IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 000588

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:	KS1
Date of birth:	1995
Date of death:	5 February 2018
Cause of death:	1(a) Complications of cutaneous burns
Place of death:	Victoria
Keywords:	Suicide; self-immolation; family violence; CALD

This finding was amended pursuant to section 76 of the *Coroners Act 2008* (Vic) on 5 February 2024 by order of the State Coroner, Judge Cain. Paragraph 83 was amended to correct an administrative error regarding pseudonyms.

INTRODUCTION

1. On 5 February 2018, KS1 was 22 years old when she succumbed to injuries from self-immolation. At the time of her death, KS1 was living in a house in Victoria with her husband, KS2, their five month old daughter, five other family members and two other children.

2. KS1 was born in Afghanistan as ZHZ.[1] She married KS2 in Afghanistan on 21 August 2013 and entered Australia under a spousal visa on 14 June 2015.[2] KS1 and KS2 had one child together, KS3, who was born on 30 July 2017 and was five months old at the time of KS1's death.[3]

3. KS1, KS2 and KS3 lived at a residence in Victoria with KS2's parents, KS2's brothers, KS4 and KS5, KS5's wife, KS6, and KS5 and KS6's two children.[4]

THE CORONIAL INVESTIGATION

4. KS1'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.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of KS1's death. The Coroner's Investigator conducted inquiries on my behalf, including taking

[1] Coronial brief, Statement of LZ, 130; Exhibit 6, 1761.
[2] Coronial brief, Exhibit 9, 733.
[3] Coronial brief, Exhibit 4, 596.
[4] Coronial brief, Statement of KS7 74.

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

8. This finding draws on the totality of the coronial investigation into the death of KS1 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.[5]

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

Circumstances in which the death occurred

9. On 29 November 2017, an interim Family Violence Intervention Order (**FVIO**) was made in the Frankston Court protecting KS1 and the children from KS2 and excluding KS2 from contacting or living with KS1 and the children. The FVIO was the result of a police application arising from a family violence incident occurring on 26 November 2017. The details of the family violence incident are discussed below.

10. KS2 reported that in the weeks preceding the fatal incident he received text messages from KS1 saying that he needed to be with her at the family residence, and that she would leave if he did not come back. As a result, he began returning to the residence despite an active FVIO with conditions excluding him from the family residence.[6]

11. At around midday on 3 February 2018, KS1 and KS2 met at the Fountain Gate Shopping Centre in Narre Warren. Later that afternoon, they returned separately to the family residence.[7]

12. The available evidence contains conflicting statements with respect to what occurred on the afternoon of 3 February 2018. KS2 and his family provided several different accounts of what occurred on this occasion, and many of these statements contradict one another. Several witnesses admitted to making deliberate omissions and factually incorrect statements in some of their statements.

13. KS2's family members initially claimed that KS2 was not present at the marital residence on 3 February 2018. However, in subsequent statements they admitted that KS2 was present at the

[5] 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 KS5e 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.

[6] Coronial brief, Exhibit 30, 1185-86.

[7] Ibid 1187-1189.

home at the time of the incident, stating that they did not disclose this initially due to fear that KS2 would get into trouble or be fined for breaching the FVIO.[8]

14. KS2's mother, stated that prior to the fatal incident, she and KS1 had a disagreement about an incident at a clothing shop at Dandenong.[9] KS2's mother reported that she packed a bag with her clothes '*as a sign of warning to KS1 that I had had enough of her anger and mood swings and that I was close to leaving the house*.'[10] However, she stated she did not intend to leave the house due to her concerns for KS3's safety.[11]

15. KS2's sister-in-law, KS6, stated that KS5 returned home from work and called everyone together for a family discussion. He reportedly assured everyone that they would not have to all live together for much longer, and that he and KS6 were looking for their own house to live in. KS5 reportedly said that he hoped that everyone would get along in the house after they moved out and that they all needed to be nice to one another.[12]

16. KS2 stated that he told KS2's mother to stay at the residence and said that he and KS5 would leave. He also stated that he told KS1 to pack some clothes and put them in his car, in preparation for leaving, which she did.[13]

17. KS2 further stated that after the family meeting KS1 asked him several times to leave the residence with her.[14] In response, he told her that it was too late to leave that day and that they would leave in the morning.[15]

18. KS5 stated that he saw KS1 and KS2 having a discussion and KS1 appeared to be upset. KS5 believed that she was angry with herself because KS2 was unable to live at the house. KS2 was reportedly explaining that he would be home soon.[16] KS5 stated that he spoke to KS1 to calm her down and took the keys from the car in the garage to prevent her from leaving. He explained that he did this because '*in the past when KS1 has got angry about [KS2] not living with her she will get any of our cars and drive off. KS1 only has a learners permit and is not allowed to drive by herself.*'[17] He indicated that he had similarly prevented her from taking a vehicle on at

[8] Coronial brief, Statement of family members, 72, 76, 92-93
[9] Coronial brief, Statement of KS5, 82, 91.
[10] Ibid 87.
[11] Ibid 88.
[12] Coronial brief, Statement of KS1, 122.
[13] Coronial brief, Exhibit 30, 1192.
[14] Coronial brief, Exhibit 30, 1193.
[15] Ibid 1194.
[16] Coronial brief, Statement of KS5, 100.
[17] Coronial brief, Statement of KS5, 101.

least two other occasions.[18] KS5 stated that KS1 attempted to start the car without the keys but was unsuccessful.[19] KS5 then moved the car and parked it down the street and around the corner to prevent her from driving it, and then parked his own car in the garage.[20]

19. KS1 then reportedly put KS3 in a baby seat in KS5's car and began looking for the keys to this car, which KS5 stated he had kept on his person to prevent her from taking the car.[21]

20. Family members state that at some point shortly after this, KS1 retrieved a container of petrol from a shed in the backyard, then re-entered the backyard. They suggest that KS1 then poured the petrol on herself, although none of them directly witnessed her doing so, and set herself alight.[22]

