IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000345

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:	Joshua Tovey
Date of birth:	06 November 1991
Date of death:	18 January 2021
Cause of death:	1(a) Stab wound to the chest
Place of death:	Western Port Marina, Mullet Street, Hastings, Victoria, 3915
Keywords:	Family violence related homicide; Community Corrections Order

INTRODUCTION

1. On 18 January 2021, Joshua Tovey was 29 years old when he was fatally stabbed by his brother, Jesse Tovey. At the time of his death, Joshua lived at Hastings, Victoria with his mother, Deanne Tovey. Joshua was the eldest of six siblings born to parents, Deanne Tovey and Brandon Furlan.

2. Joshua grew up in the southeast region of Victoria and after completing year 12, he trained as a chef through tertiary vocational training in Ballarat. Joshua worked as a sous-chef at a number of restaurants in the Frankston area.

3. Joshua unfortunately suffered from Crohn's disease which significantly impacted his ability to work. Joshua eventually discontinued employment and moved in to live with his mother on Arthur Street in Hastings in January 2020.

4. Jesse, one of Joshua's younger siblings was serving a prison term and was incarcerated at the Ravenhall Correctional Facility between 9 June 2020 and 9 September 2020. During Jesse's detention, Joshua had deposited a sum of money into Jesse's prison account for him to use whilst he was in prison.

5. Upon Jesse's release on 9 September 2020, he was provided with accommodation in Sunshine and Joshua joined him for a period of time between September to November 2020. After November 2020, Joshua returned to his mother's residence due to financial disputes with Jesse.

THE CORONIAL INVESTIGATION

6. Joshua'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.

7. 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.

8. 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Joshua'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.

10. This finding draws on the totality of the coronial investigation into the death of Joshua Tovey 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.[1]

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

Circumstances in which the death occurred

11. On 5 January 2021, Joshua and Jesse had a physical altercation in which Joshua assaulted Jesse with a mallet or a similar object.[2] This altercation stemmed from a disagreement between the brothers regarding the repayment of money that Joshua had provided to Jesse when Jesse was incarcerated earlier in 2020.[3] This assault was reported by both Joshua and Jesse to family and friends[4], but there is no evidence suggesting that it was reported to police or any service agencies.

12. Available SMS message records between the brothers evidenced continued animosity between the two and this resulted in Jesse attending his mother's residence to retaliate against Joshua for the prior assault on 5 January 2021.[5]

13. On the morning of 18 January 2021 at approximately 7.00am, Joshua was stabbed several times by his younger brother Jesse while outside their mother's home.[6]

---

[1] 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.

[2] Coronial brief, Statement of D Tovey, 143.

[3] Ibid.

[4] Ibid. Coronial brief, Statement of A Cresswell, 187. Coronial brief, Statement of N Mace, 306.

[5] Coronial brief, Appendices A and B – Cellebrite Extraction Report SMS contact between accused and deceased, 427-440

[6] Coronial brief, Statement of Material Facts, 7.

14. Jesse fled the scene and Joshua died a short time later while being treated by paramedics and was pronounced deceased at 8.05am.[7] Jesse was later arrested on the same day and charged with the murder of his brother Joshua.

15. Jesse was convicted and found guilty of manslaughter in the Supreme Court of Victoria. Jesse was sentenced to eight years and three months imprisonment with a non-parole of five years.

Identity of the deceased

16. On 20 January 2021, Joshua Tovey, born 6 November 1991, was visually identified by his father, Brandon Furlan.

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

Medical cause of death

18. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 18 January 2021 and provided a written report of her findings dated 25 May 2021.

19. The following was noted in the autopsy:

    a) The main mechanism of death was a stab wound to the chest, which injured the right lung and pierced the heart. This resulted in a haemothorax mainly on the right side and totalling 1.26 litres. There was also a small hemopericardium (blood in the membranous sac surrounding the heart), and partial collapse of the right lung.

    b) There were three further stab wounds to the left root of the neck, the right back of the shoulder, and the left back of the shoulder. However, these did not contribute to the death, and terminated in underlying muscle without causing any vital damage.

    c) There was no significant natural disease that could have caused or contributed to death. The only findings were of a mild left ventricular hypertrophy and an enlarged liver with fatty change.

[7] Coronial brief, Statement of Ambulance paramedic dated 2 February 2021, 76

20. Toxicological analysis of post-mortem samples identified the presence of Delta-9-tetrahydrocannabinol, Temazepam, Altropine, Ketamine, none of which contributed to the death.

