



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 4974

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:	Simone Quinlan
Date of birth:	23 March 1982
Date of death:	25 August 2015
Cause of death:	1(a) Multiple Injuries
Place of death:	Abandoned mineshaft in Kangaroo Flat, Victoria
Catchwords:	Intimate partner homicide, family violence

INTRODUCTION

1. On 25 August 2015, Simone Quinlan was found deceased in an abandoned mineshaft in the Kangaroo Flat area of Victoria. At the time of her death, Ms Quinlan was 33 years old. At the time of her death she was homeless and living with friends and her partner, Brendan Neil. Ms Quinlan is survived by her two children.
2. Ms Quinlan was born in Melton and grew up in the family home with her parents Lynda and Wayne Quinlan and her brother Troy. In her youth, Ms Quinlan enjoyed dancing and played netball.
3. Ms Quinlan completed Year 11 at Sydenham Catholic Regional College before commencing a Veterinary Science Course at Victoria University. Ms Quinlan discontinued her studies after falling pregnant with her first child.
4. After her relationship broke down with the father of her first child, Ms Quinlan became engaged to Nathan Mitchell. She had a second child with Mr Mitchell.
5. Ms Quinlan had an extensive illicit substance use history and mainly used Cannabis, Methamphetamines and Heroin. Ms Quinlan eventually lost care and responsibility for her children due to her lifestyle and substance misuse but had limited access supervised through family and her former partner, Mr Mitchell.
6. Ms Quinlan formed a relationship with Mr Neil in April 2015 and Ms Quinlan moved into Mr Neil's residence at 21 Killarney Drive, Melton.
7. Ms Quinlan had been periodically homeless in the period leading up to her death and her lifestyle was unstable. She was incapable of caring for her two sons and, due to her lack of stable accommodation and her substance misuse, she tended to drift to and from Mr Neil's address, despite the fact that she had from time to time endured controlling and violent treatment at his hands.
8. An incident occurred on 13 June 2015 when Ms Quinlan sought medical treatment at night for an injury to her head that needed to be sutured. She later reported to police that this injury had been caused by Mr Neil hitting her with a baseball bat.
9. Sometime in July 2015, Ms Quinlan sought refuge with her close friend, Tammy Newton who lived in Hillside. Ms Quinlan stayed on and off with Ms Newton, living between her residence and Mr Neil's in the lead up to the fatal incident.

10. On 10 August 2015, Ms Quinlan arrived at Ms Newton's residence and alleged that Mr Neil had assaulted her with a baseball bat. She was observed by Ms Newton to have bruises on her arms, upper thighs, back and defensive injuries to her hands and knuckles.
11. There was a subsequent incident at Ms Newton's house on 19 August 2015 when Mr Neil allegedly drove onto the front yard of the home and threw a rock through the front windows of Ms Newton's house whilst Ms Quinlan was taking refuge there. Police attended the incident and Ms Quinlan made a statement that day to police about the incidents on 13 June 2015 and 19 August 2015.
12. Ms Quinlan stated that she was very scared of Mr Neil. The police initiated a Family Violence Intervention Order (**FVIO**) to protect her on the strength of her statement. Police invited Mr Neil to attend for an interview about these matters on 20 August 2015, but he did not attend.

THE CORONIAL INVESTIGATION

13. Ms Quinlan'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.
14. 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.
15. 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.
16. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Quinlan'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.

17. This finding draws on the totality of the coronial investigation into the death of Ms Quinlan, 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

18. In the lead up to the fatal incident, Mr Neil blamed Ms Quinlan for unwanted police attention, and was upset that she had re-ignited contact with her ex-boyfriend, Danny Fisher, upon his release from prison. Mr Neil believed that Ms Quinlan and Mr Fisher were using heroin together and that Ms Quinlan had stolen property from him to use for her own purposes or give to Mr Fisher.²
19. On 25 August 2015, at approximately 12.02 pm, Ms Quinlan contacted police seeking to withdraw her family violence complaint and saying that the statement she made on 19 August 2015 was false.³ The call was made from Mr Neil's phone. Mr Neil failed to attend another appointment with police in relation to the same subject matter, which had been arranged for 2.00 pm that day.⁴
20. Later that afternoon, Mr Wayne Marmo, an associate of Mr Neil, and others had planned to bring some stolen chainsaws to exchange with Mr Neil for some of the drug, 'ice'. However, on arrival at the premises it was apparent that Mr Neil was angry with Ms Quinlan and she was being interrogated and accused of 'lagging'.⁵ Mr Marmo and his associates sat in the vicinity of the kitchen taking turns to smoke ice supplied by Mr Neil whilst he assaulted her in the living room.
21. Mr Marmo was in possession of a .22 rifle during the time he was at the Killarney Drive premises that day.⁶ Mr Marmo was cutting down the barrel of the rifle in the vicinity of the