21. There are conflicting accounts as to the location of KS2 when this occurred. KS5 stated that he and KS2 were talking to each other on the front lawn when they heard a scream and ran towards the garage.[23] However, KS2 stated that he had been speaking to KS1 immediately prior to the incident and was sitting in the car in the garage when he saw KS1 go to the tool shed and retrieve the petrol container.[24] He initially stated that he watched her walk out of the shed and pour fuel on herself and light the clothing she was wearing on fire, but later stated that he did not know she had poured the petrol on herself until she set herself alight.[25]

22. KS7 reported that he was inside watching television when he saw KS1 in the backyard through a window. In his first statement he stated that he saw KS1 pour petrol on herself, but in subsequent statements he stated that he did not actually see this occur. In all his statements KS7 said that he ran outside and towards KS1, but she set herself alight before he could reach her.[26]

23. KS7, KS5 and KS2 reportedly tried to put out the flames and escorted KS1 to the bathroom where they put the fire out in the shower.[27] KS5 told KS2 to leave as he was not supposed to be at the house and contacted emergency services.[28] Witnesses reported seeing KS2 fleeing from the residence on foot.[29]

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[18] Coronial brief, Statement of KS2 110.
[19] Coronial brief, Statement of KS5, 101.
[20] Ibid 101-102.
[21] Ibid.
[22] Coronial brief, Statement of KS7, Statement of KS5, Statement of KS2.
[23] Coronial brief, Statement of KS5.
[24] Coronial brief, Exhibit 30, 1195, 1198-99.
[25] Coronial brief, Exhibit 30.
[26] Coronial brief, Statement of KS7, 74, 76, 81.
[27] Coronial brief, Statements of KS7, KS5, KS2.
[28] Coronial brief, Statement of KS5, 104.
[29] Coronial brief, Statement of DJ 148.

24. An ambulance attended the residence at approximately 6.51pm and KS1 was conveyed to hospital,[30] however she died due to complications from her injuries on 5 February 2018.[31]

Identity of the deceased

25. On 13 February 2018, KS1, born 8 March 1995, was identified by DNA comparison to samples taken from her infant child.

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

Medical cause of death

27. Forensic Pathologist Dr Essa Saeedi from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 7 February 2018 and provided a written report of his findings dated 11 July 2018.

28. The post-mortem examination revealed the following:

    a) There were skin burns involving a total body surface area in excess of 75% with variable depths including full thickness burns.

    b) The cutaneous burns sustained by the deceased were non-survivable as a consequence of disseminated intravascular coagulation, shock and multi-organ failure. The mechanism of sustaining these injuries cannot be specified as the features of such injuries do not differentiate between self-infliction and an act of a third party.

    c) There was no evidence of any natural disease which may have caused or contributed to death.

29. Toxicological analysis of post-mortem samples identified the presence of Morphine, Fentanyl, Paracetamol, Metoclopramide, Ketamine and Lignocaine. None of the substances detected were in concentration levels that affected the cause of the death, most of the substances were administrated by paramedics attending the scene of the fatal incident.

30. Dr Saeedi provided an opinion that the medical cause of death was 1 (a) Complications of cutaneous burns.

[30] Coronial brief, Statement of Ambulance Paramedic, 247
[31] Coronial brief, Exhibit 26 – Alfred Health records, 1068-1069

31. I accept Dr Saeedi's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

32. For the purposes of the *Family Violence Protection Act 2008*, the relationship between KS1 and KS2 was one that fell within the definition of '*spouse*'[32] under that Act. Moreover, KS2's actions in physically assaulting KS1 in the proximate period leading to the fatal incident and breaching conditions of an active FVIO at the time of the fatal incident constitutes '*family violence*'.[33]

33. In light of KS1's death occurring under circumstances of proximate family violence, I requested that the Coroners' Prevention Unit (**CPU**)[34] examine the circumstances of KS1's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[35]

Relevant family violence history between KS1 and KS2

34. KS1 experienced numerous forms of family violence in her relationship with KS2. There was a mixture of unreported family violence and reported family violence with services.

35. On 7 September 2016, KS1 attended the Park Avenue Medical Centre with a cut to her left wrist which she reported was the result of self-harm. She disclosed that she was experiencing suicidal ideation and reported that KS2 had slapped her and that she was feeling depressed.[36] KS1's General Practitioner (**GP**) referred her to the Casey Hospital Emergency Department.

36. KS1 attended the Casey Hospital the same day and reported experiencing occasional suicidal thoughts, including thoughts of stabbing herself or jumping from a tall building. It was also noted that KS1 had previously made impulsive overdose attempts whilst living in Afghanistan. KS1 reported that she was having conflict with her in-laws and felt unsupported by her husband.[37] Notes from this admission indicate that KS1 reported that KS2 had '*anger issues*' and had '*smashed [KS1's] phone*'[38] and that there was '*lots of conflict*'[39] in the home. They

[32] Family Violence Protection Act 2008, section 8(1)(a)
[33] Family Violence Protection Act 2008, section 5
[34] 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
[35] 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
[36] Coronial brief, Exhibit 22.1, 866; Exhibit 22.2, 872-926, 934.
[37] Coronial brief, Exhibit 22.2, 875, 877, 880, 911; Exhibit 23, 946-948.
[38] Coronial brief, Exhibit 23, 946.
[39] Ibid 947-948.

also indicate that KS2 was reportedly reluctant for KS1 to be admitted to hospital as he did not want his family to know about KS1's mental health concerns.[40] However, it was noted that he appeared more supportive at a post-discharge mental health appointment on 11 September 2016.[41]

37. KS1 was discharged from Casey Hospital on 9 September 2016, with a plan to attend her GP to obtain a Mental Health Care Plan (**MHCP**), undertake follow up appointments with the Crisis Assessment and Triage Team (**CATT**) and present to the Emergency Department if she became suicidal.[42]

38. On 27 September 2016, KS1 attended an appointment with her GP and obtained a MHCP.[43]

39. On 3 October 2016, KS2 contacted emergency services and reported that KS1 had tried to cut herself with a knife.[44] The following day, on 4 October 2016, he again contacted emergency services and reported that KS1 was suicidal. LEAP records from this report indicate that police attended and conducted a family violence risk assessment, during which they identified KS1 as the respondent and KS2 as the affected family member. KS1 reportedly denied any intent to self-harm on this occasion and disclosed that she was making threats of self-harm to get attention from KS2. The notes from this interaction recorded that KS1 was reliant on her husband as she was on a spousal visa, and that she was upset as she had limited family and social supports in Australia. Police assessed that there were no grounds for a Family Violence Intervention Order (**FVIO**) as neither party was fearful of the other. Formal referrals were submitted for both parties.[45]

