IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 001635

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Mr A
Date of birth:	19 October 1986
Date of death:	7-8 April 2018
Cause of death:	1(a) Hanging
Place of death:	Victoria
Keywords:	Suicide; Family violence; Corrections; Victoria Police

INTRODUCTION

1. On 8 April 2018, Mr A was 31 years old when he was discovered hanging from a tree branch in the backyard of his residence in Victoria. At the time of his death, Mr A was living with his sister temporarily whilst separated from his wife, Ms B and their three children.

2. The available evidence indicates that Mr A regularly used cannabis from the age of 12 or 13,[1] and methylamphetamines from the age of 26 until his death.[2]

3. Mr A and his wife, Ms B, met when they were teenagers and were married when Mr A was 21 years old.[3] Ms B identifies as Aboriginal.[4] Mr A and Ms B had three children together who were aged one, seven and ten years old at the time of Mr A's death.[5]

4. Mr A was unemployed in the period leading up to his death and was receiving social welfare support.

THE CORONIAL INVESTIGATION

5. 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.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. 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

[1] Corrections Victoria, COATS assessment for Mr A, 151.
[2] Corrections Victoria, COATS assessment for Mr A, 151.
[3] Ibid.
[4] DFFH, Child Protection records, 152.
[5] Ibid, 251.

statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. 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.[6]

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

Circumstances in which the death occurred

10. In the year prior to Mr A's death, Victoria police were contacted about three incidents in which Mr A allegedly perpetrated family violence against Ms B. Following the first incident on 16 April 2017 police successfully applied for a FVIO which was issued for the period 18 April 2017 to 17 April 2018 and prohibited Mr A from perpetrating family violence or damaging Ms B's property.[7] This FVIO was active at the time of the fatal incident.

11. Evidence within the coronial brief indicates that Mr A commenced an '*ice binge*'[8] on approximately 1 April 2018. This continued until the fatal incident on 8 April 2018.

12. On 6 April 2018, Ms B invited Mr A to be present at her home when her mother dropped her home from a visit with the children, in order for him to be able to see the children who would be in Ms B's mother's car. Mr A attended Ms B's address but fell asleep on the couch and so did not see the children that day.[9]

13. Mr A woke up at 3.30pm the following day on 7 April 2018 and realised that he had missed out on seeing his children. Mr A became verbally abusive towards Ms B, punched holes in the walls, and smashed the television.[10] The police were not contacted. Ms B fled the property and contacted Mr A's father to assist. Mr A's father attended the address and took him out for a

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[6] 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.

[7] Victoria Police, Certified extract of FVIO, 32-33.

[8] Coronial brief, Statement of Mr D, 7.

[9] Coronial brief, Statement of Ms B, 5.

[10] Ibid; Coronial brief, Statement of Mr D, 7.

drive during which Mr A expressed suicidal ideation. Mr A's father stopped at Coles on Mr A's request and was unable to locate him after he went inside. [11]

14. At approximately 10am on 8 April 2018, Ms B returned to the property and found Mr A hanging in her back yard.[12]

15. Emergency services were contacted and arrived at approximately 10.30am.[13] Attending Ambulance paramedics confirmed that Mr A was deceased and had been deceased for a while as evidence of rigor mortis was present.[14]

Identity of the deceased

16. On 8 April 2018, Mr A, born 19 October 1986, was visually identified by his wife, Ms B.

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

Medical cause of death

18. Forensic Pathologist Dr Melissa Baker from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 9 April 2018 and provided a written report of her findings dated 17 April 2018

19. The external examination revealed the following:

    a) The ligature mark around the neck was consistent with hanging and no other injuries were identified; and

    b) Post mortem CT scans revealed a possible fracture of the left hyoid bone but was otherwise unremarkable.

20. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine, diazepam, nordiazepam and cannabis. All substances identified were not at concentration levels that impacted on the cause of death.

