IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006382

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Mr A*
Date of birth:	25 March 1988
Date of death:	21 November 2020 to 22 November 2020
Cause of death:	Neck compression in the setting of hanging
Place of death:	Victoria
Keywords:	Family Violence; Suicide

* This finding was de-identified in accordance with a pseudonym order made by her Honour on 15 March 2024 to protect the identities of parties and children involved in Children's Court proceedings (section 534 of the *Children, Youth and Families Act 2005*).

INTRODUCTION

1. On 23 November 2020, Mr A was 32 years old when his body was discovered in the rear shed of his former partner's residence in Victoria. Mr A had recently been released from prison after being convicted for family violence related charges (consistent breaching of a Family Violence Intervention Order). Mr A was living with an associate in Colac at the time of the fatal incident.

2. Records provided to the Court indicate that Mr A experienced family violence throughout his childhood and early adulthood.[1] A psychological assessment completed with Mr A approximately two months prior to the fatal incident linked this abuse to his criminal offending and experience of mental health and substance misuse issues later in life.[2]

3. Mr A received various mental health diagnoses throughout his life, including bipolar mood disorder and schizophrenia, and had several admissions to hospital following suicide attempts.[3] From 2009 onwards, Barwon Health provided Mr A with mental health treatment in the context of these crises. Their last contact with Mr A was in June 2018, after which they were unable to contact him.[4]

4. Mr A's most recent psychological assessment occurred while he was incarcerated in September 2020.[5] The assessing psychiatrist concluded that Mr A's symptoms, including impulsivity and an '*unstable emotional state'*, were consistent with Post-Traumatic Stress Disorder (**PTSD**) and a personality disorder.[6]

5. Mr A had a history of substance dependency and reported using methamphetamines from the age of 21. At the time of his death Mr A had alcohol and cannabis in his system.[7]

6. Mr A commenced a relationship with Ms B approximately three years prior to the fatal incident. The couple had a daughter, Child C, who was born in June 2020.

[1] Correction Victoria, Justice History Part 2, 58-59.
[2] Ibid, 62-63.
[3] Coronial Brief, Statement of S Moylan, 15-16.
[4] Ibid, 16.
[5] Correction Victoria, Justice History Part 2, 60
[6] Ibid.
[7] VIFM, Toxicology Report, 1

THE CORONIAL INVESTIGATION

7. Mr A'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.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr A's death. The Coroner's 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.

11. This finding draws on the totality of the coronial investigation into the death of Mr A 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.[8]

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

Surrounding circumstances in which the death occurred

12. Evidence provided to the Court indicates that Mr A perpetrated family violence against Ms B during their relationship by physically assaulting her on at least one occasion, threatening to kill her, and behaving in a controlling manner.[9] As a result of the family violence perpetrated

[8] 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.

[9] Victoria Police, Record of incident 8 May 2020, 6

by Mr A, Police applied for FVIOs on three separate occasions to protect Ms B. Mr A breached FVIOs and bail conditions prohibiting him from having contact with Ms B on several occasions.[10] Ms B consistently objected to having FVIOs in place and reports attending court on more than one occasion to have FVIO conditions varied to allow Mr A to have contact with her.[11]

13. In June 2020, Ms B and Mr A had a daughter named Child C. Child Protection were already involved with the family due to an unborn report made during Ms B's pregnancy relating to various concerns including substance misuse by Mr A and Ms B, and Mr A's perpetration of family violence.[12] After Child C's birth Ms B was discharged from hospital to 13 Wheal Street, Colac - public housing she attained with the assistance of the Horizon Specialist Family Violence Program (**Horizon**). Ms B was instructed by Child Protection not to disclose this address to Mr A.[13] At this time Mr A was reportedly staying with a mutual friend within close walking distance, and Child Protection were concerned about the risk this posed to Ms B and Child C.[14] The available evidence indicates that Ms B declined an offer of refuge accommodation prior to Child C's birth.