40. KS3 was born on 30 June 2017[46] and KS1 began attending Maternal and Child Health Nurse (**MCHN**) appointments for KS3 from 4 August 2017 onwards. At her initial appointments in August and September 2017, KS1 was accompanied by KS2 or other members of his family. As a result, screening for family violence was unable to be conducted on these occasions.[47]

41. On 4 October 2017, KS1 indicated to the MCHN that her '*home situation could be better'* and reported that her mother-in-law was expecting her to do more house duties even when she was

[40] Coronial brief, Exhibit 22.2, 873.
[41] Ibid 884.
[42] Ibid 913.
[43] Coronial brief, Exhibit 23, 933.
[44] Coronial brief, Exhibit 1, 279-281.
[45] Ibid 282-283; Exhibit 2, 284-286.
[46] Monash health, medical records relating to KS1, '7949338 KS1- SMR', 272.
[47] City of Casey, Maternal and Child Health Nurse records relating to KS1, 'Progress Notes', 82, 85, 88-89.

trying to settle KS3.[48] The MCHN conducted a family violence assessment, however KS1 denied that she was experiencing any family violence. The MCHN noted that KS1 did not have any social supports, all of her extended family lived overseas, she had no friends, and no access to transport, and would like to learn English. They referred her to Enhanced Maternal and Child Health Nurse services (**EMCHN**) to assist her with these matters.[49]

42. KS1 attended an assessment with the EMCHN on 20 October 2017. During this appointment she disclosed that she had an incident of self-harm whilst she was pregnant, which led to a brief period of hospitalisation. She reported experiencing frequent low mood and reduced appetite but denied any suicidal ideation. She also reported feeling safe in the family home, although she reported that her mother-in-law '*does not like her'* and was often in a '*bad mood'* and verbally abusive.[50] She also reported that her mother-in-law was extremely controlling and disapproving of KS1. KS1 indicated that she would prefer to live in the family home without KS2's extended family.[51]

43. The EMCHN offered to link KS1 in with childcare and English language classes, and KS1 indicated she would like to do this once KS3 was older. The EMCHN also gave KS1 information for local playgroups. KS1 declined ongoing support from the EMCHN, and they advised her of their re-referral process if she wanted to engage with them in the future.[52]

44. On 26 November 2017, KS1 reportedly had an argument with her father-in-law, KS7, during which he allegedly slapped her to the face.[53] In a statement to police after KS1's death, KS7 denied that he assaulted KS1 on this occasion. He stated that he had told KS1 not to hit KS3 and that he had only touched her on the face and caressed her cheeks.[54] In subsequent conversations with the Department of Families, Fairness and Housing – Child Protection (**Child Protection**), however, KS7 reportedly admitted that this assault had occurred but stated there was no force or malice in his actions.[55] Following this incident KS1 left her home on foot late at night, taking KS3 with her. KS2 reportedly followed KS1 in his car but did not approach to offer her assistance or answer his mobile phone when she attempted to call him.[56]

[48] Ibid 79-80.
[49] Ibid.
[50] Ibid 76-77.
[51] Ibid.
[52] Ibid.
[53] Coronial brief, Exhibit 4, 596-599.
[54] Coronial brief, Statement of KS7, 80.
[55] Coronial brief, Exhibit 4, 490-491, 586-587.
[56] Ibid 598-599.

45. KS1 contacted a female friend for assistance and arranged to be picked up by her friend's husband, MM, at the carpark of a McDonald's restaurant in Cranbourne. When MM attended to retrieve KS1 and KS3, at approximately 1.00am, KS2 approached them and assaulted both KS1 and MM. Witnesses to this assault contacted police.[57]

46. A witness to this incident reported seeing KS2 use '*his right hand to forcefully slap [KS1] to the face with an open hand three to four times. The baby was in [KS1's] hand while he was hitting her.*'[58] MM also stated that KS2 assaulted KS1 and that while he *'was attacking KS1 I was holding his arms to protect myself and her.*'[59] He also stated that a witness took KS3 from KS1 because KS2 was trying to attack KS1. In an interview with police following KS1's death, KS2 admitted to slapping KS1 on this occasion but claimed that it was an accident that occurred when KS1 put herself between him and MM during their altercation.[60]

47. KS2 was arrested and subsequently charged with assault.[61] KS1 refused to make a statement of complaint against KS2 and reportedly tried to intervene and stop police from taking KS2 to the station. Police issued a Family Violence Safety Notice (**FVSN**) to protect KS1 and KS3 from KS2. KS1 was noted as not being in agreement with the FVSN being issued.[62]

48. A notification was made to Child Protection about the incident, and they commenced an investigation.[63] Emergency accommodation was arranged by Safe Steps, for KS1 and KS3 to stay at a motel.[64]

49. Child Protection and Safe Steps noted that they had significant concerns about the safety of KS1 and KS3. Both services were concerned that KS1 had '*demonstrated limited insight into the father's responsibility in terms of him perpetrating family violence'*[65] and would be under significant duress to return to the family home, where she was at risk of family violence from numerous family members. [66] Notes recorded by Child Protection indicate that KS2's mother had reportedly told KS1 that '*it is well within the rights of the family to kill her given she has disobeyed her husband and specifically because she has spoken up in terms of sticking up for*

[57] Coronial brief, Statement of RC, 67; Statement of MM, 184-186; Exhibit 1, 294-295; Exhibit 4, 565-583, 539-540.
[58] Coronial brief, Statement of RC, 67.
[59] Coronial brief, Statement of MM, 185.
[60] Coronial brief, Exhibit 30, 1144-1145.
[61] Coronial brief, Exhibit 3, 298.
[62] Ibid.
[63] Coronial brief, Exhibit 4, 597-609.
[64] Safe Steps, records relating to KS1.
[65] Coronial brief, Exhibit 4, 599.
[66] Ibid 579-583, 565-608.