21. Dr Archer provided an opinion that the medical cause of death was a 1 (a) Stab wound to the chest.

22. I accept Dr Archer's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

23. 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.

24. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Jesse Tovey and Joshua Tovey was one that fell within the definition of '*family member*[8] under that Act. Moreover, Jesse's actions in fatally assaulting Joshua constitutes '*family violence'*.[9]

25. In light of Joshua's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[10] examine the circumstances of his death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[11]

26. Whilst the available evidence suggests whilst Jesse had multiple recent charges proximate to the fatal incident for breaching family violence intervention orders and unlawful assault, none of these charges identified Joshua as a respondent, victim or affected family member. There were also no orders that precluded Jesse from attending his mother's home. A review of the available evidence also confirms that there was no reported history of family violence service contact involving incidents between Jesse and Joshua.

[8] Family Violence Protection Act 2008, section 8(1)(c)
[9] Family Violence Protection Act 2008, section 5
[10] 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
[11] 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

Proximate service contact between Corrections Victoria and Jesse Tovey

27. A community correction order (**CCO**) is a criminal sentence imposed by a court that allows offenders to complete their sentences in a community setting. Offenders on CCOs may have to comply with specific conditions imposed by the courts, such as mandatory drug or alcohol treatment, mental health treatment, and significant restrictions such as curfews and judicial monitoring.

28. Jesse was sentenced at Frankston Magistrates Court on 16 July 2020 for multiple offences including persistent contravention of a family violence intervention order.[12] Jesse was incarcerated between 9 June 2020 to 9 September 2020 and upon his release he was made subject to a Community Corrections Order (**CCO**) managed by staff of Community Correctional Services (Corrections Victoria) for 18 months (expiring on 8 March 2022).

29. The CCO required Jesse to comply with the following conditions:

    a) Undergo assessment and treatment for substance abuse as directed;

    b) Undergo assessment and treatment for mental health issues as directed; and

    c) Attend a behaviour change program and other programs to reduce re-offending.

30. Jesse was a high risk offender, he had breached two prior CCOs in 2016 and 2018. Jesse had also breached bail conditions in 2017. Jesse received a risk assessment from Corrections which is primarily based on his criminal history, mental health and substance abuse history. This risk profile guides Corrections case managers as to the appropriate supervision frequency and case management of offenders who are subject to CCOs.

31. Upon Jesse's release from Ravenhall on 9 September 2020, he was commenced on twice weekly telephone reporting in according with the Practice Guideline *Remote Case Management and Services Delivery* in response to COVID-19.

32. Whilst the available evidence suggests that referrals were made for drug and alcohol assessment and treatment, Jesse was required to attend a behaviour change program to reduce re-offending and attend his General Practitioner to be assessed for mental health treatment. There is no

[12] Other offences included trafficking cannabis and methamphetamine, dealing with the proceeds of crime, unlicensed driving, possession of a schedule 4 poison and theft of a motor vehicle.

available evidence confirming that he in fact attended any treatment for mental health or a behaviour change program.

33. From October 2020, Jesse reported drug use after being issued a direction to attend drug testing on 13 October 2020 which he never attended. At his next appointment on 19 October 2020, Jesse refused to participate in drug testing. The available evidence indicates that Jesse's substance use was raised as a concern between his housing provider (Bridge Centre) and Corrections case officer. There was reported substance use and complaints from neighbours at the property Jesse was residing at the time.

34. Whilst Jesse eventually commenced drug treatment with Caraniche on 26 October 2020, he was directed to attend testing on 6 November 2020 and failed to attend the testing appointment. On 18 November 2020, he was directed to attend testing on 20 November 2020. The 20 November 2020 test came back positive for methamphetamine and alcohol use.

35. Jesse committed further offences (multiple driving, theft, unlawful weapon and drug possession) on 24 November 2020. This was in breach of the conditions of his CCO and cause for contravention action to be taken due to the further offending whilst subject to a CCO. Corrections staff are expected to initiate contravention proceedings within six weeks of a serious contravening incident. Since Jesse was convicted of further offending during the operation of his CCO, the six weeks commenced on 10 December 2020 (when he was found guilty and sentenced for the further offending), meaning proceedings needed to be initiated by 21 January 2021.

36. At the time of the fatal incident on 18 January 2021, a contravention authorisation was yet to be submitted and a charge was yet to be authorised. Contravention action was approved, and a charge was authorised on 21 January 2021. While within the requisite timeframes, best practice would be to ensure proceedings had commenced while Jesse was still in custody to facilitate service of a Charge and Summons on him while incarcerated.

