IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 6105

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:	MWJ
Date of birth:	5 February 1979
Date of death:	24 December 2016
Cause of death:	1(a) Acute external and internal blood loss and 1(b) Single stab wound to upper left chest
Place of death:	Kangaroo Flat, Victoria
Catchwords:	Intimate partner homicide; community corrections order

INTRODUCTION

1. On 24 December 2016, MWJ was fatally stabbed in his home residence at Pauline Street, Kangaroo Flat. At the time of his death, MWJ was 37 years old.

2. MWJ was born in Frankston Hospital and grew up in the Mount Eliza area. MWJ completed high school and partially completed university studies. He loved the outdoors and worked at several outdoor camping retailers until gaining employment as a tree lopper and studying to become an Arborist.

3. MWJ commenced a relationship with MM and they had one child together, a son born in 2008. The relationship unfortunately broke down in December 2013 and MWJ was observed by family to have experienced a rapid deterioration in his mental health. MWJ was also reported to have started abusing illicit substances around this time.

4. MWJ started a relationship with EW in late 2013. EW had two children from a past relationship and was living an itinerant lifestyle with MWJ. During the relationship, friends and family of MWJ and EW observed the couple to both be abusing drugs, in particular cannabis and methylamphetamine.

5. EW initially moved into a house that MWJ owned with his former partner but due to financial difficulties, the property was sold. The couple then became homeless for a period of time. During this period, EW's children went to live with their father.

6. MWJ and EW eventually relocated to Bendigo towards the end of 2015 until September 2016 when MWJ was remanded in custody for one month due to driving and property offences.

7. Shortly after MWJ returned to the community and resumed living with EW, the couple were evicted from their rental property and began staying with friends until the couple moved to a unit leased to a friend of EW on Pauline Court in Kangaroo Flat. The couple stayed at this unit until the fatal incident.

THE CORONIAL INVESTIGATION

8. MWJ'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.

9. 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.

10. 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.

11. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of MWJ'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.

12. This finding draws on the totality of the coronial investigation into the death of MWJ, including evidence contained in the coronial brief and further evidence obtained under my direction. 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

13. EW and MWJ had allegedly been arguing in the days preceding the fatal incident.[2] EW reported that she had also struck MWJ to the face in the days prior to the fatal incident.[3]

14. On 24 December, around midday, EW went out and bought some groceries and alcohol; MWJ was still in bed asleep at the time. EW returned home around 2:00 pm, and woke MWJ up about 45 minutes later.[4]

[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*, Record of Interview with EW, 137
[3] Ibid, 149
[4] Ibid, 146

15. After MWJ got up, the couple argued again about their plans for Christmas; the argument escalated and continued over the course of the next three hours.

16. During this period, several neighbours heard a man and woman yelling, screaming and swearing at each other, coming from the couple's residence.[5] They also heard numerous doors being slammed. On several occasions, EW attempted to leave the house. On a number of these occasions MWJ followed her out onto the street, and either told her to come back inside, or dragged her back inside.[6] On one occasion, EW left the address before returning to the house voluntarily. Another time, as EW was walking out the front door, her head appeared to suddenly snap back, as though somebody had grabbed her hair from behind.[7]

17. Shortly after 5:30 pm, one of the neighbours called the police to report that there was a "*domestic*" going on at the couple's residence.[8] EW left the house with blood on her arms, legs and clothes, she appeared hysterical and was asking for someone to call an ambulance.[9]

18. Police members arrived at the residence around 6:00 pm, they found the front door open and EW sitting in the hallway.[10] As they approached the front door, they saw MWJ lying on his back on the hallway floor. The carpet around him was observed to be soaked with blood and his body was cold to touch.[11]

19. EW reportedly told police members that, "*I was trying to get out of the house and I stabbed him, is he ok?*"[12] EW confirmed that she had stabbed MWJ about 30 minutes earlier and that he had walked around for a bit before he had collapsed.