herself.'[67] Given these concerns, Safe Steps agreed to notify Child Protection if KS1 left the emergency accommodation.[68]

50. On 28 November 2017, Child Protection visited KS1 at her emergency accommodation, using a telephone interpreter to communicate with her. KS1 denied that KS2 had assaulted her and disclosed that she had ongoing conflict with KS2's family but there had been no physical assaults prior to the most recent incident. Child Protection advised KS1 that they did not want her to return home until they had completed their initial assessment.[69]

51. On 29 November 2017, an Interim Family Violence Intervention Order (**FVIO**) was issued at the Frankston Magistrates' Court. This order included conditions that KS2 not contact, communicate, or reside with KS1 and KS3. KS2 was present at the hearing and consented to the order being made without admitting to any of the allegations in the application.[70]

52. On 1 December 2017, KS1 presented to the Alfred Hospital with pain to her finger. During this attendance she made disclosures about KS2 and reporting that she wanted to reunite with her husband. A hospital social worker liaised with Safe Steps and Child Protection to assess the situation and ensure that KS1 had appropriate supports in place.[71]

53. On 2 December 2017, KS1 advised State Steps that she was going to return home and intended to speak to police to ask them to vary the FVIO so that KS2 could communicate and live with her. Safe Steps notified Child Protection, who contacted KS1. KS1 confirmed her plans to Child Protection, stating that she was lonely and homesick. She also stated that she felt safe in the marital home if KS2 was there but did not feel safe alone with her in-laws. Child Protection sought KS1's agreement to remain in emergency accommodation until they completed their assessment due to their concerns about her returning to the marital home.[72]

54. On 4 December 2017, KS1 returned to live with KS2's family at their residence.[73] Child Protection followed up with Safe Steps on the morning of 4 December 2017. Safe Steps confirmed with Child Protection that KS1 had remained in emergency accommodation over the weekend and was still in that accommodation, but it was reported that KS1 was '*adamant that she wants to return home with her husband'*. Later that day (around 7.30pm) KS1 reported to

[67] Ibid 599.
[68] Ibid 579-583, 565-608.
[69] Ibid 533, 594.
[70] Ibid 518-519.
[71] Ibid 586, 514-516.
[72] Ibid.
[73] Ibid 502.

Safe Steps that she was returning to the family home. She was subsequently picked up by her brother in law, but it is not clear whether that was late on 4 December or in the morning of 5 December 2017. Child Protection was informed of this on 5 December 2017.

55. On 5 December 2017, KS1 attended a MCHN appointment. She stated that she was feeling well and had no concerns about herself or KS3. Notes from this appointment suggest that the MHCN asked KS1 about family violence, but KS1 denied having any concerns.[74]

56. On the same day, Child Protection conducted an unannounced home visit at the marital residence. During this visit they confirmed with KS2's parents that KS2 was not living there, and that KS2 was complying with the conditions of the FVIO and not returning to the home.[75] Child Protection advised the family of the consequences of KS2 returning to the home, specifically that KS1 and KS3 would be removed from the home. Child Protection continued to recommend that KS1 return to emergency accommodation, however KS1 insisted that she wanted to reside in the family home.[76]

57. On 13 December 2017, KS1 was admitted to Casey Hospital with stomach pains.[77] During the intake assessment, it was noted that there was a FVIO between KS1 and KS2, and KS1 was referred to the hospital social work team.[78]

58. On 14 December 2017, Child Protection met with KS2 and explained the FVIO and consequences of breaching it to him. On the same day, Child Protection also spoke to KS1, who advised them that she needed KS2 for support and that she would not be able to cope if he was not present.[79] Child Protection reiterated the terms of the FVIO to KS1 and nursing staff at the hospital. They refused to support a variation of the FVIO to allow KS2 to return to the family home and requested KS2 obtain a MHCP and engage in counselling in relation to his mental health, alcohol misuse, and relationship with KS1. They also requested that he undertake a Men's Behaviour Change Program (**MBCP**). KS2 agreed to undertake these actions before the next scheduled court hearing on 23 February 2018.[80]

59. On 18 December 2017, a Casey Hospital social worker met with KS1. KS1 advised them that she wanted the FVIO revoked so that KS2 could have contact with her and KS3. The social

[74] City of Casey, Maternal and Child Health Nurse records relating to KS1, 71-72.
[75] Coronial brief, Exhibit 4, 586, 535-538, 500-501.
[76] Ibid 490-491, 586-587.
[77] Monash Health, medical records relating to KS1, '7949338 KS1- SMR', 8.
[78] Ibid 206-207.
[79] Coronial brief, Exhibit 4, 467.
[80] Ibid 467-470, 587.

worker contacted Child Protection and requested that they meet with KS1 and explain the FVIO to her to ensure she understood the process. The social worker took no further action noting that the matter was being managed by Child Protection and Victoria Police, and that KS1 had a solicitor.[81]

60. On the same day, KS1 was granted leave from the hospital to attend a meeting with Child Protection. During this meeting she asked Child Protection whether KS2 could look after KS3 whilst she was in hospital. She also asked when KS2 would be able to return home, whether he could travel with them for Christmas, and whether she could see him without KS3 present. Child Protection advised her that KS2 could not currently return home, see her, care for KS3, or travel with the family for Christmas.[82]

61. On 4 January 2018, KS1 again advised Child Protection that she wanted KS2 to return home. Child Protection advised her that he could not do so until he had completed counselling. They reiterated that she and KS2 had to comply with the FVIO. They offered support and counselling to KS1, which she declined, reportedly stating that she did not need counselling.[83]

62. On 8 January 2018, KS2 advised Child Protection that he had obtained a MHCP and asked what else he needed to do in order to be able to return home. Child Protection advised him that he needed to attend counselling and attend a MBCP. They provided him with the details of a MBCP.[84]

63. On 24 January 2018 Child Protection conducted a home visit with KS1. KS1 indicated that she planned to reunite with KS2 and again asked if Child Protection would agree to KS2 returning to the home. Child Protection reiterated their position on the matter, noting that their support of KS2 returning to the home would depend on how well he engaged with counselling. KS1 noted that she was having difficulties with settling and feeding KS3. Child Protection assisted her to call Nurse on Call with an interpreter and assisted her to make a MCHN appointment for further support.[85]