37. The approval to take contravention against Jesse wasn't authorised until after the fatal incident, whilst in line with 6 week timeframe, given his status as a high risk offender, action could have been authorised any time after Corrections became aware of his further offending. Corrections were made aware shortly after Jesse's arrest on 24 November 2020 using the E*Justice electronic system shared with Victoria Police. This is a systemic issue in many CCO related FV

deaths (and non-FV cases) where Corrections have delayed authorising contravention action after significant non-compliance with CCO conditions by high risk offenders.[13]

38. By 20 November 2020, Jesse had already accrued four unacceptable absences including:

    a) 13 October 2020 – failure to attend drug testing;

    b) 26 October 2020 – failure to attend supervision without lawful excuse;

    c) 6 November 2020 – failure to attend drug testing; and

    d) 20 November 2020 – testing positive for drug and alcohol use.

COMMENTS

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

Corrections' case management of Jesse Tovey

39. Corrections Victoria has 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, are accountable for their actions and undergo any court-ordered rehabilitation, while they make amends for their offences. By providing case management services to offenders subject to CCOs, there is a responsibility to ensure that risks to the community and safety of the offender's family members/intimate partners are minimised.

40. File records and notes on Jesse's Corrections management file appear to be lacking details, missing or completed late. The appropriate actions to mitigate Jesse's substance abuse escalation appear to have not been taken as evident in the records provided to the Court by Corrections Victoria.

41. The failure to take earlier action through proactive monitoring of Jesse's CCO compliance is a significant missed opportunity to intervene in the circumstances leading to Joshua's death. Whilst Joshua's death may not have been prevented, failing to take earlier contravention action was a missed opportunity to actively manage and hold Jesse to account and ensure that he underwent any court-ordered treatment for his substance abuse, mental health and offending behaviour.

[13] Past relevant coronial investigations including: COR 2016/2831, COR 2016/2914, COR 2016/6105, COR 2015/4974, COR 2017 2477 and COR 2019 0022

42. This case, and other similar family violence homicide related deaths[14] in this period, highlight systemic issues in the way CCO offenders are case managed, including but not limited to: poor risk identification and management, inadequate drug testing and compliance, failures to attend supervision and seek treatment and significant delays in authorising contravention action.

43. Corrections Victoria has informed the Court that in 2017 as a part of statewide changes, the organisation has introduced the Professional Practice Stream (**PPS**). This framework separates practitioners into three streams depending on their core role and provides more in-depth supervision and training according to their work stream. The PPS reportedly aims to '*improve the application of evidence-based approaches by Community Correctional Services (**CCS**) practitioners and shift the focus from compliance to offender management, and to increase the quality and integrity of offender case management*'[15]. Corrections Victoria also advised that offender compliance could now be reviewed by '*newly created practices',* such as the establishment of Risk and Review Panels and Compliance Review Hearings.

44. An Enhanced Supervision Framework has also been introduced which has been designed to '*reinforce accountability, support professional development and assist CCS staff to achieve best practice*'.[16] Supervision is now required to occur fortnightly with the understanding that case managers will discuss their management of offenders on their caseloads.

45. The Victorian Auditor-General's Office prepared a report in February 2017 on the management of CCOs and they noted in their report that, "*there is a shortage of adequately trained staff to meet the increase in offenders on CCOs, business processes are inefficient, and the fragmented information management environment impedes timely decision-making and effective coordination*."[17]

46. I note that the evidence from Corrections Victoria provided in the coronial inquest into Kylie Cay's death[18] and responses the Department of Justice and Community Safety (**DJCS**) indicating that the organisation is heavily reliant on paper files and that an overhaul of the current paper-based system with appropriate prompts for compliance, would greatly improve

[14] COR 2016/2831, COR 2016/2914 and COR 2015/4974
[15] Corrections Victoria, Response to the Court dated 12 March 2021, 1-2
[16] Ibid
[17] Victorian Auditor-General Office, *Managing Community Correction Orders*, report dated February 2017, available online at: www.audit.vic.gov.au/sites/default/files/20170208-Community-Corrections.pdf
[18] COR 2016/2831, 46

the efficient case management of CCO offenders to ensure that non-compliance does not get out of control and continue for long periods of time unchecked.

47. I refer to the Secretary to the Department of Justice and Community Safety's response dated 8 November 2021 in a previous coronial investigation in which a commitment was made to support the introduction of improvements to electronic case management to improve responses to non-compliance subject to Government Budgeting.[19] The Court will continue to monitor coronial investigations evidencing similar concerns raised in this case and suggest appropriate recommendations where systemic issues arise.