14. Towards the end of June 2020, at the behest of Child Protection, Ms B agreed to her Horizon worker applying for an interim FVIO on her behalf, in protection of herself and Child C. The FVIO was granted and prohibited Mr A from contacting or coming with 5 metres of Ms B and Child C, and from coming within 200 metres of their address.[15]

15. In July 2020, Mr A breached the FVIO by coming within 200 metres of Ms B's address. Police members were outside the address at the time as they were present for a Child Protection visit with Ms B.[16] Victoria Police later contacted Mr A by phone to arrange to interview him about the breach, but he refused.[17]

16. In August 2020, Ms B successfully applied for a new FVIO with limited conditions which prohibited Mr A from perpetrating family violence but not from having contact with Ms B or Child C.[18]

[10] Victoria Police, Records of Mr A and Ms B, 34, 43 and 51.
[11] Coronial Brief, Statement of Ms B, 7
[12] Corrections Victoria, Court assessment documentation, 22; DFFH, Child Protection records, 907.
[13] c 833.
[14] Ibid, 761 and 728.
[15] Ibid, 760.
[16] Victoria Police, Records of Mr A, 51-52.
[17] Corrections Victoria, Justice History Section Part 2, 19
[18] Corrections Victoria, Victoria Police Event Report – IVO History, 1-2.

17. Later that month Mr A was charged with driving offences and arrested after attempting to assault a police member. Police found a weapon similar to a police baton and '*deal bags, scales and glass pipes'* in his car.[19] Mr A was remanded into custody at Ravenhall Correctional Centre on 11 August 2020 and remained in prison until 17 November 2020.

18. On 15 October 2020, Child Protection successfully applied for an IAO from Geelong Children's Court placing Child C in the care of Ms B. The IAO contained 13 conditions, including that Mr A could not live with Child C, and that his contact with Child C must be supervised by Child Protection (or its nominee) until Child Protection assessed that this was not necessary. The IAO conditions also prohibited Mr A from being affected by alcohol or illegal drugs when with Child C.[20]

19. On 2 November 2020, a Court Assessment and Prosecution Service (**CAPS**) practitioner[21] completed a court assessment with Mr A which indicated that he was suitable for a CCO following his custodial sentence. The CAPS practitioner identified that Mr A was a '*high risk'* offender with a history of family violence and current Child Protection involvement. However, they did not ascertain whether any Child Protection orders were in place, nor was their assessment informed by family violence risk assessment or management activities.[22]

20. Following his court assessment, Mr A was sentenced to four months of imprisonment, most of which he had already served, followed by a 24-month CCO which included the following conditions:[23]

- supervision by Geelong Community Correctional Services (**CCS**);
- assessment and treatment for drug dependency as directed;
- assessment and treatment for mental health as directed; and
- offending behaviour programs as directed.

21. During this sentence Mr A's mental health fluctuated and he attempted or threatened suicide or self-harm on three occasions.[24] Evidence provided to the Court suggests that Ms B visited Mr A regularly while he was incarcerated, but it is not clear whether they remained in a

[19] DFFH, Child Protection records, 325.
[20] DFFH Child Protection records, 118-122.
[21] The Court Assessment and Prosecution Service practitioner role is to conducting court assessments to determine an offender's suitability for a court order; facilitating the variation or cancellation of an order and prosecuting individuals who fail to comply with their orders.
[22] Corrections Victoria, Allocation emails 2 November 2020; Corrections Victoria, Mr A Manager's Review, 1.
[23] Corrections Victoria, JARO Review, 2.
[24] Corrections Victoria, JARO Review, 2.

relationship during this time.[25]