64. On 25 January 2018, KS1 contacted Child Protection and advised them that KS2's mother had been upset with her after the Child Protection visit the previous day. KS1 requested that future

[81] Monash Health, medical records relating to KS1, '7949338 KS1- SMR', 207.
[82] Coronial brief, Exhibit 4, 464-465, 587.
[83] Ibid 453.
[84] Ibid 452, 587.
[85] Ibid 443, 447-448, 588.

meetings take place at the Child Protection office '*so as not to anger the family*.'[86] Subsequent Child Protection notes indicate that KS2's mother left the home for several days after the Child Protection home visit and was quite distressed because of it.[87] Child Protection confirmed with KS1 that she still felt safe living with her in-laws.[88]

65. On the same day KS1 contacted Safe Steps asking for their assistance to secure emergency accommodation. They advised her not to contact them using the number she had utilised and provided her with a contact number for housing support. The following day KS1 contacted Safe Steps again, stating that she still needed housing assistance and that the number they had provided her with was not working. KS1 was again advised not to contact them using the number she had used, and they provided her with the correct number for '*Opening Doors*.'[89] No risk assessment appears to have been conducted during either of these phone calls.

66. On 30 January 2018, KS1 attended a MCHN appointment. She sought their assistance with obtaining a childcare placement for KS3 and accessing English classes. The MCHN offered to re-refer her to the EMCHN and KS1 accepted the referral. The MCHN notes from this appointment do not indicate any disclosures about family violence being made on this occasion.[90]

COMMENTS

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

Specialist family violence service response - Safe Steps

67. Following the family violence incident on 26 November 2017, KS1 was referred to a number of specialist family violence services including WAYSS and Safe Steps. WAYSS is a crisis service for people who are homeless, or at risk of homelessness in the Greater Dandenong, Casey and Cardinia areas. Safe Steps is a separate specialist family violence service connecting victim survivors to a range of services including accommodation.

[86] Ibid 440, 442.
[87] Ibid 438, 588-589.
[88] Ibid.
[89] Safe Steps, records relating to KS1, 11-12.
[90] City of Casey, Maternal and Child Health Nurse records relating to KS1, 70

68. Records provided by WAYSS and Safe Steps indicate that they both had great difficulty locating appropriate accommodation for KS1.[91] Safe Steps continued to work with KS1 from late November 2017 until 26 January 2018.

69. A review of the available evidence reveals concerns in relation to Safe Steps' failure to offer KS1 appropriate supports whilst she was in emergency accommodation, their failure to link her in with mental health supports when she expressed suicidal ideation, and their failure to conduct appropriate risk assessments and provide her with appropriate services when she contacted them in January 2018.

70. Following KS1's death, Safe Steps conducted an internal review of their engagement with KS1 and her family. This review outlined a range of issues with respect to the way Safe Steps engaged with KS1, including the service's failure to:

(a) refer KS1's matter to the local Risk Assessment and Management Panel (RAMP)[92]

(b) conduct a risk assessment, or obtain further information from KS1 when she contacted Safe Steps seeking emergency accommodation on 26 January 2018

(c) follow up mental health concerns after KS1 stated in her initial assessment that she 'wanted to throw herself in front of a car'

(d) refer KS1 to culturally appropriate services, noting that the '*low level of emotional support whilst in emergency accommodation, coupled with the above factors led [KS1] to request* to return home to an abusive environment.'[93]

71. The review also noted that the case management provided to KS1 was reactive instead of proactive, with the case manager not initiating any contact with KS1 during their period of involvement. There was also a delay by Safe Steps in notifying Child Protection about KS1's return to the family home.

72. The available evidence suggests that there was an opportunity for Safe Steps to refer KS1 to legal services given that they were aware that she was on a partner visa tied to KS2 at the time of her engagement with their service and she had expressed concerns about this issue causing

[91] Safe Steps, records relating to KS1, 11-12; WAYSS Dandenong case records, 5-9

[92] A Risk Assessment and Management Panel (RAMP) is a formally convened meeting, held at an area level, of nine key agencies and organisations that contribute to the safety of children and women experiencing serious and imminent threat from family violence. This includes, Victoria Police, Child Protection, specialist family violence services, etc.

[93] Safe Steps, Desktop review report prepared by Lewis Wanstall & Associates, 6.

her significant stress. Research suggests that women on partner visas face additional stressors when contemplating ending a violent relationship due to the legal implications for the residency of doing so. This was a missed opportunity to provide KS1 with additional support and information regarding her options to remain in Australia, should she wish to end the relationship.

73. The Safe Steps review made a number of recommendations aimed at fostering service improvements, including that:

(a) Safe Steps ensure all assessment practitioners have the skill set to assess and refer promptly to appropriate services. These referrals should occur as early as possible in a case management period. Workers should be aware of services including:

a. mental health support, as per the policy requirements.

b. culturally and linguistically diverse (**CALD**) support, as per the policy requirements.

c. RAMP referrals.

(b) Safe Steps review case management practices to develop and implement a proactive case management approach. This should include a trauma informed framework for case management services.

(c) Safe Steps policy regarding Child Protection notifications be reviewed to ensure staff are aware of alternate methods of communicating with Child Protection regarding active current cases.

(d) Safe Steps ensure all RAPID staff are aware of their service obligation to undertake effective assessments during contact.

(e) Safe Steps staff are trained in trauma informed practice.

(f) Safe Steps review their support of staff following critical incidents to ensure staff are provided adequate, timely and appropriate support.

(g) Safe Steps review its response to critical incidents to ensure all critical incidents are reviewed with a quality improvement focus.

(h) That the function and performance of the Safe Steps board be reviewed to ensure that it is able to undertake adequate oversight of the Safe Steps service.[94]

74. The Department of Families, Fairness and Housing (**DFFH**)[95] also engaged in a remediation process following concerns with Safe Steps as result of this case and other similar cases. This remediation process was arranged and overseen from 2019 to 2021, which included the development of a remediation plan.[96] In October 2019, Corrs Chambers Westgarth (**Corrs**) reviewed Safe Steps' compliance with the remediation plan and found that '*significant changes have been made to safe steps' operations, culture and performance at a board, executive and operational level'*.[97]

75. Since the fatal incident, Safe Steps has become a prescribed agency under the Multi Agency Risk Assessment and Management Framework (**MARAM**) and information sharing schemes, which should have resulted in significant training and improvements to their family violence response since the completion of Safe Steps Reviews.