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 Madeline Kendall dated 24 September 2015, 162-163; Statement of Danny Fischer dated 15 September 2015, 219-220

³ *Coronial Brief*, Statement of Constable Jessica Greenwood dated 13 November 2015, 460

⁴ *Ibid*

⁵ *Coronial Brief*, Statement of Tracey Storen dated 26 September 2015, 372-373

⁶ *Ibid*, 373

kitchen during the period Mr Neil was assaulting Ms Quinlan. Mr Neil's abuse of Ms Quinlan escalated over the period that Mr Marmo and his associates were present in his house.

22. The available evidence in the coronial brief contains conflicting statements but it is clear that Ms Quinlan was brutally assaulted and bound, with a significant amount of blood covering the floor beneath her body.⁷ Mr Neil organised for his associates, mainly Mr Marmo, to carry Ms Quinlan onto the back tray of a utility vehicle that Mr Marmo had driven to Mr Neil's house.
23. Mr Marmo left the premises with some associates to dispose of Ms Quinlan. Although several statements from witnesses indicate that Ms Quinlan appeared to be dead from the assault at Killarney Drive at this stage,⁸ it is not possible to state with certainty exactly what her condition was when she was placed in the utility, other than that she was at least very seriously injured and appeared not to be moving or speaking at that time.
24. Mr Marmo stopped the utility vehicle near Anthony's Cutting, Bacchus Marsh. He expressed concern to his associates that he believed Ms Quinlan might be still alive, because he thought he saw the cover of the tray moving.⁹ Mr Marmo reportedly got out of the vehicle and lifted the cover and fired several shots into Ms Quinlan's head using the rifle that he had cut down that afternoon in Mr Neil's house. Mr Marmo then got back in the driver's seat and drove on looking for a place to dispose of Ms Quinlan's body. Mr Marmo eventually drove on towards an area of disused mineshafts at Kangaroo Flat where he unloaded Ms Quinlan's body and dropped it down a mineshaft before dousing her body in petrol and igniting it.¹⁰
25. Mr Marmo then drove to a carwash at around 1.00 am and washed the tray of the utility with a pressure hose to remove blood. At a later stage the utility was incinerated by Mr Marmo to conceal further evidence.¹¹
26. On 13 September 2015, Mr Marmo's partner attended at the Werribee Police Station and detailed concerns to a police member about Mr Marmo being involved in the murder of a female named Simone Quinlan.¹² The police then commenced an investigation and eventually

⁷ Ibid

⁸ Ibid, 375

⁹ Ibid

¹⁰ Ibid

¹¹ *Coronial Brief*, Statement of Tracey Storen dated 4 October 2015, 387

¹² *Coronial Brief*, Statement of Detective Acting Sergeant Chris Black dated 15 December 2015, 168-169

Mr Neil and his complicate associates were charged and arrested in connection to Ms Quinlan's death.

27. On 30 September 2015 an extensive search was undertaken at the Kangaroo Flat area to recover the remains of Ms Quinlan.¹³ Search teams were able to locate the mine shaft where the remains of Ms Quinlan had been placed.
28. On 14 December 2017, in the Supreme Court of Victoria, Mr Neil and Wayne Marmo were found guilty of the murder of Ms Quinlan. Mr Neil was sentenced to 26 years imprisonment with a non-parole period of 22 years. Wayne Marmo was sentenced to 22 years imprisonment with a non-parole period of 20 years¹⁴

Identity of the deceased

29. Upon reviewing the available evidence, Coroner Rosemary Carlin completed a Form 8 *Determination by Coroner of Identity of Deceased* dated 12 October 2015, concluding that the identity of the deceased was Simone Quinlan born 23 March 1982.
30. Identity is not in dispute and requires no further investigation.