22. Prior to his release Mr A was allocated a Geelong CCS case manager to supervise his CCO. On 13 November 2020, Mr A and his case manager completed a pre-release plan. This plan reflects Mr A's intention to live with friends at 45 Stewart Street, Colac upon his release. The plan includes information about the FVIO in place in protection of Ms B and Child C and lists their address as 13 Wheel [sic] Street, Colac, but does not acknowledge that this address is directly across the road from 45 Stewart Street. The plan also refers to a current Child Protection order with conditions including *'[a]nger management'* and *'AOD (urine screens)*'. It does not note the IAO conditions prohibiting Mr A from living with or having unsupervised contact with Child C.[26]

23. On 17 November 2020, Mr A was released from prison on a 24-month Community Corrections Order (**CCO**)[27] and went to stay with a friend who lived across the road from Ms B in Colac.[28] Mr A visited Ms B and Child C twice on the day of his release, in contravention of an Interim Accommodation Order (**IAO**), which was made by the Children's Court following Child Protection intervention with the family, and which prohibited Mr A from unsupervised contact with Child C.[29] Ms B described Mr A as having a positive demeanour, however when he returned later that evening in an intoxicated and '*emotional'* state Ms B requested that he leave.[30]

24. On 18 November 2020, Mr A reported to his case manager by phone. The available evidence indicates that Mr A was '*emotional'* at the start of this call but that this stabilised during the conversation. Mr A's case manager advised him to contact his General Practitioner (**GP**) to access mental health support.[31]

25. On the same day, a Child Protection worker emailed CCS requesting a copy of his CCO conditions and flagging Mr A's case for joint work due to '*high risk family violence'*.[32] Mr A's case manager responded with a summary of his CCO conditions and requested '*a copy of*

[25] Coronial Brief, Statement of G Blake, 10
[26] Corrections Victoria, MC Planning Session, 6.
[27] A Community Corrections Order is a sentencing option used in the criminal jurisdiction that allows a judicial officer to make a flexible order requiring an offender to serve a sentence in the community. The order will typically have terms and conditions including mental health assessment and treatment, supervision, community work, etc.
[28] Correction Records, JARO Review, 2.
[29] An Interim Accommodation Order is a temporary order made by the Children's Court of Victoria which contains conditions about the placement of a child, pending the final determination of an application lodged with the Court.
[30] Coronial Brief, Ms B, 7.
[31] Corrections Victoria, JARO review, 4-5; Corrections Victoria, MC Intervention Section, 13.
[32] Corrections Victoria, MC Intervention Section, 25.

his DHHS [Child Protection] order', stating that Mr A was '*keen to align his CCO and DHHS [Child Protection] order'* and was open to joint appointments.[33]

26. Mr A visited Ms B and Child C again on 18 and 19 November 2020 in contravention of the IAO. Mr A also attended a supervised visit with Child C at Colac Memorial Square on 19 November 2020.[34] Services were not aware of the IAO breaches prior to the fatal incident.

27. On 20 November 2020, Mr A attended a full induction appointment with his case manager. This was the last interaction he had with Geelong CCS.[35] During this appointment the case manager administered a Suicide and Self-Harm (**SASH**) screening checklist with Mr A which indicated he was experiencing '*significant suicidal ideation and symptoms consistent with depression and a serious mental illness'*.[36] As a result Mr A's case manager directed him to make an appointment with his GP and to confirm he had done so at his next appointment.[37] During this appointment Mr A reported that he was working towards being able to see his daughter, and spoke about making contact with Child Protection.[38]

Immediate circumstances in which the death occurred

28. At approximately 5.00am on 21 November 2020, Mr A attended Ms B's address, and began yelling and banging at the back door when she would not let him in. Ms B contacted Victoria Police who arrived at 5.22am.

