

# IN THE CORONERS COURT OF VICTORIA AT MELBOURNE

Findings of:

COR 2021 001047

# FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Judge John Cain, State Coroner

Deceased:	Ju Zhang
Date of birth:	3 December 1987
Date of death:	1 February 2021
Cause of death:	1(a) Multiple stab wounds to the chest
Place of death:	1 Winchester Avenue, Epping, Victoria
Catchwords:	Intimate partner homicide; family violence; stalking;

# **INTRODUCTION**

- 1. On 1 February 2021, Ju Zhang was 33 years old when she was found deceased at the Wollert Waste Management Facility on 55 Bridge Inn Road, Wollert. At the time of her death, Ms Zhang lived at 1 Winchester Avenue, Epping, Victoria, 3076 with her young son, Jack.
- 2. Ms Zhang was born to parents, Renqun Li and Xiaoyou Zhang and raised in the Sichuan Province of China. In 2004, Ms Zhang graduated from the Chengdu Art College and following the completion of her degree, she was employed at an insurance company and as a dance teacher.
- 3. In 2009, Ms Zhang met Ye Zhu. Mr Zhu was living with his family in Australia but would return to China every second year for the Chinese New Year. Mr Zhu met Ms Zhang on one of these trips to China in 2009 and they continued communication with each other until they commenced a relationship in 2010.
- 4. In October 2010, Ms Zhang and Mr Zhu married in Sichuan, China. The couple spent time in a long distance relationship with Mr Zhu visiting frequently. On 24 August 2012, Ms Zhang gave birth to her son, Jack.
- 5. In late 2012, Ms Zhang was granted a visa to migrate to Australia and moved to Reservoir, Victoria to live with Mr Zhu.
- 6. In 2017, the couple purchased a home at 1 Winchester Avenue, Epping. Shortly afterwards, in 2018, the couple divorced but maintained a good relationship, sharing the care of their son, Jack.
- 7. After the divorce, Ms Zhang and Jack remained living at the Winchester Avenue address. Ms Zhang maintained a close relationship with her parents in China and spoke to them daily.
- 8. Ms Zhang was well liked by her peers and had a lot of friends that she regularly socialised with. Since her divorce, Ms Zhang had several relationships and met Mr Joon Seong Tan (also known as "Sam") on 1 January 2021 through a dating app, 'YeeYi'.
- 9. For the two weeks prior to the fatal incident, Mr Tan had been staying at Ms Zhang's residence regularly.

### THE CORONIAL INVESTIGATION

- 10. Ms Zhang'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.
- 11. 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.
- 12. 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.
- 13. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Zhang'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 after the completion of a substantive criminal investigation into Ms Zhang's death.
- 14. This finding draws on the totality of the coronial investigation into the death of Ju Zhang including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.<sup>1</sup>

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

# Circumstances in which the death occurred

15. Mr Tan was reported to have become quite infatuated with Ms Zhang very early in their relationship. Ms Zhang did not share the same sentiments and was still seeing other people,

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

having commenced a relationship with another male during her relationship with Mr Tan.<sup>2</sup> Mr Tan became aware of this relationship the day prior to the fatal incident.<sup>3</sup>

- 16. On 1 February 2021 at approximately 5:00pm, Mr Tan attended Ms Zhang's residential home, where he had a meal with Ms Zhang and her son Jack. Mr Tan initially informed Police that Ms Zhang left the residential home at 6:00pm wearing only her pyjamas and a pink dressing gown after asking Mr Tan to look after Jack whilst she went out for a short time. <sup>5</sup>
- 17. The available evidence suggests that shortly prior to 6:00pm, Mr Tan and Ms Zhang had an altercation about her relationship with another man.<sup>6</sup> This altercation became physical and Mr Tan fatally assaulted Ms Zhang with an unknown sharp object.
- 18. After the altercation, Mr Tan disabled Ms Zhang's residential home CCTV system to enable him to clean up and leave the address without being recorded. Between 8.30pm (1 February 2021) and 2:00am (2 February 2021), Mr Tan is believed to have contacted a friend to assist him and upon this friend discovering that Mr Tan had killed Ms Zhang, the friend left the residence and avoided Mr Tan's attempts to reach him. 8
- 19. At 2:00am (2 February 2021), Mr Tan disposed of Ms Zhang's body in a bin in the Heidelberg West area, and it was subsequently deposited at the Wollert Waste Management Facility at 55 Bridge Inn Road, Wollert.<sup>9</sup>
- 20. On 18 June 2021, Ms Zhang's body was discovered at the Wollert Waste Management Facility. <sup>10</sup> Police were contacted and at 1.50pm on the same day, detectives from the Missing Persons Squad confirmed the discovery of a body that matched the description of Ms Zhang. <sup>11</sup>
- 21. Ms Zhang's body was transported to the Victoria Institute of Forensic Medicine for autopsy and identification.