Medical cause of death

31. Forensic Pathologist Dr Jacqueline Lee from the Victorian Institute of Forensic Medicine (VIFM), conducted an autopsy on 1 October 2015 and provided a written report of her findings dated 11 January 2016.
32. Dr Lee noted the following:
 - (a) the autopsy revealed an incinerated body with gunshot wounds to the back of the head and a single gunshot wound of the left orbital plate;
 - (b) several potentially fatal causes of death were identified at autopsy. These included gunshot wounds to the head, blunt impact force to the head with subsequent skull fractures and possible covering of the nose and mouth by tape; and
 - (c) the gunshot wound injuries, the blunt impact force injuries and the potential covering of the nose and mouth may have all contributed to or directly caused death. There is no way

¹³ *Coronial Brief*, Statement of Detective Senior Constable Sophie Leete dated 14 December 2015, 488

¹⁴ *DPP v Neil & Marmo* [2017] VSC 761, 36

to objectively find that one was more substantive than the other in causing or contributing to death.

33. Toxicological analysis of post-mortem hair samples identified the presence of amphetamines and methylamphetamine. None of these detected substances were at levels that suggest a connection to the mechanism of death in this case.
34. Dr Lee provided an opinion that the medical cause of death was ‘1(a) Multiple Injuries’.
35. I accept Dr Lee’s opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

36. As Ms Quinlan’s death occurred in circumstances of recent family violence, I requested that the Coroners’ Prevention Unit (CPU)¹⁵ examine the circumstances of Ms Quinlan’s death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).¹⁶
37. Ms Quinlan’s relationship with Mr Neil met the definition of ‘*domestic partner*’ under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).¹⁷ The fatal incident involved an assault by Mr Neil towards Ms Quinlan which meets the definition of ‘*family violence*’ in the FVPA, specifically the repeated physical assaults that contributed to her death, as did Mr Neil’s alleged assaults of Ms Quinlan prior to the fatal incident.
38. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with Mr Neil and his close associate, Mr Marmo, and Ms Quinlan prior to Ms Quinlan’s death.

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 9(1)(b) of the *Family Violence Protection Act 2008*

39. The available evidence suggests that several key risk factors¹⁸ were present in this case that indicated a greater risk of a fatal outcome.
40. Two victim specific risk factors were present with respect to Ms Quinlan, specifically substance misuse/abuse and isolation. Ms Quinlan had ongoing substance misuse issues which were present prior to and during her relationship with Mr Neil. Due to her substance abuse issues, Ms Quinlan was also isolated from her family.¹⁹ Both of these factors made Ms Quinlan susceptible to ongoing violence.
41. Mr Neil exhibited ten perpetrator specific risk factors, specifically:
- Use of weapon in most recent event,
 - Access to weapons
 - Drug and/or alcohol misuse/abuse
 - Has ever threatened to kill the victim
 - Unemployment
 - Previous or current breach of Intervention Order
 - Jealous behaviour towards victim
 - Depression/Mental Health issue
 - Has ever harmed or threatened to harm victim,
 - History of violent behaviour.
42. Of the above risk factors, the first five factors listed may indicate an increased risk of the family violence victim being killed. Two relationship specific risk factors were also present in the relationship of Mr Neil and Ms Quinlan, specifically recent separation,²⁰ and an escalation in the frequency and severity of violence.²¹ Both of these risk factors may indicate an increased risk of the victim being killed.
43. Having evaluated the available evidence in this case, I note several concerns with key services provided to Ms Quinlan, Mr Neil and Mr Marmo in the lead up to the fatal incident. These concerns relate to:

¹⁸ The *Family Violence Risk Assessment and Risk Management Framework*, known as the *Common Risk Assessment Framework* (CRAF) was used to analyse the circumstances of this case as it was the risk assessment tool available in the period leading up to the fatal incident. CRAF details a number of evidence based risk factors which have been found to impact on the likelihood and severity of family violence. These risk factors are divided into three categories: those which relate to the victim of family violence, those which relate to the perpetrator, and those which relate to the relationship. The CRAF also identifies several additional factors which can impact on the options and outcomes available to family violence victims. CRAF was in use in 2015 but has since been replaced by an updated risk assessment tool referred to as the *Family Violence Multi-Agency Risk Assessment and Management Framework* (MARAM).

¹⁹ *Coronial Brief*, Statement of Lynda Quinlan dated 15 September 2015, 181-182

²⁰ *Ibid*

²¹ *Coronial Brief*, Statement of Nathan Mitchell dated 16 September 2015, 195-196

- (a) the management of Mr Neil under a Community Corrections Order that he was subject to at the time of the fatal incident;
- (b) Victoria Police contact with Mr Neil and Ms Quinlan; and
- (c) the support provided by Women's Health West to Ms Quinlan.

