest, published 9 October 2025.

noting that the effects are highly variable, manifesting differently in each individual and changing over time.[26]

117. It is well known that child sexual abuse can have a profound and lasting effect on a person's life.[27] Some impacts, such as the effects on mental health, can last well into adulthood.[28] Unfortunately, for some survivors, child sexual abuse can be a factor in deciding to end their own lives. However, many survivors will also lead fulfilling lives.[29]

118. The Commission explained how the overwhelming distress associated with the traumatic event can cause a range of ongoing psychological and emotional problems. Survivors most commonly describe negative mental health impacts such as depression, anxiety, post-traumatic stress disorder, nightmares and flashbacks, hyper-arousal (heightened anxiety and alertness) and hyper-vigilance, hypo-arousal (delayed or weakened physical and cognitive responses), and dissociation. Other symptoms of emotional distress are common, such as feelings of helplessness, nightmares and sleeping difficulties, and feelings of shame, guilt, and low self-esteem. Mental health issues and emotional distress are often experienced simultaneously, rather than as isolated problems or disorders.[30]

119. Of particular note, the Commission identified the negative impacts of delayed disclosure of child sexual assault. The Commission found that survivors who delayed telling someone about the abuse were more likely to experience mental distress, depression, anxiety, physical symptoms and suicidality.[31]

120. The Commission also noted that over a survivor's life course, the consequences of childhood trauma may manifest in various ways and change over time.[32] In particular, the psychological impacts can intensify when a survivor reaches older age and that increased difficulty in coping with these impacts can be compounded by the loss of peer support and physiological changes in later life. Additionally, the loss of roles and resources, that at one time served to distract the survivor and alleviate the stress arising from childhood trauma, can also add to the burden of coping with the long-lasting effects of childhood sexual abuse.[33]

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[26] Commonwealth of Australia, Royal Commission into Institutional Responses to Child Sexual Abuse, Final Report: Volume 3, Impacts (2017).
[27] Final Report: Volume 3, Impacts, page 23.
[28] Final Report: Volume 3, Impacts, page 25.
[29] Final Report: Volume 3, Impacts, page 25.
[30] Final Report: Volume 3, Impacts, page 10.
[31] Final Report: Volume 3, Impacts, page 50.
[32] Final Report: Volume 3, Impacts, page 27.
[33] Final Report: Volume 3, Impacts, page 28.

121. In a paper titled *The long-term effects of child sexual abuse*, the authors reviewed Australian and international research on the long-term effects of child sexual abuse.[34] Their review of research pointed to a consistent association between child sexual abuse and adverse mental health and related outcomes for survivors. Outcomes included drug and alcohol dependence/ abuse, depression, panic disorder, PTSD, personality disorders, aggressive behaviours and conduct problems, and eating disorders – many of the issues BQU experienced during her short life.

FINDINGS AND CONCLUSION

122. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was BQU, born in 2000;

(b) the death occurred on or before 27 July 2025 in Footscray, Victoria;

(c) the cause of BQU's death was acute ethanol toxicity in a woman with new onset seizures; and

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

123. BQU's life and death occurred within a very complex psychosocial context amply documented in the brief which was commendably detailed. Her psychosocial history included a relationship with her most recent partner, which was described as 'coercive and controlling' by her family, fractured family relationships including allegations of sexual abuse by her stepfather and his failed prosecution in New South Wales, anorexia as a teenager, various diagnoses including anxiety/depression, borderline personality disorder, OCD, PTSD, and polysubstance abuse including alcohol.

124. Her cause of death following autopsy is acute alcohol toxicity in a woman with new onset seizures and findings included aspiration of gastric contents into the airways, multiple minor traumatic injuries, and a blood alcohol content (**BAC**) of 0.49 g/100mL in blood (and 0.59 g/100mL in vitreous). The BAC alone was sufficient to account for her death.

125. While BQU had a history of suicidality, the weight of available evidence does not support a finding of intent on this occasion.

[34] J Cashmore and R Shackel, *The long-term effects of child sexual abuse*, CFCA Paper No. 11, Australian Institute of Family Studies, 2013.

126. BQU appears to have first experienced a seizure in about May 2024. At this time, she was treated at Footscray Hospital but failed to attend a referral to Western Health's outpatient First Seizure Clinic. She presented to Footscray Hospital about a year later, in July 2025, with seizures, at which time she was commenced on anti-epileptic medication for follow-up by the First Seizure Clinic. She was found deceased in her apartment the following day, with evidence of vomitus nearby, having apparently drunk herself into a stupor.

127. The family concerns centre on the destructive nature of her relationship with LZX and the belief that the failed prosecution against her stepfather caused her life to spiral out of control. Certainly, her history is consistent with what we understand can happen to children subjected to sexual abuse as they grow into adulthood. While there were multiple family violence incidents in the months before her death, there is no evidence before me to indicate that a different response from Victoria Police or the involvement of additional family violence support services would have prevented BQU's death.

128. Having considered all available evidence, I am satisfied that BQU's death was the unintended consequence of the deliberate ingestion of a significant amount of alcohol in the context of dothiepin and levetiracetam use in the setting of new onset seizures, an extremely complex psychosocial history.

129. I convey my sincere condolences to BQU's family for their loss,

130. 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:

OHD, senior next of kin

REU, senior next of kin

Eastern Health

Western Health

Mercy Mental Health and Wellbeing Services

Senior Constable Gregory Martin, Victoria Police, Coronial Investigator

Signature:





Deputy State Coroner Paresa Antoniadis Spanos

Date: 28 October 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.