21. Dr Baker provided an opinion that the medical cause of death was 1 (a) Hanging.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

[11] Coronial brief, Statement of Mr D, 8.
[12] Coronial brief, Victorian Institute of Forensic Medicine (VIFM) Inspection Report, 28.
[13] Coronial brief, Statement of SC Donaldson, 12
[14] Ibid

22. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr A and Ms B was one that fell within the definition of '*spouse'*[15] under that Act. Moreover, Mr A's actions in damaging property in the lead up to the fatal incident constitutes '*family violence'*.[16]

23. In light of Mr A's death occurring under circumstances of proximate family violence, I requested that the Coroners' Prevention Unit (**CPU**)[17] examine the circumstances of Mr A's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[18]

History of family violence between Mr A and Ms B

24. On 1 December 2015, Mr A reportedly assaulted his sister in the presence of Ms B. This was reported to police, who issued a Family Violence Safety Notice (**FVSN**).[19] A Family Violence Intervention Order (**FVIO**) was subsequently issued in protection of Mr A's sister, and Mr A was charged with unlawful assault.[20] On 21 April 2016 Mr A was convicted of this offence and placed on a Community Corrections Order (**CCO**) for 6 months.[21]

25. On 6 July 2016, Mr A was arrested after illicit substances and a '*dagger'*[22] were found in his car.[23]

26. Reports were made to Child Protection in relation to Mr A and Ms B's children in November 2016 and January 2017 detailing concerns about the couple using methylamphetamines, neglecting the children, and Mr A perpetrating family violence.[24] The second report indicated that Mr A's children were '*terrified of their father'*.[25] Both of these reports were closed at the intake phase with Child Protection noting that family support services were being arranged or already involved with the family.[26]

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[15] Family Violence Protection Act 2008, section 8(1)(a)
[16] Family Violence Protection Act 2008, section 9
[17] 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
[18] 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
[19] Corrections Victoria, Preliminary Brief, 162
[20] Community Corrections, Community Corrections Order, 181.
[21] Coronial brief, Criminal record of Mr A, 45.
[22] Correction Victoria, Police Preliminary Brief, 160.
[23] Coronial brief, Criminal record of Mr A, 40-5.
[24] DFFH, Child protection records, 250-252.
[25] Ibid, 250.
[26] Ibid, 250-252.

27. On 16 April 2017, Mr A perpetrated family violence against Ms B by damaging household property during a conversation about ending their relationship. Police were contacted and a FVSN was issued.[27] On 18 April 2017, a final FVIO with an expiry date of 17 April 2018 was issued preventing Mr A from perpetrating family violence against Ms B or damaging her property.[28]

28. On 23 October 2017, Mr A attended Court and was convicted of various offences relating to the incident of family violence on 16 April 2017 and his previous arrest on 6 July 2016. These offenses included contravening his CCO, wilfully damaging property, possessing amphetamine, using an unregistered motor vehicle, failing to answer bail, and carrying a weapon without approval.[29] Mr A was sentenced to a 12 month CCO with conditions requiring that he complete community work and engage in supervision, treatment and rehabilitation for drug abuse and mental health, and an offending behaviours program.[30]

29. Whilst at court on 23 October 2017, a Corrections Victoria worker completed a Suicide and Self Harm (**SASH**) checklist with Mr A which indicated that he was depressed but not experiencing suicidal ideation.[31] A mental health treatment condition was included on Mr A's CCO as a result.[32]

30. Mr A engaged with Case Managers from Community Correctional Services (**CCS**) Bendigo for supervision of his CCO from 25 October 2017 until his death. A CCS case manager worked with Mr A to meet the conditions of his CCO by linking him in with AOD services and encouraging him to seek a Mental Health Care Plan (**MHCP**) for mental health support.[33]