Corrections and the management of Community Correction Orders

44. 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.
45. At the time of the fatal incident, both Mr Neil and Mr Marmo were the subject of a CCO and had a case manager from Corrections Victoria.
46. On 29 April 2015, Mr Neil had was found guilty and convicted of unlawful assault and persistent contravention of an FVIO in relation to his former partner. Mr Neil was sentenced to a 15-month CCO with conditions requiring him to participate in 275 hours of community work, be assessed and treated for drug abuse and dependency, participate in mental health assessment, and offending behaviour programs.²² Mr Neil was also required to attend a Judicial Monitoring Hearing²³ on 24 August 2015.
47. 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 Mr Neil's and Mr Marmo's CCOs in the circumstances of this case raised significant concerns, including:
- (a) the appropriate identification of family violence risk to family members close to Mr Neil;
 - (b) timely responses to Mr Neil's failure to comply with his CCO conditions; and
 - (c) the preparation of accurate judicial monitoring reports prior to Judicial Monitoring Hearings.

²² Corrections management file – Brendan Neil, 299-300

²³ Judicial Monitoring Hearings are hearings at which a Magistrate reviews the progress, personal circumstances and compliance of an offender who is subject to a CCO.

48. On 1 June 2015, Mr Neil's case manager incorrectly assessed Mr Neil as being at Moderate Risk - Priority 2. Her assessment indicated that Mr Neil had 'no History of harmful behaviour.'²⁴ However, on 23 September 2015, Mr Neil was updated to a High Risk – Priority 1, with this change purportedly due to the update that Mr Neil did in fact have a '*history of harmful behaviour*.'²⁵ The supervisor's earlier assessment had failed to take into account the charges that resulted in the CCO. Had Mr Neil been assessed as High Risk – Priority 1 initially, his supervision whilst on the CCO should have been more stringent and frequent.
49. On 5 June 2015, Mr Neil reported to his supervisor that he was under stress in relation to his family law proceedings with his ex-partner, Ms Dillon. He indicated his belief that Ms Dillon was attempting to amend her FVIO to include their children, and stated that the family court matter was adjourned to the 30 September 2015. There are no further comments made by the supervisor in relation to these disclosures. They do not appear to have prompted the case manager to request a copy of the current FVIO, nor does it appear to have prompted an updated risk assessment to occur.²⁶
50. On 18 June 2015, in Drug and Alcohol supervision Mr Neil self-reported that he had used methamphetamine in the prior week due to not being able to see his child for his birthday. This information was relayed to Mr Neil's Melton CCS supervisor; however, this did not prompt them to begin drug testing or to undertake further risk assessment.²⁷
51. Risk assessments assist case managers and offenders in identifying whether the offender's risk has changed since conviction, and tailor the level of intervention to the needs of the offender. Under the policies in place at the time of the fatal incident, case managers and senior officers were also required to undertake '*holistic consideration and monitoring*'²⁸ of an offender's circumstances in order to determine their risk to themselves, others and the community. In doing so, case managers were instructed to consider the past behaviours of the offender, the extent of harm posed to the community should the offending behaviour occur, trends in the case and file pertaining to risk, the relationship between current presenting behaviours/attitudes and the risk of re-offending, compliance with the CCO (both historic and current) and any other relevant factors.

²⁴ Corrections management file – Brendan Neil, 137

²⁵ Risk of Harm and Priority Rating Matrix, 1 June 2015 and 23 September 2015.

²⁶ Corrections management file – Brendan Neil, 5 June 2015.

²⁷ Corrections management file – Brendan Neil, 98.

²⁸ Department of Justice and Regulations, 10.2.2. *Deputy Commissioner's Instruction- management of Court Orders*, 21.