20. Despite attempts at resuscitation by attending police and paramedics, MWJ was unable to be revived.[13] EW was arrested on scene by attending police members and was taken to the Bendigo Police Station.

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[5] *Coronial Brief*, Statement of John Camm dated 24 December 2016, 38-40; Statement of Benjamin James Camm, dated 24 December 2016, 42-43; Statement of Zoe Kate Sanders dated 24 December 2016, 48-49
[6] *Coronial Brief*, Statement of John Camm dated 24 December 2016, 38-40
[7] Ibid
[8] *Coronial Brief*, Statement of Zoe Kate Sanders dated 24 December 2016, 49
[9] Ibid
[10] *Coronial Brief,* Statement of Constable Amanda Carrod dated 24 December 2016, 88-89
[11] Ibid
[12] Ibid, 89
[13] *Coronial Brief*, Statement of MM dated 27 February 2017

21. On 28 March 2018, in the Supreme Court of Victoria, EW was found guilty and convicted for the manslaughter of MWJ. EW was sentenced to 7 years imprisonment with a non-parole period of 4 years.[14]

Identity of the deceased

22. Upon reviewing the available evidence, Coroner Rosemary Carlin completed a Form 8 *Determination by Coroner of Identity of Deceased* dated 27 December 2016, concluding that the identity of the deceased was MWJ born 5 February 1979.

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

Medical cause of death

24. Forensic Pathologist Dr Malcolm Dodd from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 26 December 2016 and provided a written report of his findings dated 6 March 2017.

25. Dr Dodd noted the following:

    (a) external examination of the body revealed a single stab wound to the upper left chest measuring 18mm in length;

    (b) the blade used in the fatal incident entered the body to a depth of 40 to 50mm as measured from the skin surface to the small incised injury to the apex of the left upper lobe of the lung. It would appear that the blade has incised the vascular complex leading to external blood loss and also a large blood collection within the left chest cavity; and

    (c) external examination also showed an area of bruising to the dorsum of the left hand and a small superficial abrasion measuring 15x4mm, indicative of defensive type injury.

26. Toxicological analysis of post-mortem samples identified the presence of methylamphetamines, alcohol and cannabis. None of these detected substances were at levels that suggest a connection to the mechanism of death in this case.

27. Dr Dodd provided an opinion that the medical cause of death was '1(a) Acute external and internal blood loss' and '1(b) Single stab wound to the upper left chest'.

[14] *DPP v Walker* [2018] VSC 83, 9

28. I accept Dr Dodd's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

29. As MWJ's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**) [15] examine the circumstances of MWJ's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[16]

30. The available evidence suggests that MWJ and EW's relationship was tumultuous and characterised by numerous family violence incidents primarily perpetrated by MWJ.

31. MWJ's relationship with EW met the definition of '*partner'* under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).[17] The act of stabbing MWJ during the fatal incident met the definition of '*family violence'* in the FVPA.

32. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with MWJ and EW prior to MWJ's death.

History of family violence between MWJ and EW

33. The available evidence suggests that MWJ and EW engaged in drug use, predominately methylamphetamine, throughout their relationship. EW's mother, JS, reported that she observed MWJ to be controlling and verbally aggressive towards EW[18] and advised that he exerted coercive control and often threatened suicide[19]. It is alleged that MWJ also had access to weapons and that he had previously had a weapons room with homemade weapons and baseball bats. MWJ reportedly spoke about the damage he could inflict on others with these weapons and made such comments in front of EW's children.[20]

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[15] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[16] 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.

[17] Section 8(1)(a) of the *Family Violence Protection Act 2008*

[18] Ibid, 68

[19] Ibid, 71

[20] Ibid.