29. Police members searched the property but did not find Mr A. They subsequently submitted an application and summons to vary an existing Family Violence Intervention Order (**FVIO**)[39] to prohibit Mr A from attending Ms B's address or having contact with her or Child C. The court granted this variation on 23 November 2020.[40]

30. On 23 November 2020, Ms B found Mr A deceased in the shed in her rear yard.[41] Ms B contacted police who arrived shortly thereafter and confirmed that Mr A was deceased. The

[33] Ibid 26.
[34] Ibid.
[35] Corrections Victoria, JARO review, 5
[36] Corrections Victoria, JARO review, 4.
[37] Ibid 4-5.
[38] Corrections Victoria, MC Intervention Section, 12
[39] In August 2020, Ms B successfully applied for a FVIO with limited conditions which prohibited Mr A from perpetrating family violence but not from having contact with Ms B or Child C.
[40] Coronial Brief, M Hobbs, 14.
[41] Coronial Brief, Ms B, 8.

available evidence suggests that Mr A may have been deceased for some time due to the state in which his body was found.[42]

Identity of the deceased

31. On 23 November 2020, Mr A, born 25 March 1988, was visually identified by their former partner, Ms B.

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

Medical cause of death

33. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of Mr A's body on 24 November 2020. Dr Beer considered the Victoria Police Report of Death (Form 83) and post mortem computed tomography (CT) scan and provided a written report of his findings dated 7 December 2020.

34. The external examination revealed findings in keeping with the clinical history and evidence of decomposition.

35. Toxicological analysis of post-mortem samples identified the presence of alcohol, venlafaxine[43] and delta-9-tetrahydrocannabinol.[44]

36. Dr Beer provided an opinion that the medical cause of death was 1 (a) Neck compression in the setting of hanging.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

37. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr A and his former partner, Ms B, and their child was one that fell within the definition of '*partner'*, parent and *'family member'*[45] under that Act. Moreover, Mr A's actions in the lead up to the fatal incident involved '*family violence'*.[46]

[42] Medical Examiners Report dated 7 December 2020, 2
[43] Venlafaxine is used in the treatment of depression.
[44] Delta-9-tetrahydrocannabinol is the active form of cannabis (marijuana).
[45] Family Violence Protection Act 2008, section 8(1)(d)
[46] Family Violence Protection Act 2008, section 5

38. As this death occurred under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[47] examine the circumstances of Mr A's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[48]

DIRECTIONS HEARING

39. In light of issues identified in the coronial investigation, I held a Directions Hearing into the death of Mr A on 15 March 2024. Prior to the Directions Hearing, the interested parties including Victoria Police, Department of Families, Fairness and Housing – Child Protection (**Child Protection**) and the Department of Justice and Community Safety – Justice Services (**Community Corrections**), were provided a copy of the coronial brief and informed that the following general concerns which were identified during the course of the coronial investigation:

    a) *Victoria Police* – The investigation into Mr A's whereabouts when police attended Ms B's residence on 21 November 2020 was not adequate.

    b) *Victoria Police* – The FVIO that existed at the time of the fatal incident should have been varied by police by way of application and warrant instead of the application and summons utilised.

    c) *Victoria Police* – The investigation to locate Mr A after police members attended Ms B's residence on 21 November 2020.

    d) *Child Protection and Community Corrections* – There was a lack of coordination of service cooperation between Child Protection and Community Corrections regarding management of Mr A's risk to Ms B and her child after his release from prison on 17 November 2020.

    e) *Child Protection and Community Corrections* – There was a lack of formal family violence risk assessment by Child Protection and Community Corrections regarding management of Mr A's risk to Ms B and her child after his release from prison on 17 November 2020

[47] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

[48] 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

f) *Community Corrections* – There appears to be a lack of proactive pre-release planning by Corrections and Justice Services regarding the planned address for Mr A to be residing at after his release from prison on 17 November 2020.

40. All three parties provided a written response and submission addressing the above concerns to the Court prior to and on 8 March 2024. I accept the submissions from Victoria Police that there is insufficient evidence to determine whether an application and warrant should have been considered on 21 November 2020 and merits of the police investigation to locate Mr A after attending Ms B's residence. However, I do not accept that the search of Ms B's property on 21 November 2020 was adequate. I find that it would have been reasonable and appropriate for police members to search any dwelling on the premises including the storage shed that Mr A was ultimately discovered deceased in. On the balance of the available evidence, I am however, unable to find that this oversight would have resulted in a different outcome in this case.