52. Case managers are also instructed to consider ‘*red flags*’ when assessing risk, including consideration of whether the offender had had ‘*further police contact and/or interest since order commencement*’.²⁹ Current iterations of this document provide similar advice.
53. Despite the policies in place at the time of the fatal incident and in reflection of the policies available now, the case manager did not address the presenting risk factors or ‘*red flags*’ noted during case management.
54. A report was prepared by Corrections Victoria on 13 July 2015 for Mr Neil’s Judicial Monitoring hearing on 24 August 2015. The report mentioned Mr Neil’s ongoing drug usage, stating that Mr Neil had used methamphetamine the previous week. However, the family violence incident between Mr Neil and Ms Quinlan on 19 August 2015 and her subsequent reports of his ongoing violence took place in the period between when the report was prepared, and when the judicial monitoring hearing occurred. This meant that important information about Mr Neil’s increasing risk was not contained in the report prepared for the judicial monitoring hearing.
55. The important information about risk indicators which occurred between the time the report was drafted, and the date of the hearing included the following:
- (a) On 16 July 2015, Mr Neil reported to his CCO case manager that his Family Court hearing had not gone well for him, and that he had left in tears.³⁰
 - (b) On 20 July 2015 Mr Neil reported to his CCO case manager that his partner of three months had moved into his house four weeks ago. He further reported that he had Family Court coming up on the 10 September 2015.³¹ Mr Neil reported no drug or alcohol use to his case manager and that he was due to see his Drug and Alcohol counsellor that day.³² Mr Neil then presented to Stepping Up for Drug and Alcohol counselling and reported that he had been using drugs daily ‘*due to peer associations, stress due to court and ‘having too much free time.*’³³
 - (c) On 30 July 2015, during a supervision appointment Mr Neil again did not report any drug use to his CCO case manager. However, Mr Neil stated to his Drug and Alcohol counsellor

²⁹ Ibid, 22.

³⁰ Corrections Records, 16 July 2015.

³¹ Corrections management file – Brendan Neil, 81.

³² Ibid.

³³ Stepping Up Clinical Notes, 20 July 2015.

that he was still using but had reduced his consumption considerably due to participating in work and not being able to engage with the acquaintances he usually used drugs with.³⁴

(d) On 14 August 2015 Mr Neil informed his supervisor that he and Ms Quinlan had broken up and he asked for the authority to exchange information with Ms Quinlan to be revoked. Mr Neil also reported that an FVIO had been put against him by a former partner's friend. The CCO case manager requested a copy of the FVIO from Mr Neil.³⁵ Mr Neil reported using methamphetamine the day before to deal with his separation from Ms Quinlan.³⁶

(e) At around this time the CCO case manager was also informed by Mr Neil's treating psychologist that he was extremely depressed and suicidal and arrangements were made for Mr Neil to participate in weekly sessions with her.³⁷ Mr Neil then failed to appear at his next psychologist appointment on 21 August 2015, his stated reasons being that he *'forgot about appointment due to drama occurring in his personal life.'*³⁸

56. The above factors of separation, substance misuse, perpetration of violence against others and mental health issues are family violence risk factors and should have been flagged as such as they indicated a heightened risk of Mr Neil perpetrating family violence against Ms Quinlan, including lethal violence. Whilst some of this information was not directly disclosed to Mr Neil's CCO case manager, they should have made reasonable enquiries with his providers to check on his progress and his compliance. In addition to being incorporated as part of ongoing risk assessment, these should also have been considered in relation to the judicial monitoring report that was prepared.

Victoria Police proximate service contact with Ms Quinlan and Mr Neil

57. The available evidence indicates that Mr Neil and Ms Quinlan had several interactions with Victoria Police in the lead up to the fatal incident. This service contact raises several concerns including:

(a) why Mr Neil was never prosecuted for breaching a suspended sentence in the circumstances of this case;

³⁴ Stepping Up Clinical Notes, 7 August 2015.

³⁵ Corrections management file – Brendan Neil, 68.

³⁶ Ibid.

³⁷ Corrections management file – Brendan Neil, 68.

³⁸ Corrections management file – Brendan Neil, Non Compliance Report 28 August 2015.

(b) whether the delay in arresting and interviewing Mr Neil in relation to criminal charges for assaulting Ms Quinlan on 19 August 2015 was reasonable; and

(c) whether Victoria Police should have conducted a welfare check on Ms Quinlan after she withdraw her complaint against Mr Neil.