34. JS also stated that there were instances where EW was the perpetrator of family violence and was physically violent towards MWJ. An example being an occasion where EW allegedly struck MWJ with a bottle in order to get his attention.[21]

35. On 14 May 2015, MWJ's ex-partner, MM, applied for a Family Violence Intervention Order (FVIO), citing MWJ's verbal abuse and threats to kill both her and himself. MM also referenced MWJ's drug use and mental health issues as additional concerns. MM stated that since MWJ had been removed from the family home, he had become more violent, threatening and aggressive towards her.[22] The matter was listed for 9 June 2015 and a five-year order was made against MWJ in protection of MM and their child, CJ.[23]

36. Following service of the order upon MWJ dated 9 June 2015, MWJ reportedly breached the FVIO on 18 July 2015 when he attended MM's property and spoke with Cooper. This breach was reported to the Police, and Police made several attempts to serve MWJ with a charge of breaching the FVIO.[24] From the records available, it appears that MWJ was not charged with this breach until his arrest in September 2016. At the time of this breach, MWJ was on a 12-month Community Corrections Order (CCO).[25] This breach is the only reference to family violence in MWJ's LEAP record.

37. On 26 July 2016, MR, EW's former partner and father to her two children, applied for a FVIO at Frankston Magistrates Court against EW. MR stated in the narrative of his FVIO application that the children had been residing with him since March 2015, and that in February 2016, EW had taken the children for a weekend and had failed to return them. MR further stated that one of the children had returned to live with him in May 2016 because he had been scared while in the care of EW, and that their other child had return to live with him in July 2016. As further detailed in his application, MR reported that their daughter had witnessed physical violence between EW and MWJ as well as drug usage. MR also noted that EW had sent a text message threatening to kill him following discussions about Child Protection's alleged preference for the children to be in his care.[26]

38. On 18 September 2016, an incident occurred where MWJ was heavily intoxicated and driving erratically with EW in the car. EW claimed that she feared for her safety and tried to stop the

[21] Ibid, 70, 72.
[22] Family Violence Intervention Order Application F11717909 made 14 May 2015
[23] Family Violence Intervention Order F11717909 made 9 June 2015.
[24] LEAP records of MJ, incident number 150224345, 388.
[25] Corrections Victoria, Corrections record of MJ, 85.
[26] Family Violence Intervention Order Application G12036871 made 26 July 2016.

car. EW alleged, and subsequently told family and friends, that MWJ had pulled the car over, picked up a brick and threatened to assault her with it.[27] The police attended at the scene, however, at the time, EW did not disclose the violence perpetrated by MWJ. On this occasion, MWJ was remanded into custody for a range of charges, including reckless conduct endangering, theft charges, breach of a FVIO (in relation to his ex-partner MM) and for committing an indictable offence whilst on bail.[28]

39. As a result of these charges, MWJ was held on remand from 18 September 2016 to 21 October 2016. While MWJ was remanded in custody, EW reconnected with an old friend, RM. EW disclosed to RM that there was physical violence in her relationship with MWJ as well as isolation and emotional and psychological abuse.[29] EW informed RM that MWJ '*controlled everything including all the money*'[30]. RM, who had experience working with family violence services, reported overhearing MWJ's phone calls to EW whilst he was in remand. RM advised that MWJ would sound '*manic and demanding*',[31] and rant about '*people he was going to kill when he got out*'[32].

40. On 21 October 2016, MWJ was granted bail from Bendigo Magistrates Court. As a part of his bail conditions, MWJ was required to reside at Carpenter Street, Kangaroo Flat, the address of friend, RJ. Following MWJ's release, EW also lived at this property and her relationship with MWJ resumed.

41. Whilst residing at this property, RM observed MWJ being verbally and emotionally abusive towards EW. RM stated that MWJ was often manic and '*had an obsession with knives and sticks from the garden*'[33]. RM also stated that there was an occasion at the start of December 2016, when she was verbally and physically assaulted by MWJ in front of EW. On this occasion, MWJ reportedly threatened to kill RM and drove her car erratically while RM and EW were passengers.[34]

42. Approximately two months before MWJ's death, MWJ and EW left Ms Jenkin's address upon Ms Jenkin's request.[35] The couple began staying with JL at Pauline Court, Kangaroo Court.