41. The Chief Commissioner of Victoria Police, Child Protection and Community Corrections were legally represented at the Directions Hearing. Family Violence Senior Solicitor, Nicholas Ngai, appeared to assist me during the Hearing. Mr Ngai read out a summary of the circumstances of Mr A's death and an outline of the progress of the coronial investigation to date. No further substantial submissions were made from parties in attendance at the Directions Hearing.

42. At the close of the Directions Hearing, I confirmed to the parties that I did not anticipate the need to proceed to a full inquest as written submissions had adequately canvassed the concerns raised by my investigation.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments:

43. I make observations concerning various frontline service engagement with Mr A and his immediate family as they arise from the coronial investigation into Mr A's death. However, I confirm that the available evidence does not support a finding that there is any causal connection between the circumstances highlighted in the observations made below and Mr A's death.

44. 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 potentially*

distorting prism of hindsight'.[49] I make observations about frontline service contact with Mr A and his immediate family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Community Corrections and Child Protection - Family violence and Child information sharing schemes and MARAM

45. Following recommendations made by the *Royal Commission into Family Violence* (**RCFV**), the Victorian Government (in consultation with relevant stakeholders) developed a new risk assessment tool named the Family Violence Multi-Agency Risk Assessment and Management (**MARAM**) and associated practice guides to provide relevant services with comprehensive guidance on identifying, assessing and responding to family violence.

46. Importantly, the *Family Violence Protection Act 2008* (Vic) empowers the relevant Minister to prescribe *'[f]ramework organisations'*[50] which must comply with the MARAM. Child Protection, Corrections Victoria and Victoria Police were prescribed in August 2018. The Family Violence Information Scheme (**FVISS**) was also implemented in 2018 and underpins the MARAM. All three agencies were prescribed under the FVISS as Information Sharing Entities (**ISEs**) in August 2018,[51] meaning they can proactively request and share information with other ISEs for family violence protection purposes. Child Protection and Victoria Police are also Risk Assessment Entities (**RAEs**) under the FVISS, and are able to request and share information with other ISEs for family violence assessment purposes.[52]

47. Framework organisation staff have different responsibilities in relation to family violence depending on their roles. Corrections Victoria Court Assessment and Prosecution Services (**CAPS**) practitioners and Advanced Case Manager (**ACMs**), in assessing and providing advice to the court on an offender's suitability for a CCO and case managing offenders on CCOs respectively, are responsible for intermediate level risk assessment and risk management. Child Protection practitioners are also responsible for intermediate level risk

[49] *Adamczak v Alsco Pty Ltd (No 4*) [2019] FCCA 7, [80]
[50] Family Safety Victoria, *Multi-Agency Risk Assessment and Management Framework* (2018), 13.
[51] State Government of Victoria, *Appendix 1: Prescribed Organisations* (11 April 2023) <Appendix 1: Prescribed organisations | Victorian Government (www.vic.gov.au)>.
[52] Family Safety Victoria and State Government of Victoria, *Family Violence Information Sharing Guidelines – Guidance for Information Sharing Entities* (April 2021) 38-9 < Ministerial Guidelines - Family Violence Information Sharing Scheme_2 (2).pdf>.

assessment and risk management.[53]

48. Intermediate risk assessment requires structured professional judgement based on an analysis of information including the victim survivor's self-assessment of risk, other evidence-based risk factors, and information shared by professionals working with the victim survivor/s and offender/s.[54]

49. Intermediate risk management can include:

- information sharing and consideration of the actions of other services[55]
- safety planning with the person using violence when it is safe to do so[56]
- talking to the person using violence about options that create safety, including accommodation options[57]
- determining whether there is a family violence intervention order or other court orders in place with conditions that exclude the person using violence from the family home, and using this to inform discussion and suggestions for safe accommodation options.[58]

50. My view of the available evidence is that Corrections Victoria and Child Protection's family violence risk assessment and management in the period proximate to the fatal incident was not optimal in light of their MARAM responsibilities. I note several observations below regarding the use of family violence risk information and the sharing of this risk information with relevant agencies.