<sup>&</sup>lt;sup>2</sup> CHI statement

<sup>&</sup>lt;sup>3</sup> Coronial Brief, Statement of Bun Kiat 'Jeff' Chan dated 9 April 2021, 300

<sup>&</sup>lt;sup>4</sup> LI and HUNG statements

<sup>&</sup>lt;sup>5</sup> TAN statement exhibit 23

<sup>&</sup>lt;sup>6</sup> Coronial Brief, Statement of Bun Kiat 'Jeff' Chan dated 9 April 2021, 300

<sup>&</sup>lt;sup>7</sup> Missing CCTV footage

<sup>&</sup>lt;sup>8</sup> Coronial Brief, Statement of Bun Kiat 'Jeff' Chan dated 9 April 2021, 301-302

<sup>&</sup>lt;sup>9</sup> Ibid, 303

<sup>&</sup>lt;sup>10</sup> Coronial Brief, Statement of Detective Senior Constable Jennifer Black dated 28 July 2021, 1469

<sup>11</sup> Ibid

- 22. Mr Tan was arrested and interviewed on 7 February 2021 and 10 February 2021 in relation to the disappearance of Ms Zhang. On both occasions, Mr Tan was attempting to leave the State of Victoria.<sup>12</sup>
- 23. On 21 July 2023, in the Supreme Court of Victoria, Mr Tan was convicted of murder and sentenced to 28 years' imprisonment with a non-parole period of 23 years' imprisonment.

# Identity of the deceased

- 24. On 22 June 2021, Ju Zhang, born 3 December 1987, was identified via DNA comparison.
- 25. Identity is not in dispute and requires no further investigation.

### Medical cause of death

- 26. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (VIFM), conducted an autopsy on 19 June 2021 and provided a written report of her findings dated 29 October 2021.
- 27. The post-mortem examination revealed the following:
  - a) There were widespread fractures and traumatic injuries to the remains that were in keeping with crush injuries sustained post-mortem from transport in a waste disposal truck and at the waste transfer station where the deceased's body was found;
  - b) The crush injuries along with the significant decomposition limited the interpretation of the sharp force injuries and lacerations that were evident across the deceased's body; and
  - c) The deceased had multiple sharp force injuries to the chest and limbs. Injuries produced by objects with sharp edges (such as a knife) are referred to as "sharp force injuries." Sharp force injuries are characterized by a relatively well-defined traumatic separation of tissues, occurring when a sharp-edged or pointed object comes into contact with the skin and underlying tissues. In this case the deceased had multiple sharp force injuries with the appearance of stab and incised wounds. Some of these were associated with haemorrhage and discolouration of the skin in keeping with

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<sup>&</sup>lt;sup>12</sup> DPP v Tan [2023] VSC 416, 4-5

having occurred during life. Other sharp force injuries had no haemorrhage and may have occurred post-mortem.

- 28. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.
- 29. Dr Parson provided an opinion that the medical cause of death was 1 (a) Unascertained.
- 30. I accept Dr Parson's opinion.

### FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

- 31. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.
- 32. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr Tan and Ms Zhang was one that fell within the definition of 'de facto partner' under that Act. Moreover, Mr Tan's actions in fatally assaulting Ms Zhang constitutes 'family violence'. 14
- 33. In light of this death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)<sup>15</sup> examine the circumstances of Ms Zhang's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).<sup>16</sup>
- 34. There are indications in the coronial brief that Mr Tan perpetrated family violence towards Ms Zhang prior to the fatal incident, specifically in the form of sexual abuse, and coercive, jealous and controlling behaviour. He also appears to have stalked Ms Zhang, monitoring her communications and tracking her movements.<sup>17</sup> Friends and family of Ms Zhang and Mr Tan

<sup>14</sup> Family Violence Protection Act 2008, section 8(1)(a)

<sup>&</sup>lt;sup>13</sup> Family Violence Protection Act 2008, section 9

<sup>&</sup>lt;sup>15</sup> 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

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

<sup>&</sup>lt;sup>17</sup> Coronial brief, Statement of X Chi, 155-156; Statement of B Chan, 300; Statement of C Cheang, 338.

were aware of Mr Tan's behaviour, <sup>18</sup> however, there are no indications in the available material that this behaviour was reported to any service agencies.

### **COMMENTS**

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

Family violence risk factors in newly formed relationships

- The Australian Domestic and Family Violence Death Review Network, & Australia's National 35. Research Organisation for Women's Safety recently compiled a national data report<sup>19</sup> which examined 202 cases where male family violence perpetrators killed their current or former female intimate partners and found that prior to the fatal incident:
  - emotional and psychological abuse had occurred in 81.6% (n=173) of these cases, and
  - stalking had occurred in 41.5% (n=88) of these cases.
- Further, in 10.4% (n=25) of cases, the offender and the deceased had been in a relationship for 36. less than a year at the time of the homicide.<sup>20</sup>
- 37. Family violence homicides are not always preceded by physical violence and can occur at any stage of a relationship.
- 38. Following the recommendations of the Royal Commission into Family Violence<sup>21</sup>, the Victorian Government developed the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) to support practitioners like police members, child protection practitioners and other specialist family violence services in assessing, monitoring and managing risk of family violence.<sup>22</sup>
- 39. I have considered the risk factors as they are set out in the MARAM which is the current risk assessment tool available to support services at the time of the fatal incident.

<sup>&</sup>lt;sup>18</sup> Ibid.

<sup>&</sup>lt;sup>19</sup> Australian Domestic and Family Violence Death Review Network, & Australia's National Research Organisation for Women's Safety. (2022). Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010-2018 (2nd ed.; Research report 03/2022). ANROWS, 27-28, 49.

<sup>&</sup>lt;sup>21</sup> Victorian Government, Royal Commission into Family Violence (March 2016) Final Report, Chapter 6 – Risk assessment and management.

<sup>&</sup>lt;sup>22</sup> Family Safety Victoria, Family Violence Multi-Agency Risk Assessment and Management Framework (2018).

- 40. There are several perpetrator specific risk factors applicable to Mr Tan. In particular, Mr Tan displayed 'controlling' behaviours over Ms Zhang, specifically monitoring Ms Zhang's mobile phone and social media communications. Mr Tan also stated to his close associates that he would kill Ms Zhang if he found out that she was cheating on him. Mr Tan engaged in various stalking behaviours of Ms Zhang, including watching her residence from afar, monitoring her phone and social media. Mr Tan also displayed obsessive and jealous behaviour towards Ms Zhang.
- 41. Coercive control describes a systematic pattern of behaviour used by a person to dominate and control another person, usually an intimate partner. It involves a range of behaviours that are not exclusively physical. While physical and sexual violence may be present, coercive control is characterised by non-physical behaviours, including emotional and psychological abuse, financial abuse, technology-facilitated abuse, stalking and intimidation.<sup>23</sup> These behaviours follow a distinct pattern and are repeated and integrated into everyday life as a means to control, manipulate and dominate. Coercive control is a recognised risk factor for intimate partner homicide.
- 42. I note that the criminalisation of coercive control is currently being considered by many Australian states and territories. Presently only Tasmania and New South Wales have introduced new criminal offences for coercive control. I note that there is still substantial ongoing debate in Australia around the criminalisation of coercive control and any legislation designed to address coercive control must have a nationally consistent definition distinguishing it from physical and non-physical aggression that does not seek to deny personhood.<sup>24</sup>
- 43. I support further research by the Victorian Government into a comprehensive coercive control framework, where any future legislation is implemented alongside improvements to family violence education, training and best practice in the courts. I confirm that the circumstances of this case suggest that criminalisation of coercive control would not have had a significant impact on the fatal outcome.
- 44. The available evidence suggests that in this case there were a number of close family and friends of Ms Zhang who were aware of Ms Zhang's experiences of family violence but did not report this to services. Informal supports are persons who are aware of family violence occurring in a