[27] Coronial Brief, Record of Interview of EW, 157.
[28] Ibid, 7.
[29] Statement of R Maddox, 3.
[30] Ibid.
[31] Ibid, 2.
[32] Ibid.
[33] Ibid, 3.
[34] Ibid.
[35] Coronial Brief, Statement of JS

This property was owned by the Department of Health and Human Services – Housing and was let to Ms Lawton at the time.

43. JL stated that she had known EW for approximately 30 years and MWJ for 3-4 years.[36] JL stated that the couple both consumed considerable amounts of alcohol and were both using methylamphetamines, however, noted that she had never observed any physical violence between the parties.[37] JL advised that EW had stayed with her several months prior to this occasion and that she had previously requested EW leave. JL claimed that on this occasion, EW had perpetrated psychological abuse towards her and that she had changed the locks following her departure.[38] JL believed that EW had also perpetrated similar behaviour towards MWJ.[39]

44. RM returned to Bendigo to visit the Pauline Court property on the night of 22 December 2016. That evening, RM observed EW as withdrawn and formed the view that EW was preparing to leave the relationship.[40] RM observed MWJ '*putting knives everywhere'*,[41] including '*in between the gaps in the couch'*[42] and that he was '*sharpening sticks for most of the night'*[43].

Corrections and the management of Community Correction Orders

45. 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.

46. At the time of the fatal incident, both EW and MWJ were the subjects of CCOs and each of them had a case manager from Corrections Victoria.

47. MWJ was originally sentenced to a 12-month CCO commencing 31 May 2015. He contravened this order due to non-compliance with his conditions; failed to report within two clear working days; failed to notify change of address within two clear working days; and failed to attend two supervision appointments. The contravention was heard at the Dandenong Magistrates' Court on 2 February 2016. As a result, MWJ's contravention of his CCO was proven and his order

[36] Coronial Brief, Statement of JL, 60.
[37] Ibid.
[38] Ibid
[39] Ibid.
[40] Statement of RM, 5.
[41] Ibid.
[42] Ibid.
[43] Ibid.

varied, removing the unpaid community work condition. His varied CCO (case number 201509605) commenced on 2 February 2016 and was to run for twelve months. His ordered conditions included Assessment and Treatment for drug abuse, mental health and programs to reduce re-offending. On this same day, MWJ was sentenced to an additional CCO (case number 201601151) for driving/theft related matters which were committed during the operational period of his first order. This CCO also commenced on 2 February 2016 and was to run for twelve months, with the conditions for supervision, assessment and treatment for drug abuse, mental health, programs to reduce re-offending and to perform 200 unpaid community work hours.[44]

48. On 8 June 2016, EW was found guilty of drink driving, two counts of unlicensed driving, failing to answer bail, driving an unregistered vehicle, assaulting an emergency worker, drug possession and a number of property/deception related offences. EW was sentenced and placed on a CCO which expired on 7 August 2017. EW's CCO required her to perform 100 hours of community work; attend regular supervision with a CCS case manager and undergo assessment and treatment as directed for drug abuse, alcohol abuse and mental health as directed.[45]

49. Corrections Victoria is responsible for the management of offenders who are made subject to CCOs and usually a case manager from a regional Community Correctional Service (**CCS**) is assigned to each offender in their local catchment. The management of both EW's and MWJ's CCOs in the circumstances of this case raised significant concerns, including:

(a) the case management of EW's and MWJ's compliance with their respective CCO conditions; and

(b) the timeliness of responses to EW's and MWJ's failure to comply with their respective CCO conditions.

Concerns with the case management of MWJ's and EW's CCO

50. MWJ only completed 7.5 hours of his mandated 200 hours of community service work and only attended one day of work at Eaglehawk Recovery Yard on 25 May 2016 and never returned.

51. Additionally, MWJ only attended one session with ASCO for drug treatment assessment on 6 June 2016 and was not recommended for drug and alcohol counselling but was strongly recommended to refer to a general practitioner (GP) for a mental health care plan to address his

[44] Corrections Victoria response dated 12 March 2021, 2-3
[45] Ibid, 9

current stress and emotional regulation. Whilst MWJ's CCO case manager directed him to seek a GP for approval for a mental health care plan, MWJ never saw a GP to get this referral and thus never got assessment or treatment for his mental health.