51. Mr A was released from prison on 17 November 2020 to an address across the road from Ms B and Child C without in-depth family violence risk assessment or management, despite there

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[53] Family Safety Victoria and State Government of Victoria, *MARAM Practice Guides – Responsibility 3: Intermediate Risk Assessment – Working with Adult People using Family Violence* (February 2021) 56 < MARAM practice guides_Guidance for professionals working with adults_Foundation Knowledge.pdf (content.vic.gov.au)>; Family Safety Victoria and State Government of Victoria, *MARAM Practice Guides – Responsibility 4: Intermediate Risk Management - Working with Adult People using Family Violence* (February 2021); Family Safety Victoria and State Government of Victoria, *Understanding the Responsibilities for Organisational Leaders* (June 2020) 6 <Designed MARAM Responsibilities.pdf>; DFFH – Child Protection, *MARAM in Child Protection Practice* < MARAM in Child Protection practice | Child Protection Manual | CP Manual Victoria>.

[54] Family Safety Victoria and State Government of Victoria, *Family violence multi-agency risk assessment and management framework: A shared responsibility for assessing and managing family violence* (June 2018) 6 <MARAM Framework>.

[55] Family Safety Victoria and State Government of Victoria, *MARAM Practice Guides – Responsibility 4: Intermediate Risk Management - Working with Adult People using Family Violence* (February 2021) 143.

[56] Ibid 144.

[57] Ibid 145.

[58] Ibid 164.

being an IAO in place which prohibited him from having unsupervised contact with Child C, and a current FVIO in protection of Ms B and Child C. This would appear to be a missed opportunity to optimise Ms B and Child C's safety, and to support Mr A to adhere to the conditions of the IAO and the CCO.

52. At the time of Mr A's court assessment Child Protection and Corrections Victoria were aware of family violence risk related information, including that:[59]

- Mr A had a history of breaching court orders, including FVIOs and CCOs
- Mr A had a long history of substance misuse, including methamphetamine use, and was likely to relapse on release from prison
- Mr A and Ms B were likely to breach the IAO
- Mr A was impulsive
- Mr A planned to stay close by to Ms B on release from prison.

51. The above information could have informed a more proactive approach to collaborative, MARAM aligned risk assessment by Child Protection and Corrections Victoria prior to Mr A's release, particularly in relation to the risks associated with Mr A living across the road from Ms B and Child C. Risk assessment based on information sharing under the legislative tools available[60] or with Ms B and Mr A's consent, could then have informed risk management activities, including:

    a. Possible discussions with Ms B about Mr A's plan to stay across the road from her on his release from prison, and the impact of this on her safety and Child C's safety;

    b. Possible discussions with Mr A regarding the risks of residing across the road, particularly in relation to his ability to meet the conditions of the CCO and the IAO under these circumstances, noting that while he was in prison Child Protection observed Mr A to be relatively insightful and cooperative;[61]

[59] Corrections Victoria, JARO review, 1-2 and 4-7.
[60] Noting that Child Protection and Corrections Victoria are Information Sharing Entities under the FVISS and Child Protection are also Risk Assessment Entities (RAEs) under the FVISS.
[61] DFFH, Child Protection records of Child C, 132, 164.

c. Potential consideration of alternative accommodation options for Mr A which put more distance between Mr A, Ms B and Child C, and may have reduced the likelihood of Mr A impulsively attending Ms B's address in breach of the IAO; and

d. Potential consideration of restrictive CCO conditions to promote Ms B and Child C's safety.