31. On 3 January 2018, Mr A completed a Community Offender Assessment & Treatment (**COAT**) assessment. Family violence was not explicitly discussed during this assessment, however COAT staff also recommended that Mr A obtain a MHCP from his GP and use this to engage with treatment focussing on '*learning control with emotional regulation'*.[34] COAT staff viewed this as particularly important given that Mr A was living with his children and had reported '*an*

[27] Corrections Victoria, Preliminary Brief, 164.
[28] Victoria Police, Certified extract of FVIO, 32.
[29] Community Corrections, Community Corrections Orders, 179-181; Coronial brief, Criminal record of Mr A, 40-5.
[30] Coronial Brief, Criminal History, 40-45.
[31] Corrections Victoria, Suicide and Self-Harm Risk Screening Checklist Suite, 105-107.
[32] Corrections Victoria, CCO assessment outcome report, 157.
[33] Corrections Victoria, Managers Review, 139-40.
[34] Corrections Victoria, COAT assessment for Mr A, 153.

issue with his anger'.[35] During this assessment Mr A disclosed attempting suicide in December 2016 in the context of separating from Ms B.[36]

32. A CCS case manager referred Mr A to a Men's Behaviour Change Program (**MBCP**) on 11 December 2017.[37] Mr A was assessed by the Centre for Non-Violence on 9 February 2018 and found suitable for their program. Mr A attended one session on 1 March 2018 and was subsequently removed from the program on 15 March 2018 due to non-attendance.[38] A CCS case manager re-referred Mr A and he attended another MBCP assessment on 23 March 2018 and was deemed suitable for a group due to commence on 12 April 2018.[39]

33. On 16 February 2018, Mr A's mother made a report to Child Protection in relation to Mr A's children due to concerns about Ms B using methylamphetamines, neglect of the children, the parentification of Mr A's eldest daughter and neglect of the home environment.[40] Child Protection contacted the children's school to gather further information and learned that the eldest daughter had disclosed witnessing her parents fighting recently. In consultation with Lakidjeka,[41] the Aboriginal Child Specialist Advice and Support Service (**ACSASS**)[42] provided by the Victorian Aboriginal Child Care Agency (**VACCA**), Child Protection decided to transfer the case to an investigation team for further assessment given the history of reports in relation to family violence.[43] A further report to child Protection was made by Ms B's sister on 26 February 2018 due to similar concerns.[44]

34. Child Protection workers conducted a home visit on 7 March 2018.[45] During this visit Ms B reported that Mr A had never physically assaulted her but had hit walls when using substances, most recently two years earlier.[46] Ms B also described '*yelling and screaming*'[47] by Mr A. Child Protection workers noted during this home visit that the family home was in a state of disrepair, with holes in the walls, cuts in a hallway door which appeared to have been made with a sharp object, and some of the windows boarded up.[48] Mr A's two eldest children were also

[35] Ibid, 153.
[36] Ibid, 151.
[37] Corrections Victoria, email dated 11 March 2017, 73.
[38] Corrections Victoria, MBCP Non-Completion Report by the Centre for Non-Violence, 115-6.
[39] Corrections Victoria, Case notes, 17.
[40] DFFH, Child protection records, 263.
[41] Ibid, 259.
[42] ACSASS provides advice on the best interests of Aboriginal children and young people when Child Protection are making decisions regarding their safety and wellbeing.
[43] DFFH, Child protection records, 264.
[44] Ibid, 225.
[45] Ibid, 205.
[46] Ibid, 207.
[47] Ibid, 150.
[48] Ibid, 207, 159.

interviewed by Child Protection, and both reported feeling safe with Ms B but fearful of Mr A's behaviour.[49] Both children reported hearing their parents shouting and Mr A's son reported that a few nights earlier he had heard shouting and a window breaking.[50]

35. Child Protection and Ms B agreed that the children should stay with Ms B's parents while the house was cleaned, and Child Protection interviewed and attained urine drug screens from Mr A. Ms B also agreed to undertake urine drug screens.[51] At around this time Mr A and Ms B separated and Mr A went to live with his sister.[52]