<sup>&</sup>lt;sup>23</sup> Australia's National Research Organisation for Women's Safety (ANROWS)(2021). *Defining and responding to coercive control: Policy brief*, 1, Available online at: <a href="https://20ian81kynqg38bl313eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2021/02/Coercive-Control-Policy-Brief-ANROWS-Insights-1.0.pdf">https://20ian81kynqg38bl313eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2021/02/Coercive-Control-Policy-Brief-ANROWS-Insights-1.0.pdf</a>

<sup>&</sup>lt;sup>24</sup> Australia's National Research Organisation for Women's Safety (2021), *Defining and responding to coercive control: Policy brief* (ANROWS Insights, 01/2021, 3-4.

relationship, either through witnessing it or having it disclosed to them, and who know either of the parties to the relationship. They are generally providing, or would like to provide, support to one or both of the parties to seek assistance. Such persons can include family members, friends, work colleagues or other community members. Generally, these persons do not contact Victoria Police.

- 45. Research has found that a friend's response to a disclosure of family violence can have a profound impact on the psychological well-being of young women who are victims of family violence. Negative or stigmatizing responses can hazard wellbeing and result in further psychological distress for the victim.<sup>25</sup> These findings highlight the importance of ensuring that friends and other acquaintances are equipped to manage these conversations and provide effective responses.
- 46. In most of the cases investigated by the Court the informal supporters did not take any steps to engage the victim with support services, either by suggesting that the victim make contact or by contacting such services themselves. Statements from many individuals suggested they did not feel equipped to assist or were concerned that becoming involved may make the situation more dangerous for the victim or themselves. Other informal supporters did not appear to recognise the actions of the perpetrator as family violence, particularly where there was no physical violence.
- 47. The coronial findings into the deaths of Mrs FS,<sup>26</sup> Mrs K<sup>27</sup>, Mrs VT,<sup>28</sup> John Reed,<sup>29</sup> and Mrs ZT<sup>30</sup> recommended that the Victorian Government and Family Safety Victoria develop a research-based strategy, in consultation with victim survivors, informal supporters, priority communities and specialist family violence services, to provide targeted services to informal supporters assisting persons affected by family violence.
- 48. On 11 November 2021 Family Safety Victoria (FSV) responded to this recommendation and confirmed that they accepted the recommendation in full. They also noted that they are

Dworkin, Emily R., Charlotte D. Brill, and Sarah E. Ullman, 'Social reactions to disclosure of interpersonal violence and psychopathology: A systematic review and meta-analysis' (2019) 72 Clinical psychology review doi:10.1016/j.cpr.2019.101750; Edwards, Katie M., Christina M. Dardis, Kateryna M. Sylaska, and Christine A. Gidycz 'Informal social reactions to college women's disclosure of intimate partner violence: Associations with psychological and relational variables' (2015) 30(1) Journal of interpersonal violence, 25-44; Overstreet, Nicole M., and Diane M. Quinn 'The intimate partner violence stigmatization model and barriers to help seeking' (2013) 35(1) Basic and applied social psychology, 109-122.

<sup>&</sup>lt;sup>26</sup> COR 2017 2423.

<sup>&</sup>lt;sup>27</sup> COR 2017 1889.

<sup>&</sup>lt;sup>28</sup> COR 2016 1879.

<sup>&</sup>lt;sup>29</sup> COR 2015 3624.

<sup>&</sup>lt;sup>30</sup> COR 2016 2733.

'undertaking work across several areas to aid informal supporters assisting persons affected by family violence, as well as priority communities.'31