48. Despite recent developments, I still hold strong concerns regarding the management of non-compliance of CCO offenders and the procedures for contravention action. I note that current practice guidance provided to CCS practitioners suggests that non-compliance should usually be addressed by applying the least interventionist measure possible, for example by starting with a caution and eventually escalating to contravention proceedings.[20] However, contravention proceedings can be considered immediately if the offender absconds, if the conditions of the CCO will not be completed before the CCO expires, if further offending has occurred, or if the risk to the community becomes too high.[21]

49. There appears to be no detailed guidance within current policies to assist a case manager in determining when a risk to the community has become too high. Such guidance could provide additional assistance to CCS practitioners in better using their discretion to commence contravention action when appropriate. This guidance should also be based on MARAM risk assessments in situations where the offender has contact with an intimate partner or family members in the community.

50. I further note concerns that after CCS practitioners decide to authorise contravention proceedings it can take several weeks, if not months, for the matter to be listed for hearing and for a warrant to be served on the offender. The hearing can also be delayed further if the offender requests an adjournment of the proceedings.

51. The Royal Commission into Family Violence noted the importance of perpetrator accountability in preventing future perpetration of family violence. Swift and efficient

[19] COR 2016/6105, response from the Secretary to the Department of Justice and Community Safety dated 8 November 2021.
[20] *Deputy Commissioner's Instruction 10.7.2 – Responding to non-compliance* (version 2, February 2018, 15 under heading 6.10 – Contravention.
[21] Ibid.

responses to breaches of FVIOs and CCOs can enhance perpetrator accountability by ensuring that perpetrators receive timely and appropriate consequences for their actions. Delays in enforcement of FVIOs and CCOs can embolden family violence perpetrators and lead them to believe that there are no consequences for their actions.[22]

52. It is therefore important that contraventions of CCOs are responded to in a timely manner, particularly in relation to family violence perpetrators. A limited pilot program to fast-track proceedings relating to contravention of CCOs has been trialled at the Dandenong Magistrates' Court.[23] This trial aimed to reduce the time in between when the contravention was authorised to when the proceedings were heard in court. An evaluation of this program has been conducted but is confidential and has not been released to the CCOV.

RECOMMENDATIONS

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

Corrections Victoria

To improve processes related to the administration of justice, I recommend that Corrections Victoria review case management policies relating specifically to managing non-compliance for CCO offenders and the procedures for contravention action.

The policies should provide greater clarity to assist a case manager in determining when a risk to the community has become too high. Such guidance could provide additional assistance to CCS practitioners in better using their discretion to commence contravention action when appropriate. This guidance should also be based on MARAM risk assessments in situations where the offender has contact with an intimate partner or family members in the community.

Attorney-General – Department of Justice and Community Safety

To improve processes related to the administration of justice, I recommend that the Attorney-General and the Secretary of the Department of Justice and community Safety review funding for the Magistrates Court of Victoria so the Magistrates Court is funded to expand fast-track contravention hearings for breaches of a CCO state-wide. Fast-track approaches should be a standard practice across Magistrates' Courts in Victoria. The ability of a specialised court list to efficiently deal with CCO contravention proceedings involving family violence offending

[22] *Royal Commission into Family Violence Final Report (March 2016), Volume III, Chapter 17, 231*
[23] See Practice Direction No.10 of 2017 – Fast tracking of the hearing and determination of contravention of community corrections orders (Magistrates Court of Victoria).

could reduce the time between a contravention of a CCO and proceedings being listed in court thereby reducing the risk of harm or serious injury.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Joshua Tovey, born 6 November 1991;

    b) the death occurred on 18 January 2021 at Western Port Marina, Mullet Street, Hastings, Victoria, 3915, from a stab wound to the chest; and

    c) the death occurred in the circumstances described above.

55. I convey my sincere condolences to Joshua's family for their loss.

56. 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.

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

Ms Deanne Tovey, Senior Next of Kin

Mr Brandon Furlan, Senior Next of Kin

The Honourable Jaclyn Symes MLC, Attorney-General of Victoria

The Honourable Enver Erdogan MP, Minister for Corrections, Minister for Youth Justice, Minister for Victim Support

Ms Kate Houghton, Secretary to the Department of Justice and Community Safety

Ms Melissa Westin, Deputy Commissioner, Custodial Operations, Corrections Victoria

Ms Karen Holmes, Acting Director, Community Operations and Parole, Corrections Victoria

Detective Sergeant Jake Ferguson, Coroner's Investigator

Signature:

Judge John Cain

Date : 13 September 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.