58. On 5 June 2013 Mr Neil was imprisoned for reckless conduct endangering life and failing to stop a motor vehicle. These charges arose from an incident where Mr Neil fled from police in his vehicle at a high speed. The sentence he received was for six months imprisonment, three months of which were to be suspended for 18 months.³⁹ Mr Neil was released in September 2013 subject to the terms of his suspended sentence which would expire in March 2015.⁴⁰
59. Mr Neil continued to perpetrate family violence and engage in criminal activity during the term of his suspended sentence. In March 2014 Ms Dillon obtained a FVIO protecting her and her children from Mr Neil. On 25 April 2014 Ms Dillon reported that Mr Neil had breached the FVIO by sending Ms Dillon numerous text messages and emails. These breaches were not logged in LEAP until 11 July 2014, when Mr Neil was charged with persistent breaches of a FVIO and unlawful assault.⁴¹
60. On 29 April 2015 Mr Neil was convicted of unlawful assault and persistent contravention of a FVIO, with respect to Ms Dillon, at the Sunshine Magistrates' Court and was placed on a 15-month CCO. Victoria Police do not appear to have prosecuted Mr Neil for a breach of the suspended sentence when they prosecuted these charges.
61. On 19 August 2015 Mr Neil was reported to have perpetrated family violence, including criminal assaults, against Ms Quinlan, but was not present when police attended this incident. A FVIO was applied for via Complaint and Warrant and the LEAP records for this incident indicate that Mr Neil was to be arrested and interviewed in relation to potential criminal charges. Victoria Police called Mr Neil the following morning, 20 August 2015, and arranged for him to attend the Melton police station for interview, but he did not attend. Victoria Police then attended Mr Neil's property four days later, on 24 August 2015, but he was not present, so they left a card.⁴² Mr Neil then arranged to attend the station at 2.00pm on 25 August 2015, but he again did not attend.⁴³

³⁹ Corrections management file – Brendan Neil, Victoria Police Court Outcomes Report page 2 of 3, 271.

⁴⁰ Ibid.

⁴¹ LEAP records of B Neil, 101.

⁴² LEAP records of B Neil, 57.

⁴³ Coronial Brief, Statement of J Greenwood, 460

62. Mr Neil was not arrested in relation to the warrant arising from this incident until 27 August 2015, eight days after the family violence incident and two days after Ms Quinlan’s death. At that time, he was charged with criminal damage, conduct endangering life and discharging a missile, and released on bail pending a hearing on 31 August 2015. The bail conditions included conditions protecting Ms Quinlan from Mr Neil.⁴⁴
63. I note that the Victoria Police Code of Practice⁴⁵ at the time, specifically provides that when a warrant is issued, police ‘*take immediate steps to have it executed as soon as possible.*’⁴⁶ Victoria Police possibly should have been more proactive in arresting and interviewing Mr Neil between 19 August 2015 and 27 August 2015.
64. During the day of 25 August 2015 Ms Quinlan called Victoria Police to withdraw her statement and FVIO in relation to Mr Neil. It is unclear whether this phone call occurred during the fatal assault, but call records indicate that the call was made from Mr Neil’s phone. The member who spoke to Ms Quinlan on this occasion said that there was no indication that Ms Quinlan was distressed or under duress during this phone call, although they noted that she did sound ‘*odd.*’⁴⁷
65. It is important to note that whilst Ms Quinlan indicated that she wanted to withdraw her complaint, this did not result in police withdrawing the FVIO application for her protection or the criminal charges against Mr Neil. There are no requirements in police policies and procedures that require them to subsequently conduct a ‘welfare check’ on an affected family member if they have attempted to withdraw an application over the telephone.

COMMENTS

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

Women’s Health West and L17 referrals

66. Following the family violence incident between Ms Quinlan and Mr Neil on 19 August 2015 a VP Form L17 (L17) referral was made to Women’s Health West (**WHW**) with respect to Ms Quinlan.⁴⁸ An L17 refers to the Victoria Police Risk Assessment and Management Report that

⁴⁴ LEAP records of B Neil, Briefing Note 19 August 2015, 56.

⁴⁵ Code of Practice for the Investigation of Family Violence, Edition 3 V2 2014, 32-34

⁴⁶ Ibid

⁴⁷ Coronial Brief, Statement of J Greenwood, 461.

⁴⁸ Records provided to the Court by Women’s Health West dated 19 August 20, 2-6

Victoria Police are required to complete after they have attended a family incident. The report is completed when family incidents, interfamilial-related sexual offences, and child abuse are reported to police. The report includes information on the incident itself, the affected family member and other party (OTH), hazards/risk factors present at the time of the incident and any actions taken by Victoria Police following the incident including referrals for support.