Child Protection proximate contact with KS1, KS3 and KS2

76. A report was made to Child Protection following the family violence incident on 26 November 2017. Child Protection commenced an investigation in relation to the safety and wellbeing of KS3 and had several interactions with KS1, KS2, and KS2's parents in the lead up to KS1's death. The coronial investigation has revealed several concerns with respect to Child Protection's service interaction with KS1 in the lead up to the fatal incident.

CP – Linking KS1 with appropriate supports

77. Immediately following the family violence incident on 26 November 2017, Safe Steps assisted KS1 to obtain emergency accommodation. As there was no available refuge accommodation at the time, KS1 was funded to stay at a motel with KS3, who was approximately five months old at the time. KS1 stayed at the motel from 26 November 2017 to 4 December 2017.

78. KS2 had been excluded from contact with KS1 and KS3 who were listed as affected family members on a FVIO at the time.

[94] Safe Steps, Desktop review report prepared by Lewis Wanstall & Associates.
[95] Then known as the Department of Health and Human Services (DHHS).
[96] Safe Steps, letter to CCOV dated 22 June 2022.
[97] Safe Steps, letter from Corrs Chambers Westgarth regarding follow up review, dated 31 October 2019.

79. Child Protection repeatedly reinforced to KS2 that he was not permitted to interact with KS1 or KS3, but did not appear to have taken any other steps to ensure that KS1 was engaged with appropriate support to assist her with caring for KS3. Although they referred her to the MCHN, they did not liaise or share information with the MCHN.

80. KS1 was not linked in with culturally appropriate support during her involvement with Child Protection. Whilst there was one reference in the Child Protection notes indicating that they could refer her to InTouch, it is unclear whether this referral was ever made. InTouch confirmed with the Court that they never had any contact with KS1 or her family.[98]

81. The Child Protection Manual (**CPM**) notes that cultural values and immigration status can place culturally and linguistically diverse (**CALD**) families at higher risk of family violence and families from CALD backgrounds may have additional traumas, experiences and challenges that increase their vulnerability.[99] The CPM suggests that multicultural services such as InTouch '*can provide secondary consultations and case management to address cultural complexities and assist practitioners to work with families [in a way] which is culturally responsive.*'[100]

82. Having access to InTouch support may have provided KS1 with safety to elaborate on her experiences of violence and receive culturally informed support and advice to navigate the service system and the legalities of her immigration status.

CP - response to disclosures of family violence perpetrated by KS2's family

83. In her interactions with Child Protection, KS1 stated that KS7 had assaulted her on 26 November 2017. Child Protection spoke to KS7 during a home visit on 7 December 2017. During this conversation he reportedly admitted to slapping KS1 but stated that there was no force or malice in his actions and that he had apologised afterwards. In response to this, Child Protection advised KS7 that there should be no further violence in the house and that they would contact police if there was any further violence.[101] No discussion appears to have been had regarding KS3's exposure to violence during this incident and no further action appears to have been taken in response to KS7's use of violence.

[98] InTouch, email dated 15 March 2022.
[99] Child Protection Manual, *Planning for children's safety where there is family violence – advice,* 'CALD families including refugees', version 2, dated 6 June 2017
[100] Ibid.
[101] Department of Families, Fairness and Housing, records relating to KS3, 'DHHS record', 126.

84. Throughout her involvement with Child Protection KS1 repeatedly stated that she was unhappy living with her in-laws. On 25 January 2018, KS1 told Child Protection that her in-laws were upset about Child Protection continuing involvement with the family and requested that she meet with the service outside of the home. It is noted that KS1 also provided information about this incident to Safe Steps, but there was no sharing of information between Child Protection and Safe Steps at this time.

85. Child Protection met with KS1 four days later and confirmed that she felt safe in the home, offering her a referral to counselling services. They did not undertake any safety planning during their involvement and took no further action to address the family violence allegedly perpetrated towards KS1 by KS2's family, whom she continued to live with.

86. The Child Protection *Best interest case practice model: Working with families where an adult is violent*, which was in place at the time of the fatal incident and is a current operational policy, suggests that Child Protection practitioners should not rely on the accounts of a person accused of violence as they may deny or minimise the violence and should seek further information '*to ensure risk can be assessed and action taken to ensure safety*'.[102] The guide further instructs practitioners to consider contacting police and undertaking further criminal history checks in instances where violence is reported to their service.[103] Following a disclosure or suspicion of violence, practitioners are also required to undertake a risk assessment to determine the likelihood of ongoing or future violence towards the non-offending parent and their children. In doing so, practitioners should consider a range of information, evidence and factors that may denote increased risk. In response to this assessment, practitioners are guided to work collaboratively with family violence support services to develop a safety plan for the family with a view to reducing risk and improve safety options for those effected by the violence.[104]

87. On 15 December 2017, KS2 reported to Child Protection that KS1 had assaulted KS3, and that this had led to a disagreement between KS1 and KS7 on 26 November 2017.[105] The Child Protection Manual states that where new allegations are made in an open case they should be treated similarly to new protective intervention reports, which includes recording them as a separate report and making an assessment of harm in relation to such reports.[106] In the

[102] Child Protection Manual, *Best interest case practice model: Working with families where an adult is violent*, 2014, 54.
[103] Ibid, 60.
[104] Ibid, 89.
[105] Department of Families, Fairness and Housing, records relating to KS3, 'DHHS record', 119.
[106] Child Protection Manual, *Policies and Procedures*, 'Phases – Intake – New Allegations', dated 6 June 2017.

circumstances, Child Protection do not appear to have taken any steps to investigate this allegation further.

88. Child Protection do not appear to have taken these steps in their engagement with KS1, KS3 or their family and, as such, lacked the insight and information required to adequately understand the risk posed to KS1 and KS3's safety and provide meaningful intervention to support their safety needs.