36. On 9 March 2018, a Child Protection worker heard Mr A shouting in the background whilst she was speaking to Ms B on the phone. She noted that he sounded '*extremely angry and heightened*', [53] and she was concerned for Ms B's safety. Ms B reported that Mr A had stolen her car and taken the children's hand and feet moulds off the walls, making her fearful of leaving the house to do a urine drug screen. A Child Protection worker spoke to Mr A on the phone and encouraged him to leave the address. However, Mr A terminated the call stating that he would '*f****** sort it out'*.[54] A Child Protection worker subsequently contacted emergency services due to concerns for Ms B's welfare and asked that police conduct a welfare check.

37. Later that day, Ms B told a Child Protection worker that police attended the property after Mr A had left, and that Mr A had stolen her bank card and withdrawn funds from her bank account.[55] Victoria Police have advised the Court that they do not have any record of this visit.[56] Ms B's parents later advised Child Protection that around this time Mr A had also taken items from the home which she considered precious, '*destroyed*'[57] their youngest son's room by overturning the bed and putting his toys all over the floor, and had removed all the cleaning products from the house, presumably to impede Ms B's ability to clean the house as requested by Child Protection.

38. On 11 March 2018, Victoria Police were contacted due to another family violence incident. Mr A had left the address by the time police arrived. Ms B reported that Mr A had visited her to discuss how to work with Child Protection. She stated that during an argument Mr A grabbed

[49] Ibid, 161.
[50] Ibid, 153-155.
[51] Ibid, 207.
[52] Coronial brief, Statement of Ms B, 5.
[53] DFFH, Child protection records, 187.
[54] Ibid.
[55] Ibid, 184.
[56] Victoria Police, Email from Emma Donaldson dated 3 August 2021.
[57] DFFH, Child protection records, 79.

her, pushed her against a cabinet, and threw her phone on the floor when she tried to call the police.[58] Ms B told police that she was scared during this incident, and that Mr A had told her he would '*get the kids'*.[59]

39. Mr A attended the police station later that day and police interviewed him. He reported that it was Ms B who had assaulted him and thrown her phone on the ground. Police made referrals for Ms B and Mr A, and charged Mr A with contravening a final FVIO, unlawful assault, and wilful damage.[60] A court date was set for 2 May 2018.[61]

40. Child Protection records indicate that during a home visit on 13 March 2018, Ms B told Child Protection workers that during the incident on 11 March 2018 Mr A had grabbed her around the throat and threatened her. Child Protection workers noted during this home visit *'[t]here were holes in the walls of every room in the house and the majority of the windows have been broken'*.[62] Child Protection workers took a photo of one of the holes and captioned it *'[h]ole in window above sink, made Sunday 11 March 2018'*.[63] Child Protection workers observed that Ms B appeared '*quite shaken and fearful'*[64] during this visit. Child Protection workers also interviewed Mr A on 13 March 2018 and recorded that he did not have insight into the impact of family violence on children, and '*consistently deflected/blamed others'*.[65] Both Mr A and Ms B completed urine drug screens which returned positive results for methamphetamines on 13 March 2018.[66]

41. Due to the ongoing issues of family violence, environmental neglect and substance misuse Child Protection issued a protective application by notice on 14 March 2018, requiring that Mr A's children remain in the care of Ms B's parents. A court date was set for 9 April 2018,[67] and a plan was put in place to allow Mr A and Ms B to have supervised visits with the children twice weekly.[68]

42. Mr A met with his GP on 12 March 2018 and 14 March 2018 to discuss his mental health and complete a MHCP. Mr A's MHCP recommended a combination of medication and