67. On 20 August 2015, WHW workers attempted to contact Ms Quinlan by calling her mobile phone and leaving a message.⁴⁹ Notes from records provided by WHW state that they intended to call her again, however they did not make any further attempts to do so.⁵⁰
68. The prevailing Police Referral (L17) Triage Policy at the time of Ms Quinlan's death required WHW staff respond to referrals in an '*appropriate and timely manner and in order of their level of risk*'.⁵¹ The level of risk is dictated by codes used on the L17 report. In this case, the WHW worker had recorded that the risk level was code 2 in accordance with the likelihood of future family violence occurring and the severity of family violence recently experienced by Ms Quinlan. The '*Case Progress Narrative*' described Ms Quinlan as having being assaulted with a baseball bat and noted that assault charges were pending against Mr Neil.⁵² The triage policy and procedure required workers to make their first attempt to contact Ms Quinlan within 24 hours and subsequently make six attempts over two weeks to contact her. They were to reassess priority if no contact was made after those six attempts.
69. Ms Quinlan was killed five days after the first and only attempt at contact. It appears that WHW workers did not adhere to the applicable policies when they made no further attempts to contact Ms Quinlan again. While there is no indication that Ms Quinlan would have accepted support had she been contacted successfully, it is nevertheless a missed opportunity to have provided Ms Quinlan with further support.
70. WHW confirm that since Ms Quinlan's death, the organisation continues to implement a range of continuous improvements including regular internal and external training, comprehensive orientation for new case managers, development of client databases, frequent staff supervision and partnering with external services to support the exit of victim survivors to other agencies.⁵³

⁴⁹ Records provided to the Court by Women's Health West dated 19 August 20, 7

⁵⁰ Records provided to the Court by Women's Health West dated 19 August 20, 1

⁵¹ Women's Health West – Police Referral (L17) Triage Policy and Police Referral L17 Triage Procedure

⁵² Records provided to the Court by Women's Health West dated 19 August 20, 6

⁵³ Response from Women's Health West dated 2 July 2021

In 2020, WHW have also engaged external consultants to develop and implement a range of demand management strategies to optimise processes and maximise service capacity.⁵⁴

71. WHW also confirm that in order to manage the growth in demand for family violence services that has not been matched by commensurate funding growth, they have revised their L17 triage and response protocols.⁵⁵ The discrepancy in increasing demand and lack of funding growth means that:

(a) call frequency to L17s has had to be reduced to meet demand;

(b) regular daily triaging is now conducted by an assigned senior case manager to prioritise L17s holding higher risk indicators; and

(c) dedicated specialist family violence roles have been developed to respond to victim survivors with a police application intervention order, those exiting crisis accommodation and to support victim survivors on the case management waiting list.

Corrections Victoria

72. 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 partner are minimised.

73. This case and other similar family violence homicide related deaths⁵⁶ 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 inadequately prepared judicial monitoring reports.

74. 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*

⁵⁴ Ibid

⁵⁵ Ibid, 4

⁵⁶ COR 2016/2831, COR 2016/2914, COR 2016/6105 and COR 2014/6608

*compliance to offender management, and to increase the quality and integrity of offender case management*⁵⁷. 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.

75. 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*’.⁵⁸ Supervision is now required to occur fortnightly with the understanding that case managers will discuss their management of offenders on their caseloads.
76. 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.*”⁵⁹
77. I note that the evidence from Corrections Victoria provided in the inquest into Kylie Cay’s death⁶⁰ 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 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.

Victoria Police

78. The available evidence indicates that Mr Neil was never charged in relation to breaching his suspended sentence. Whilst it is not for the Court to speculate on the possible sentencing outcomes had Mr Neil been prosecuted for breaching a suspended sentence, it is likely that given his failure to comply with his CCO, and his multiple contraventions of FVIOs, that a period of imprisonment was highly probable.
79. I note that it is speculative to suggest that Mr Neil serving a period of imprisonment would have had any positive impact on him or altered the trajectory of his relationship with Ms Quinlan. I confirm, however, and Victoria Police have conceded, that this was a missed opportunity for intervention and to hold Mr Neil accountable for his actions. I also confirm that suspended

⁵⁷ Corrections Victoria, Response to the Court dated 31 July 2020, 4

⁵⁸ Ibid

⁵⁹ 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

⁶⁰ COR 2016/2831, 46

sentences in the Magistrates' Court were abolished in 2014 for all offences committed on or after 1 September 2014.⁶¹

80. In relation to the actions taken by police members to execute the outstanding warrant against Mr Neil, the available evidence confirms that:

(a) upon their return to Melton Police Station on 19 August 2015, the attending police members submitted a 'whereabouts' for Mr Neil, noting that if located he was to be arrested and interviewed;⁶²

(b) on 20 August 2015, a police member spoke with Mr Neil by telephone and requested that he attend the Melton Police Station to be interviewed in relation to the family violence incident and the alleged assault of Ms Quinlan. Mr Neil told the police member that he would attend that day but did not;⁶³ and

(c) four days later, on 24 August 2015, a police member attended Mr Neil's property, but he was not present, so she left a card for him to contact police.⁶⁴

81. I note however that Mr Neil had a significant history of perpetrating violence against multiple partners over many years and a clear disregard for the conditions of FVIOs imposed on him. Whilst it is speculative to suggest that charging Mr Neil earlier would have prevented Ms Quinlan's death, it is important for investigating police members to prioritise the execution of warrants based on risk associated with specific case scenarios.