52. MWJ also failed to attend his regular supervision appointments with his case manager and disengaged from Corrections as early as 4 June 2016.

53. EW completed her initial induction with her CCO case manager on 30 June 2016 but only attended supervision on two further occasions, the 18 July 2016 and the 18 August 2016. EW failed to attend any further supervision appointments in person after 18 August 2016 even though she was meant to meet with her case manager on a monthly basis depending on her progress and compliance with her order.

54. EW attended a supervision appointment with her case manager on 18 August 2016 and provided a medical clearance indicating that she was fit for work. This documentation was provided to the Community Work team and she was contracted to commence unpaid community work at Bendigo Family and Financial on Thursdays on a weekly basis commencing 15 September 2016. EW did not commence her unpaid community work, as she failed to attend her supervision appointments in order to sign this contract. As such, her contract was cancelled on 19 September 2016 and she never completed any of her required unpaid community work.

55. Whilst EW was initially assessed by a GP for a mental health care plan and by a drug and alcohol counsellor for drug and alcohol treatment, EW never attended any appointments for treatment throughout her CCO operational period. She also failed to do a drug screen on 19 August 2016 and whilst her case manager followed up with telephone calls and text messages on 24 August 2016, no further steps were taken to action this unacceptable absence.

Delays in taking contravention action in the appropriate timeframe

56. Corrections Victoria confirms that case managers in 2016 were guided by Deputy Commissioner's Instruction 10.3 – Non-Compliance Management – Court Orders. A review of the relevant Deputy Commissioner's Instruction indicates that during 2016:

(a) The key requirements for case managers are that *"investigation of all non-compliance is to commence within five working days of notification and resolved within three weeks of the instance of non-compliance"*.[46]

[46] *Deputy Commissioner's Instruction 10.3 – Non-Compliance Management – Court Orders*, Issue May 2016, page 1.

(b) Activating an intervention step should be considered when: two or more consecutive absences from the same program area have occurred.[47]

57. An intervention step should be activated based on the offender's individual circumstances, with the primary purpose to re-engage with the offender. The intervention steps that were available as of May 2016 were:

(a) Compliance Meeting;

(b) Case Management Review Meeting;

(c) Senior Officer Caution – Operations Manager or delegate;

(d) Administrative Review Hearing;

(e) Application to vary CCO;

(f) Contravention proceedings.

58. For MWJ, the requirement to take an intervention step was met as early as 18 May 2016 after he failed to perform unpaid community work as directed on 1 March 2016 and 18 May 2016, yet no intervention step was taken by his CCO case manager throughout the duration of his CCO other than an authority to commence contravention action which wasn't approved until 28 October 2016. Victoria Police were unable to successfully serve MWJ having attempted service on 20 December 2016 and 24 December 2016.

59. For EW, the requirement to take an intervention step was met as early as 21 July 2016 after she failed to attend supervision on 7 July 2016 and 21 July 2016 after completing induction on 30 June 2016.[48] In EW's case, the following intervention steps were taken:[49]

(a) A Compliance Meeting was held between EW and her case manager on 18 August 2016, in order to discuss with EW her non-compliance with the intent to identify those issues that were impacting upon her engagement and compliance with her order. Strategies such as providing transport assistance through the provision of a Myki card and continued text messages to remind her of appointments were to no avail.

[47] Ibid, page 4
[48] Corrections Victoria response dated 12 March 2021, 9-10
[49] Ibid, 12-13

(b) A Case Management Review Meeting also occurred on 2 September 2016 in order for the case manager to discuss alternative strategies to engage EW.

(c) An Administrative Review Hearing was scheduled for 22 September 2016, however this was subsequently cancelled as a result of CCS being unable to serve EW with the required documentation.

(d) An authority to commence contravention action was submitted and approved on 7 December 2016.