[58] Victoria Police, LEDR Mk2 dated 11 March 2018, 2.
[59] Victoria Police, Brief of Evidence – Statement of Ms B, 29.
[60] Vicrotia Police, LEAP Incident Record Enquiry, 6.
[61] Victoria Police, LEAP – Offender Charge Summaries, 9-11; Victoria Police, LEAP – Offender Record Enquiry, 8.
[62] DFFH, Child protection records, 164.
[63] Ibid, 165.
[64] Ibid, 164.
[65] Ibid, 152.
[66] Ibid, 114-116.
[67] Ibid, 135.
[68] Ibid, 73.

psychotherapy and was sent to a local specialist psychology practice called the Anna Centre. Mr A later told his CCS Case Manager, that he had a referral in place for counselling, but that there was a fee attached. The CCS Case Manager offered to apply for funding to assist with this fee, however Mr A decided to try to find a bulk billing counsellor himself in order to avoid further delays.[69]

43. Mr A's last GP appointment was on 24 March 2018. In a statement provided to the court, Mr A's GP stated that Mr A presented with symptoms of anxiety and major depression, but that he did not disclose any suicidal ideation or intent at any of his appointments in March 2018.[70]

44. In late March and early April 2018, Mr A's CCS Case Manager and his Bendigo Community Health Services AOD Counsellor attempted to facilitate his admission to AOD residential rehabilitation by making the relevant referrals,[71] however this was likely delayed by Mr A's limited engagement with Bendigo Community Health AOD services.

COMMENTS

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

Corrections management of Mr A's CCO

45. Mr A was sentenced to a 12-month CCO on 23 October 2017,[72] and attended supervision with a Case Manager from CCS Bendigo from 25 October 2017 until his death. CCS Case Managers attempted to support Mr A to meet the conditions of his CCO by assisting him to link in with various services, including alcohol and drug treatment and a Men's Behaviour Change Program (**MBCP**).

46. CCS have a significant role in ensuring that offenders who are subject to CCOs have the opportunity to maintain and improve their social and economic support networks in a community setting. At the same time, they are also held accountable for their actions and required to comply with the conditions of the CCO, including by undertaking any court-ordered rehabilitation, treatment or counselling.

[69] Corrections Victoria, Case notes, 17.
[70] Statement of Dr A's GP, 1-2.
[71] BCHS, Records of Mr A, 2, 19; Odyssey House, Records of Mr A, 1-3.
[72] Coronial brief, Criminal history of Mr A, 40-45.

47. As a service providing supervision and case management of offenders subject to CCOs, CCS also has a responsibility to assess and manage their risk to ensure the safety of the community and the safety of the offender's family, including intimate partners. When CCS does not supervise, regularly assess, and address offender risk and non-compliance with CCOs in a timely manner, this can result in increased risk to the offender, their family, and the community.

48. Mr A was rated '*high risk'* at the start of his CCO, and CSS policy at the time required the creation of an intervention plan that addresses specific criminogenic needs and reduces re-offending.[73] The available evidence suggests that case managers supervising Mr A did appear to consistently check and assess whether he was complying with the conditions of his CCO, including by attending his required treatment programs, checking in with treatment providers proactively to verify attendance, and conferring with other agencies like Child Protection to share relevant risk information.

49. This case and other similar cases[74] indicate that there are limited information sharing systems available to CCS and officers are often required to make proactive enquiries to ascertain whether an offender was complying with their relevant treatment programs.

50. Family violence risk is dynamic and can fluctuate over time. For this reason, it is vital that family violence risk is assessed on a regular and ongoing basis, particularly when circumstances change, and new family violence risks become apparent. CCS should conduct ongoing family violence risk assessments with offenders under their supervision, particularly where the CCO was ordered in relation to family violence offences.

51. In this case, CCS appears to have been unaware that a FVIO was in place in protection of Ms B for the duration of their engagement with Mr A.

52. On 11 December 2017, Mr A's CCS case manager referred him to a MBCP[75] and he was assessed by Anglicare Victoria for this service on 23 March 2018.[76] The assessment outcome completed by Anglicare Victoria indicates that they were aware that a FVIO was in place in 2015, but there is no mention of the FVIO issued in 2017.[77] It appears that Anglicare Victoria were not made aware of the FVIO in place at the time of their assessment.