82. Victoria Police confirm that the current version of the Code of Practice contains a practice note to assist members in the service of FVIOs and states that if the respondent has been identified as high risk, consideration of service of a FVIO must be given priority by police.⁶⁵ With respect to criminal offences, the *Victoria Police Manual and Guidance – Family Violence* states that where an alleged offender is not at the scene, members are to conduct an investigation in order to locate and interview the alleged offender within 24 hours and if unable to locate within 24 hours, to submit a Person Whereabouts Desired and consider a Person Warning Flag.⁶⁶ I accept

⁶¹ *Sentencing Amendment (Abolition of Suspended Sentences & Other Matters) Act 2013* (Vic)

⁶² *Coronial Brief*, Statement of Constable Jessica Greenwood dated 13 November 2015, 460

⁶³ *Ibid*

⁶⁴ *Ibid*

⁶⁵ Statement of Assistant Commissioner Lauren Callaway dated 14 October 2020, 10

⁶⁶ *Ibid*

that current police practices for service of FVIOs and family violence related criminal charges prioritise making contact with the alleged offender.

83. In relation to conducting a welfare check after an alleged family violence victim contacts police by telephone to withdraw a complaint, I note that a welfare check may not necessarily uncover any harm beyond establishing that the affected family member is alive and physically well. It may be difficult for police to establish if there are ongoing safety concerns if the affected family member is concealing duress or coercion for fear of retribution by the perpetrator. I accept the submissions of Victoria Police that the potential benefits of a system of welfare checks is likely to outweigh the significant burden on police resources.
84. I note that there is no requirement that police are not to notify respondents prior to the service of an Application and Warrant for FVIOs and/or Family Violence Safety Notices to the effect that they are the subject of a complaint of family violence. This is a gap in the system that should be addressed as the circumstances of this case illustrate: once perpetrators are made aware of a complaint of family violence allegations against them, it is possible that they could evade service and perpetrate further violence against the affected family member. The affected family member is also vulnerable as the protections offered by a FVIO do not take effect until service upon alleged perpetrator.

RECOMMENDATIONS

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

Victoria Police:

I recommend that Victoria Police update the Code of Practice and relevant family violence policies and procedures to include advice recommending that police members do not contact alleged family violence perpetrators by telephone prior to the service of a family violence safety notice or intervention order. The advice should highlight the vulnerability of affected family members when a safety notice or intervention order is not yet in effect and the potential evasion of service by an alleged perpetrator upon notification that a family violence allegation has been made against them.

Corrections Victoria:

I endorse the recommendation of Deputy State Coroner English in her findings into the death of Kylie Cay⁶⁷ 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. 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.

I also recommend Corrections Victoria implement training for all Community Correctional Services staff state-wide who are involved in preparation of Judicial Monitoring reports, regarding their composition and contents to improve the quality and accuracy of these reports.

FINDINGS AND CONCLUSION

86. Pursuant to section 67(1) of the Coroners Act 2008 I make the following findings:
- (a) the identity of the deceased was Simone Quinlan, born 23 March 1982;
 - (b) the death occurred on 25 August 2015 at an abandoned mineshaft in Kangaroo Flat, Victoria from 1(a) Multiple Injuries; and
 - (c) the death occurred in the circumstances described above.
87. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.
88. I convey my sincere condolences to Ms Quinlan's family for their loss.

⁶⁷ COR 2016/2831

89. 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.

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

Mr Wayne Quinlan, Senior Next of Kin

Ms Alison Boughey, Director, Women's Health West

The Honourable Natalie Hutchins, Minister for Corrections

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

Ms Lauren Callaway, Assistant Commissioner, Family Violence Command, Victoria Police

Ms Lindsey Walker, Victorian Government Solicitor's Office

Detective Leading Senior Constable Peter Towner, Coroner's Investigator

Signature:



JUDGE JOHN CAIN

STATE CORONER

Date: 6 July 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.