60. In EW's case, the available evidence suggests that an authority to commence contravention action could have been exercised as an intervention step much earlier due to EW's lack of progress and response to her order and engagement with her case manager. By August 2016, EW had already accrued six unacceptable absences from supervision and failed to attend drug and alcohol treatment on two occasions on 8 and 19 August 2016.[50] Whilst there is a discretion to choose which intervention step to take in response to non-compliance, EW's case manager should have considered commencing contravention action much earlier in light of the negative responses to earlier intervention steps and continued non-compliance with CCO conditions.

COMMENTS

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

Corrections Victoria

61. 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.

62. The failure to take earlier action through proactive monitoring of both EW's and MWJ's CCO compliance was a significant missed opportunity to intervene in the circumstances leading to MWJ's death. Whilst MWJ's death may not have been prevented, failing to take earlier

[50] Ibid, 12

contravention action was a missed opportunity to actively manage and hold MWJ and EW to account and ensure that they undergo any court-ordered rehabilitation.

63. This case, and other similar family violence homicide related deaths[51] 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.

64. 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 CCS practitioners and shift the focus from compliance to offender management, and to increase the quality and integrity of offender case management*'[52]. 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.

65. 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*'.[53] Supervision is now required to occur fortnightly with the understanding that case managers will discuss their management of offenders on their caseloads.

66. 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*."[54]

67. I note that the evidence from Corrections Victoria provided in the coronial inquest into Kylie Cay's death[55] indicated that the organisation was heavily reliant on paper files and that an overhaul of the current paper-based system with appropriate prompts for compliance, would

[51] COR 2016/2831, COR 2016/2914 and COR 2015/4974
[52] Corrections Victoria, Response to the Court dated 12 March 2021, 1-2
[53] Ibid
[54] 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
[55] COR 2016/2831, 46

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

Third party reporting of family violence

68. MWJ's death, and deaths similar to his[56], highlight the difficult and often dangerous predicament that family violence presents to family, friends and others who either become aware of it, or suspect it is occurring. Many times, third parties feel, understandably, ill-equipped to assist or are concerned that any intervention may increase the danger for the victim or themselves.

69. In an effort to address the barriers that third parties face in obtaining access to information about family violence and providing information and assistance to victims of family violence, the Royal Commission into Family Violence[57] reviewed the available resources for third parties.

70. At its conclusion, predominantly by way of recommendations 10 and 37, the Royal Commission encouraged the adoption of a model whereby third parties (as well as victims and perpetrators of family violence) can access information via a website to assist in recognising family violence and how to seek help, both in the crisis period and during longer term recovery.[58]

71. This Court is advised that the Victorian Government has selected the Orange Door[59] website as the most suitable existing site with the capacity to develop into a space for the delivery of accessible information for those experiencing, witnessing and being affected by family violence. The Court is also informed that, in line with the Royal Commission's recommendation, the website is now currently in operation.[60]

The introduction of Support & Safety Hubs (Orange Doors)

72. A central feature of the State Government's response to the Royal Commission's recommendations is the introduction of the Orange Doors (also known as Support and Safety Hubs)[61] at locations across Victoria, a central point for the family violence response network which will:

    a) receive police referrals, referrals from non-family violence services, including family and

[56] CIR 2016 1876, COR 2017 2423 and COR 2017 1889
[57] Victoria, Royal Commission into Family Violence Final Report (March 2016).
[58] Victoria, Royal Commission into Family Violence, Recommendation 10
[59] http://orangedoor.vic.gov.au
[60] http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=12>; *The Lookout* website can be found at http://www.thelookout.org.au
[61] Victoria, Royal Commission into Family Violence, Recommendation 37

friends, as well as self-referrals;

b) provide a single, area-based entry point into local specialist family violence services, perpetrator programs and integrated family services and link people to other support services;

c) perform risk and needs assessments and safety planning using information provided by the recommended state-wide central information point;

d) provide prompt access to the local Risk Assessment and Management Panel;

e) provide direct assistance until the victim, perpetrator and any children are linked with services for longer term support;

f) book victims into emergency accommodation and facilitate their placement in crisis accommodation;

g) provide secondary consultation services to universal or non-family violence services; and

h) offer a basis for co-location of other services likely to be required by victims and any children.[62]

73. In MWJ's case, education and information via a website, such as the Orange Door website may have provided an initial avenue for family members and friends to assist him and EW, while the Orange Doors may have provided an opportunity to report concerns and create more tangible opportunities for intervention and prevention. The challenge for informal supporters assisting persons affected by family violence is often knowing what information and services are available and how to access these supports.