52. It would appear from the available evidence that there was a lack of optimal collaborative family violence risk assessment and management by Child Protection and Corrections Victoria. Such risk assessment and management may have had a preventative impact by reducing the likelihood of Mr A impulsively attending Ms B's address in a dysregulated and/or substance affected state.

53. I note that the proportion of family violence offenders who transition to a CCO following a period of imprisonment is significant. Between 2012 and 2020, 42% of sentences which included both imprisonment and a CCO (known as combined orders) were imposed in circumstances where at least one of the offences involved family violence.[62]

54. Both Child Protection and Corrections Victoria are responsible for family violence risk assessment and management prior to the release of perpetrators who pose a risk to children engaged with Child Protection, and who were incarcerated for family violence offences. While the circumstances of this case indicate that Child Protection attempted to establish when Mr A would be released from prison, Corrections Victoria did not contact Child Protection until after Mr A was released.

55. I confirm that in 2013, a *Protocol between Community Correctional Services, Corrections Victoria and Child Protection* was developed. Its purpose was to identify the processes for requesting and exchanging information regarding:

- assessments of offenders being considered for a CCO with an attached Residence Restriction, Curfew and/or Alcohol Exclusion condition; and

- children who may reside or have overnight access in the household of the offender.[63]

[62] Sentencing Advisory Council, Combined Orders of Imprisonment with a Community Correction Order in Victoria (Report, November 2023), 7 <Combined Orders of Imprisonment with a Community Correction Order in Victoria (sentencingcouncil.vic.gov.au)>.

[63] *Protocol between Community Correctional Services, Corrections Victoria and Child Protection* (2013) 7 <Microsoft Word - ~2791346.doc (cpmanual.vic.gov.au)>.

56. This protocol does not appear to reflect recent reforms in family violence, including the introduction of the MARAM and the FVISS, nor does it include guidance on pre-release information sharing regarding all offenders who are imprisoned for family violence related offenses and who pose a risk to children currently engaged with Child Protection.

RECOMMENDATIONS

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

1. With the aim of improvements to the administration of justice and preventing like deaths, I recommend that the **Department of Justice and Community Safety** and the **Department of Families, Fairness and Housing** review and update existing protocols between Justice Services and Child Protection to ensure that MARAM aligned information sharing, risk assessment and risk management activities take place prior to the release of offenders who are imprisoned for family violence related offenses and who pose a risk to children who have pre-existing engagement with Child Protection. The departments should consider the circumstances of Mr A's death, including the lack of family violence risk assessment and management surrounding his release to an address across the road from Ms B, when updating these protocols.

2. With the aim of improvements to the administration of justice and preventing like deaths, I recommend that the **Department of Justice and Community Safety** also review the above existing protocols with the **Department of Families, Fairness and Housing** to ensure that other relevant frontline services including Victoria Police and the Orange Door are notified to proactively share risk information and provide additional supports to affected family members.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Mr A, born 25 March 1988;

   b) the death occurred sometime between 21-22 November 2020 in the state of Victoria;

   c) I accept and adopt the medical cause of death as ascribed by Dr Brian Beer and I find that Mr A died from neck compression due to hanging in circumstances where I find that he intended to end his own life.

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

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

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

Carmel Kavanagh-Mills, Senior Next of Kin

Lena Catto, Department of Families, Fairness and Housing

Namrata Kant, Department of Families, Fairness and Housing

Kelly Kandelaars, Lander & Rogers

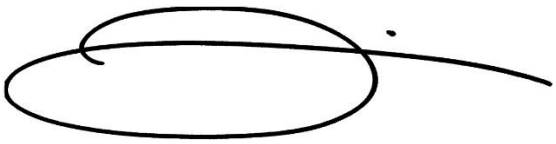
Jenny Roberts, Operations Director, Department of Justice & Community Safety – Justice Services

Renae Petulla, Victorian Government Solicitor's Office

Assistant Commissioner Lauren Callaway, Family Violence Command, Victoria Police

Leading Senior Constable Darren Busfield, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 29 April 2024

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.