CP – Information sharing and child protection

89. The Child Protection Manual requires practitioners to regularly seek and gather information about a child and their family throughout the course of the family's involvement with the service.[107] Information gathering is noted to promote case practice that is dynamic and supports up to date risk assessments, the sustainability of protective factors and the needs of the child, and assists practitioners in understanding the often-changing circumstances and needs of children and their families.[108] Practitioners are further encouraged to work collaboratively with services, noting that '*achieving positive outcomes for vulnerable children and families requires the broader system around the family to flexibly and creatively engage the family, in a solution-focused process that is timely, respectful, and culturally appropriate'*.[109]

90. The available evidence confirms that with the exception of Safe Steps, there is limited evidence in the Child Protection records to suggest that practitioners proactively liaised with any of the services involved with KS1 during their involvement with her or worked collaboratively with services to support KS1 and KS3's needs. Of particular concern is that Child Protection do not appear to have made any attempts to share information or liaise with the MCHN involved with KS1 and KS3. As a result, the MCHN was unaware of Child Protection involvement and Child Protection were not provided with critical information held by this service, thus compromising any risk assessment or safety planning that occurred with the family.

Accommodation options following a family violence incident

[107] Child Protection Manual, *Advice and Protocols*, 'Advice and Protocols – Investigation – Gathering information from other sources – advice', dated 1 March 2016; Child Protection Manual, *Best Interests case practice model – Families with multiple and complex needs,* < www.cpmanual.vic.gov.au/sites/default/files/Families%20with%20multiple%20%26%20complex%20needs%20specialist%20resource%203016%20.pdf>, 26-27.

[108] Child Protection Manual, *Advice and Protocols*, 'Advice and Protocols – Investigation – Gathering information from other sources – advice', dated 1 March 2016

[109] Child Protection Manual, *Our Approach*, 'Our approach – Multi-disciplinary practice – Interagency collaboration', dated 20 January 2018.

91. This case highlights a systemic issue in Victoria of the lack of appropriate family violence crisis accommodation. Following the family violence incident in November 2017 four different services were contacted to try to obtain accommodation for KS1 and KS3, all of which had difficulty in sourcing appropriate accommodation. No refuge accommodation was available and as a result, KS1 and KS3 were placed in motel accommodation. The placement of KS1 in a motel meant that she had limited access to supports or practical services (to care for a baby) whilst she was in emergency accommodation.

92. The findings of the Royal Commission into Family Violence (**RCFV**) noted that there is insufficient accommodation options available to meet the current demand.[110] A lack of access to affordable and stable housing continues to be a significant issue faced by the family violence service system despite multiple reforms.

93. Family violence is the main reason why women and children leave their homes in Australia and is the primary reason women present for assistance at homelessness services. The Australian Institute of Health and Wellbeing (**AIHW**) Specialist Homelessness Services Annual Report 2020-21 indicated that 45% of clients who presented to a specialist homelessness service had experienced family violence and that of those 116,200 clients, 65% had cited family violence as the primary reason for requiring housing support[111].

94. The RCFV and the Federal Government's National Plan to End Violence Against Women and Children acknowledges the need for increased longer-term housing options, including social and affordable housing, and additional emergency and transitional housing.

95. The Family Violence Reform Implementation Monitor (**The Monitor**) was established to monitor implementation of the recommendations made in the RCFV. The Monitor's fourth annual report to Parliament similarly reflects that housing remains an ongoing challenge for victim survivors of family violence. The Monitor notes that many victim survivors are unable to afford to maintain a mortgage or private rental upon leaving a violent relationship and often have no other housing options due to the dearth of social housing which has subsequently created an increased demand for crisis accommodation[112]. Demand for crisis accommodation for women escaping violence is unable to be met by Victoria's current number of designated

[110] *Royal Commission into Family Violence Final Report* (May 2016), Volume 2, Chapter 9, 78
[111] AIHW, Specialist homelessness services annual report 2020–21,
<https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/summary>
[112] Report of the Family Violence Reform Implementation Monitor, November 2021, 71.

crisis accommodation beds, resulting in housing and family violence services utilising motels and other ad-hoc accommodation arrangements to house victim survivors.

96. In 2016, the Victorian State Government announced an investment of $25 million as part of the Family Violence Housing Blitz package '*to support construction of 180 new units of crisis accommodation and upgrades to existing accommodation'*[113] and while some facilities have been upgraded or newly built, there was insufficient evidence available to the Monitor to confirm whether the target has been achieved in full.[114]

97. The Victorian Government has more recently announced that *'an additional $4.07 million has been provided in 2019–20 and 2020–21 to enable the Safe Steps statewide service to place more victim survivors in crisis accommodation and cover associated motel costs'*.[115] However, The Monitor emphasised unsuitability of motel accommodation as a substitute for purpose-built crisis accommodation, noting that the same motels often accommodate perpetrators and people experiencing intersectional issues of homelessness, mental health and substance misuse issues which can be re-traumatising for victim survivors.[116]

98. Access to stable, long-term housing is acknowledged as integral for victim survivors to leave and recover from family violence. In 2019 over 90 per cent of first-time requests made by family violence clients for long-term accommodation were unable to be met by Specialist Homelessness Services.[117] In April 2022, the Department of Families, Fairness and Housing reported that since 2016 they have:

- Acquired 325 social housing dwellings and head leased 401 medium-term tenancies from the sector
- Prioritised family violence victim survivors and their families for social housing through the Victorian Housing Register
- Provided over 6,500 flexible support packages each year to help victims survivors of family violence

[113] Ibid, 71.
[114] Ibid.
[115] Ibid 70.
[116] Ibid.
[117] ANROWS, Domestic and family violence, housing insecurity and homelessness: Research synthesis 2019 (2nd Ed.; ANROWS Insights, 07/2019), 2.