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[73] Deputy Commissioner Instructions – 10.3.2 – Intervention planning and goal setting for meaningful case management version Jan 2017, 3-4

[74] The investigations into the deaths of Matthew Johnston (COR 2016 6105), Simone Quinlan (COR 2015 4974), Ashley Wayne Phillips (COR 2017 2477) and Kylie Cay (COR 2016 2831).

[75] Corrections Victoria, email dated 11 March 2017, 73.

[76] Corrections Victoria, MBCP Assessment Outcome, 123-124.

[77] Ibid.

53. It is important that CCS are aware when an offender subject to a CCO is named on an active FVIO in order to fulfill their duty to act in a manner that is responsive to the risk/s posed by the offender,[78] and to ensure that the services to which they refer can undertake informed assessments and interventions.

54. CCS have confirmed in a statement to the court that at the time of Mr A's death they did not have policies in place for the management of family violence. Further, although a process was in place enabling case managers to request FVIO information, they did not have IT systems in place which enabled them to readily view active or historic FVIOs.[79] At the time of his death there was no mandatory requitement for Mr A's FVIO status to be confirmed by CCS.[80]

55. Since 2019, CCS have rolled out significant reforms to their case management of family violence offenders and now CCS case managers have access to offenders' FVIO status via the Victoria Police event notification system E*Justice.[81]

56. In September 2019, Corrections Victoria also implemented practice guidance on managing family violence. This guidance directs CCS practitioners undertaking brief or extended court assessments to review all available information to determine whether an offender is a perpetrator of family violence. Possible sources of information are listed and include E*Justice and intervention orders.[82] CCS have confirmed that there are now no circumstances under which they would consider it reasonable for a CCS case manager not to be aware of an offender's FVIO status.[83]

Victoria Police contact with Mr A in the lead up to the fatal incident

57. In the year prior to Mr A's death, Victoria Police were contacted about three incidents in which Mr A allegedly perpetrated family violence against Ms B. Following the first incident on 16 April 2017, police successfully applied for a FVIO which was issued for the period 18 April 2017 to 17 April 2018 and prohibited Mr A from perpetrating family violence or damaging Ms B's property.[84]

[78] Corrections Victoria, Professional Responsibilities Statement: Community Correctional Services, 2.
[79] CCS, Statement by J Roberts – Director, Community Operations dated 15 July 2021, 2-3.
[80] Ibid, 3.
[81] Ibid.
[82] Corrections Victoria, *Managing Family Violence in Community Correctional Services* (September 2019), 11.
[83] CCS, Statement by J Roberts – Director, Community Operations dated 15 July 2021, 7.
[84] Victoria Police, Certified extract of FVIO, 32-33.

58. On 9 March 2018, Child Protection contacted emergency services and requested that police attend Ms B's home to conduct a welfare check after they heard Mr A shouting in the background of a call with Ms B, sounding '*extremely angry and heightened'*, [85] and Ms B advised them that Mr A had stolen her car and taken the children's hand and feet moulds off the wall causing Ms B to be fearful of leaving the house.

59. Ms B advised Child Protection later that day that the police had attended the address after Mr A had left, and that he had stolen her bank card and withdrawn funds from her account.[86] Victoria Police have confirmed that they have no records indicating that they visited Ms B on 9 March 2018.[87] Whilst it would be expected that a police member complete a Risk Assessment and Management Report (**VP Form L17**) where *'[a]ll reports of family violence must be investigated, no matter where they originated from*'[88] I accept that on the balance of the available evidence and further records provided by police that this incident could not be characterised as one involving family violence.[89] Further records provided by Victoria Police indicate that Ms B told attending police she was not fearful of Mr A, that Mr A was angry at Child Protection and not her for taking the children away and there was no reported violence or injuries between herself and Mr A.[90]

60. On 11 March 2018, police attended Ms B's address in relation to a further family violence incident. Ms B and Mr A each alleged that they had been assaulted by the other. However, despite this the incident was classified as '*verbal'*[91] and police recorded the risk of future violence as '*unlikely'*.[92]

61. I find that the balance of the available evidence suggests that there was a '*likely'* risk of future violence as there was a current FVIO in place, Mr A had allegedly breached the conditions of the FVIO with property damage and physical violence, and there was a history of emotionally abusive behaviour and damage to property.