74. The Orange Doors are required to be safe and inclusive and be designed to meet the diverse needs of the community. Specific requirements for the Orange Door accessibility will be to:

(1) actively tailor their services to the needs of CALD communities in their Local Area – including through the use of interpreting services, safe meeting places, having workers in the Hubs from CALD communities and embedding appropriate cultural practices;[63] and

(2) have the capability to recognise and meet the specific needs of people with disabilities, LGBTI people, older people experiencing violence, and adolescents who use violence in

[62] Victoria, Royal Commission into Family Violence, *Summary and Recommendations* (2016) 55
[63] Victorian Government, *Support and Safety Hubs: Statewide Concept 2017*, 19

the home.[64]

75. This Court is informed that the Department of Premier and Cabinet, along with Family Safety Victoria, is currently collaborating with partner agencies to design and implement the Orange Doors State-wide. Orange Doors currently operate in eight areas across Victoria.[65]

76. There are also a range of other websites which contain information and resources for third party supporters like friends and family to assist potential family violence victims. Some examples include:

- DVRCV: <https://www.dvrcv.org.au/help-advice/guide-for-families-friends-and-neighbours>
- Safe Steps: <https://www.safesteps.org.au/understanding-family-violence/information-for-family-friends/>
- 1800 respect: <https://www.1800respect.org.au/violence-and-abuse/domestic-and-family-violence/support>
- My Safety: <http://mysafety.org.au>
- Burndawan: <http://burndawan.com.au>
- The Safe and Together Institute (US): <http://safeandtogetherinstitute.com/wp-content/uploads/2020/05/A4_AllyDoc_web.pdf

RECOMMENDATIONS

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

Corrections Victoria:

I endorse the recommendation of Deputy State Coroner English in her findings into the death of Kylie Cay[66] and recommend that Corrections Victoria introduce an electronic case management system to enhance Community Correctional Services management of an offender's compliance with their Community Corrections Order.

[64] Ibid
[65] Bayside Peninsula, North Eastern Melbourne, Inner Gippsland, Barwon, Mallee, Loddon, Goulburn and Central Highlands
[66] COR 2016/2831

The system needs to address issues identified in this case such as the lack of awareness of non-compliance, lack of supervision and the supervisors' awareness of non-compliance, and the ability to address non-compliance early.

The system should allow case managers the ability to create a schedule outlining how each condition will be completed and contain key milestones that must be reached. This will ensure that starting at induction, case managers and offenders will have a clear case plan to complete and comply with conditions. The system should also allow supervisors the ability to oversee the management of serious offenders with an automated overview of their compliance which allows early interventions to occur when non-compliances are logged.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was MWJ, born 5 February 1979;

(b) the death occurred on 24 December 2016 in Kangaroo Flat, Victoria from 1(a) Acute external and internal blood loss and 1(b) Single stab wound to upper left chest; and

(c) the death occurred in the circumstances described above.

79. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.

80. I convey my sincere condolences to MWJ's family for their loss.

81. 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.

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

Mr and Mrs J, Senior Next of Kin

Ms Genevieve Thornton, Acting Director, Family Violence Reform, Department of Fairness, Families and Housing

Ms Eleri Butler, CEO, Family Safety Victoria

The Honourable Natalie Hutchins, Minister for Corrections

Ms Rebecca Falkingham, Secretary, Department of Justice and Community Safety

Detective Leading Senior Constable Chris Saulle, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 12 August 2021

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.