- Provided 38 new and leased properties across regional Victoria, providing women and children a safe and secure environment in which to live.[118]

99. A further 1000 '*safe homes'* for victim survivors of family violence will also be delivered as part of the Victorian Government Big Housing Build which, on completion, '*will deliver more than 9,300 social housing dwellings'*.[119]

100. Whilst these initiatives will assist in reducing the number of victim survivors facing homelessness, as at June 2020 there were 45,698 people waiting for social housing and of these, 24,472 are on the priority list which incorporates people escaping family violence, experiencing homelessness, disabled people and people with special housing needs[120]. As such, the demand for social housing significantly outweighs projected supply. This is confirmed in the Monitor's most recent report confirming that 3,500 new social housing units would need to be built every year over the next 10 years simply to address the growing gap between supply and demand[121].

Responses from Child Protection since the fatal incident

101. Child Protection were invited to comment on a number of identified concerns highlighted in this coronial investigation and provided a response to the Court dated 1 December 2023. Child Protection confirm that there have been improvements to practice and understanding of working with families where there is family violence identified since the fatal incident.

102. Since the introduction of MARAM following the RCFV, guidance and tools with which to train Child Protection staff were not released by Family Safety Victoria until mid- 2019.[122] Today, it would be expected that a MARAM be completed and since 20 November 2021, the MARAM has been aligned with the SAFER[123] children framework and risk assessment.

103. The MARAM Person Using Violence guidance tools, readiness implementation activities and training will be rolled out to the Child Protection workforce, commencing in the first half of 2024. This training will be co-facilitated with No to Violence trainers with the intent of

[118] Department of Families, Fairness and Housing, Ending Family Violence Annual Report, April 2022, 65 <https://www.vic.gov.au/ending-family-violence-annual-report>
[119] Ibid.
[120] Report of the Family Violence Reform Implementation Monitor, November 2021, 74.
[121] Ibid, 75.
[122] Department of Families, Fairness and Housing response dated 1 December 2023, 12
[123] SAFER is a guided professional judgement model integrated into CRIS and has greatly enhanced the completion and recording of risk assessment throughout all phases of Child Protection intervention. SAFER is designed to strengthen Child Protection practice by supporting and guiding practitioners in information gathering, analysis, risk judgement and decision KS5ing, formulation and enacting of a case plan and review development and wellbeing of individual children within their family, culture and community.

supporting the implementation and alignment to the MARAM Person Using Family Violence guidance and tools. The training is mandatory for the Child Protection workforce.[124]

104. Child Protection confirms that current practice when investigating family violence concerns requires practitioners to use the MARAM framework as part of the risk assessment and to develop a risk rating and risk management plan for families affected by family violence. Guidance is now available to practitioners to support the implementation of appropriate risk management strategies for the assessed level of risk. The level of risk posed by the perpetrator/s would be continually reviewed throughout the investigation phase.

105. The Child Protection workforce is also aware through training and resources that the MARAM assessment can be shared in accordance with the information sharing schemes.

106. To further enhance information sharing and collaborative practice, practitioners are encouraged to consider case conferencing, or at a minimum, discussions with services involved with the family, and to manage risk collaboratively to increase safety for children and their families. Consultation should occur with the co-located specialist family violence worker and/or senior Child Protection Practitioner (family violence), including a consultation about a possible referral to the Risk Assessment Management Panel (**RAMP**) if serious risk factors are identified.[125]

107. Information reported to Child Protection in the first report made on 26 November 2017 included that the Paternal Grandmother had informed KSI that the family had the right to kill her for disobeying her husband and had 'spoken back' to family members. Since investigation of the first report, the *Threats to kill a child, parent or carer – procedure* and *Threats to kill a child, parent or carer – advice* have been updated to incorporate the MARAM and SAFER framework. A perpetrator's threat to kill a child or an adult victim in the context of family violence is currently identified in the MARAM Framework as a serious risk factor for increased risk of the victim survivor being killed or almost being killed. Consequently, in response to either an explicit or implicit threat to kill, Child Protection's risk assessment would now include a MARAM risk rating and a judgement about the consequence of the harm and the probability of the harm occurring. Appropriate planning (immediate, short and long term) would occur to determine the intervention required for the family's safety and wellbeing.[126]

[124] Department of Families, Fairness and Housing response dated 1 December 2023, 13
[125] Ibid.
[126] Ibid.

108. Since the investigation of the first report, the practice resource *Engaging culturally diverse children and families (2022 v2)* has been introduced with the intent of enhancing the Child Protection workforce's capacity to provide culturally responsive, capable and respectful services to all children and families.[127]

109. Guided by this updated resource, current practice when investigating family violence in culturally diverse families required to engage with Child Protection would embrace engaging and partnering with the family, their community and existing services to promote a coordinated approach; applying an intersectional approach to family violence in order to better recognise barriers such as fear of being ostracised by the community, multiple perpetrators including other family, visa/immigration status, language, isolation, fear/mistrust of services, and shame; the importance of cultural and family violence consultation; undertaking a SAFER and MARAM assessment to inform risk assessment and decision-making; recording in records information relating to the cultural, ethnic, faith and linguistic characteristics of children and families; and the use of practice tools such as *In our family, Celebrating diversity – a family snapshot, My views* that support conversations with children and their families about culture.

110. The Child Protection confirms that they also deliver, both in-person and via interactive webinar training, through the *Working with multicultural and multifaith clients and communities* learning program. This program is aimed at strengthening practitioners' knowledge and understanding in working from a culturally informed position for mutual understanding and successful outcomes when interacting with multicultural and multifaith clients and communities. Several sessions remain available to staff in 2023 and sessions have been scheduled for 2024.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was KS1, born in 1995;

    b) the death occurred on 5 February 2018 in Victoria from complications of cutaneous burns, and

[127] Ibid, 14

c) the death occurred in the circumstances described above.

2. I convey my sincere condolences to KS1's family for their loss.

3. 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.

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

KS2, Senior Next of Kin

Assistant Commissioner Lauren Callaway, Family Violence Command, Victoria Police

Miriam Silva AM, Chair, InTouch Victoria

Ms Laura Colavizza, Senior Corporate Counsel, Monash Health

Ms Karen Day, Clinical Director, Alfred Health

Kelly Stanton, Acting CEO, Family Safety Victoria

Kristy Brockwell, Minter Ellison

Dr Chelsea Tobin, CEO, Safe Steps

Detective Leading Senior Constable Glen Hatton, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date : 5 February 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.