62. VP Form L17s are relied on by service agencies to assess the level of family violence risk and this informs the services they provide to victims and perpetrators of family violence. As such, it is important that they are completed correctly. I note that at the time of this incident on 11

[85] DFFH, Child Protection records, 187.
[86] Ibid.
[87] Victoria Police, Email from Emma Donaldson dated 3 August 2021.
[88] Victoria Police, *Victoria Police Manual Policy Rules Family Violence* (October 2015), 3.
[89] Response from VGSO dated 15 July 2022 attached Police CAD records of 9 March 2018 attendance.
[90] Ibid
[91] Victoria Police, LEDR Mk2 dated 11 March 2018, 4.
[92] Ibid.

March 2018, the version of the VP Form L17 relied on a subjective assessment when it came to completing the section of future risk of violence.

63. Since this incident, in August 2019, police introduced a new Family Violence Report (**FVR L17**) which incorporates an actuarial risk assessment and additional risk factor question to provide police officers with a structured mechanism to consistently and accurately identify the level of risk.

64. The new FVR L17 is based on international research and LEAP data on which factors best predict future family violence. The new actuarial component contains weighed questions, including several questions relating to prior family violence incidents involving the Respondent, contraventions of intervention orders and other court orders, and charges for violent offences, which are completed by reference to relevant LEAP records.

65. The police have also implemented policies and procedures which require more stringent monitoring of VP Form L17 compliance rates by Family Violence Liaison Officers,[93] and provide for Family Violence Training Officers to assist with addressing inadequate VP Form L17s.[94] It is hoped that this will improve the overall accuracy of risk assessments within VP Form L17s.

66. Following the incident on 11 March 2018 police made referrals for Ms B and Mr A, and charged Mr A with contravening a final FVIO, unlawful assault, and wilful damage.[95]

67. Following this incident police did not appear to consider making an application to vary or extend the FVIO in place at the time. The FVIO was due to expire approximately five weeks after this incident, and its conditions did not exclude Mr A from Ms B's address[96] It was possible at the time for investigating police members to discuss and explore further safety options with Ms B, including the possibility of seeking her consent to apply for a variation of the current FVIO to exclude Mr A from her address.

68. The available evidence indicates that Ms B did not consent to the original FVIO made on 18 April 2017 and that she continued to invite Mr A to contact her and attend her property during the operation of the original FVIO.

[93] Victoria Police, *Practice Guide- Family Violence Roles and Responsibilities*, 3-4.
[94] Ibid, 11-12.
[95] Victoria Police, LEAP Incident Record Enquiry, 6.
[96] Victoria Police, Certified extract of FVIO, 32-33.

FINDINGS AND CONCLUSION

24. 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 19 October 1986;

    b) the death occurred on sometime between the evening of 7 April and the early morning of 8 April 2018 at Victoria, from 1(a) Hanging; and

    c) the death occurred in the circumstances described above.

25. Having considered all of the circumstances, I am satisfied that Mr A intentionally took his own life.

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

27. 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.

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

Ms B, Senior Next of Kin

Assistant Commissioner Jenny Roberts, Department of Justice and Community Safety

Ms Elizabeth Morris, Victorian Government Solicitor's Office

Sergeant David Arnold, Victoria Police

Detective Senior Constable Emma Donaldson, Coroner's Investigator

Signature:

Judge John Cain
STATE CORONER
Date : 27 July 2023

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.