- 49. FSV advised that in March 2020 the Victorian Government released a 'Family Violence Support During COVID-19 Practice Note'<sup>32</sup> which gives 'informal supporters guidance on what to do if they are concerned someone they know needs help, including safe communication, safe accommodation and the contact number for Safe Steps.'<sup>33</sup> They also noted that the Orange Door website contains information and advice for people who may be worried about someone they know experiencing or perpetrating family violence.<sup>34</sup>
- 50. In addition, FSV advised they are 'developing a whole of Victorian government family violence research agenda and research program in response to the commitment made in the 2020-23 Family Violence Reform Rolling Action Plan (RAP). The research agenda (to be published by the end of 2021) sets out the Victorian government's priorities for family violence and sexual violence and harm research, with the objective of targeting research to priority evidence gaps so that we can improve family violence service delivery. The research program (to be delivered in 2022) will detail how government will work with Victorian universities, the sector and industry to deliver research aligned to the agenda, including on ways to support sector-led research, knowledge translation, and the establishment of collaborative research partnerships.' It is hoped that further research on informal supporters will form part of this plan.
- 51. FSV also outlined a range of initiatives, strategies and prevention projects targeted towards strengthening and expanding bystander programs within mainstream and priority community services. This includes funding for prevention work within multicultural and faith communities which enables them to 'implement and test innovative and culturally appropriate prevention initiatives and strengthen their capacity to identify and respond to family violence'. They also referenced Active Bystander Action and Intervention training sessions run by organisations such as Gender Equity Victoria, No To Violence and Women's Health in the North, noting that organisations that are trained in bystander action have then included it in family violence awareness workshops they have provided to their communities.

<sup>&</sup>lt;sup>31</sup> Family Safety Victoria, Response to recommendations made in COR 2016 1876, COR 2017 1889, COR 2017 2423, COR 2015 3624, COR 2016 2733, dated 11 November 2021, 1.

<sup>32</sup> https://www.vic.gov.au/sites/default/files/2020-05/Family%20violence%20support%20during%20COVID-19 0.docx

<sup>&</sup>lt;sup>33</sup> Family Safety Victoria, above n 12, 2.

<sup>&</sup>lt;sup>34</sup> Ibid 2.

<sup>&</sup>lt;sup>35</sup> Ibid 3.

<sup>&</sup>lt;sup>36</sup> Ibid 3.

- 52. The Victorian Government have subsequently released the Victorian Family Violence Research Agenda 2021-2024. This research agenda identifies the primary prevention of family violence and violence against women as a research priority and notes that 'further research, alongside monitoring and evaluation, is required to better understand 'what works' in the primary prevention of family violence.' It suggests that 'research into critical elements of primary prevention work may include topics such as... the role of bystanders.' 38
- 53. I support these recent developments by Family Safety Victoria and note that Safe and Equal<sup>39</sup> the peak body for specialist family violence services that provide support to victim survivors in Victoria, has recently undertaken work to improve family violence awareness and resources for third parties who are assisting persons experiencing family violence.
- 54. On 10 May 2022, Safe and Equal launched the inaugural 'Are you safe at home?' day which aims to raise awareness about family violence and encourages members of the community to 'start a conversation that could end family violence by asking someone, 'Are you safe at home?'. They also launched a new website which provides information and resources for the community to assist them in helping someone who may be unsafe at home. 40 This website includes information about how to approach the conversation with a potential victim/survivor or perpetrator, questions they can ask, identifying family violence and where to seek help. This information is also available in 15 community languages as well as easy English.

#### FINDINGS AND CONCLUSION

- 55. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:
  - a) the identity of the deceased was Ju Zhang, born 3 December 1987;
  - b) the death occurred on 1 February 2021 at 1 Winchester Avenue, Epping, Victoria, from 1(a) multiple stab wounds to the chest; and
  - c) the death occurred in the circumstances described above.

<sup>&</sup>lt;sup>37</sup> https://www.vic.gov.au/victorian-family-violence-research-agenda-2021-2024/research-priorities/primary-prevention-family-violence-against-women

<sup>38</sup> Ibid.

<sup>&</sup>lt;sup>39</sup> Safe and Equal is the peak body for specialist family violence services that provide support to victim survivors in Victoria. This service is an amalgamation of two previous statewide services – Domestic Violence Victoria and Domestic Violence Resource Centre Victoria.

<sup>40</sup> https://areyousafeathome.org.au/

- 56. I convey my sincere condolences to Ms Zhang's family for their loss.
- 57. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.
- 58. I direct that a copy of this finding be provided to the following:

Xiaoyou Zhang and Renqun Li, Senior Next of Kin

Ms Eleri Butler, CEO, Family Safety Victoria

Detective Senior Constable Samantha Russell, Coroner's Investigator

Signature



Judge John Cain

State Coroner

Date: 18 September 2023

Mr. Van

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.