IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006797

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

*Amended on 6 May 2026 pursuant to section 76 of the **Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	Elizabeth Susan Edwina Ferris
Date of birth:	12 January 1978
Date of death:	26 November 2022
Cause of death:	1a: Hypoxic ischaemic encephalopathy complicating cardiac arrest in the setting of presumed drug toxicity
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004
Keywords:	Family violence; intimate partner violence; drug toxicity

* Footnote 12 was missing and has been updated to reflect the correct reference.

INTRODUCTION

1. On 26 November 2022, Elizabeth Susan Edwina Ferris was 44 years old when she died in hospital following a presumed drug overdose. At the time of her death, Elizabeth lived in South Melbourne.

2. Elizabeth was born in Australia and was Māori. She was placed into residential care in her teens following Child Protection involvement with her family. She remained estranged from her family at the time of her death.[1]

3. From 1995, Elizabeth was engaged with the mental health system. She was diagnosed with schizoaffective disorder and polysubstance use at an unknown date.[2] She had multiple inpatient admissions for her mental health and was on a community treatment order under the care of the Alfred Health St Kilda Road Clinic at the time of her death, and received a fortnightly Zuclopenthixol[3] depot.[4]

4. Elizabeth had a long history of police engagement, dating back to her teens. She lived a transient lifestyle, often finding herself homeless due to her mental health issues. At the time of her death, she lived in housing provided by the Department of Families, Fairness and Housing.

5. Elizabeth had been in a relationship with Jason Beaton from around 2012. Victoria Police received several reports of family violence from 2012 until Elizabeth's death, with most of those reports identifying Elizabeth as the victim of family violence perpetrated by Mr Beaton. The reports included details of:

    a) Verbal abuse by Mr Beaton towards Elizabeth;

    b) Mr Beaton making threats to kill Elizabeth;

    c) Attempted and actual physical violence by Mr Beaton towards Elizabeth, including strangling;

    d) Controlling behaviour and financial abuse by Mr Beaton towards Elizabeth; and

[1] *Coronial Brief*, Statement of Dr Nicholas Mims, p. 15.
[2] Alfred Health Medical Records of Elizabeth Beaton; *CORONIAL BRIEF*, Statement of Dr Nicholas Mims, p. 15.
[3] Zuclopenthixol decanoate is a long-acting antipsychotic injection used for treatment of psychotic illnesses and prevention of future episodes.
[4] *Coronial Brief*, Statement of Dr Nicholas Mims, p. 15.

e) Systems abuse by Mr Beaton towards Elizabeth.

THE CORONIAL INVESTIGATION

6. Elizabeth'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 Coronial Investigator for the investigation of Elizabeth's death. The Coronial 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 Elizabeth Susan Edwina Ferris including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

11. In considering the issues associated with this finding, I have been mindful of Elizabeth's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

[5] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not 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.

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

Circumstances in which the death occurred

12. Not much is known about Elizabeth's movements or activities in the period proximate to her death. Mr Beaton told police that he last saw her on 9 November 2022, when she told him she was going to the bank.

13. Elizabeth received her last Zuclopenthixol depot during a home visit at 10:00 am on 10 November 2022.[6] Her presentation was noted to be superficially pleasant with no agitation.[7]

14. At 11:18am on the same day, members of the public located Elizabeth unconscious and not breathing in Fishley Street, South Melbourne. Emergency services attended and found her to be in Brady PEA (Pulseless Electrical Activity). They commenced cardiopulmonary resuscitation, with a return of spontaneous circulation occurring at 12 minutes. She was conveyed to the Alfred Hospital by ambulance.

15. Despite this medical intervention, Elizabeth's condition remained precarious. An MRI showed severe global hypoxic ischaemic encephalopathy, and the neurological impression was of severe and likely irreversible cognitive injury.

16. On 21 November 2022, the decision was made to palliate Elizabeth. She was intubated and passed at 12:50 pm on 26 November 2022.

Identity of the deceased

17. On 5 December 2022, Elizabeth Susan Edwina Ferris, born 12 January 1978, was identified via fingerprint identification.

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

Medical cause of death

19. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 9 December 2022 and provided a written report of her findings dated 22 March 2023.

[6] Alfred Health Medical Records of Elizabeth Beaton.
[7] *Coronial Brief*, Statement of Dr Nicholas Mims, p. 15.

20. The autopsy identified features in keeping with severe hypoxic ischaemic encephalopathy, subacute bilateral aspiration pneumonia, patchy cardiac fibrosis and rib and sternal fractures in keeping with resuscitation.

21. There was no evidence of natural disease, or injuries which may have caused or contributed to death.

22. No ante-mortem specimens were available for toxicological analysis and no toxicological analysis was performed in hospital. Analysis of post-mortem blood showed substances that were administered in hospital as part of medical treatment.

23. Toxicological analysis of hair identified the presence of 6-monoacetylmorphine[8], morphine[9], codeine[10], methadone and metabolite, diazepam and metabolite, midazolam, methylamphetamine and metabolite, cannabis metabolite, fentanyl, oxycodone, ketamine and buprenorphine[11].

24. Dr Fronczek provided an opinion that the medical cause of death was 1(a) hypoxic ischaemic encephalopathy complicating cardiac arrest in the setting of presumed drug toxicity. I accept her opinion.

Non-fatal strangulation

25. The evidence indicates that Mr Beaton strangled Elizabeth on several occasions during their relationship.

26. Australian and international research has established that non-fatal strangulation greatly increases the risk of escalating violence or death in an intimate partner relationship and is commonly screened for in family violence risk assessments. The use of strangulation by a perpetrator in an intimate partner relationship is used to exert psychological and physical dominance over the victim. Strangulation can cause victims to fear for their life and safety and experience feelings of powerlessness and terror. Strangulation can also have physical consequences for victims that may be subtle or delayed and can have consequences for their

[8] The principal metabolite of heroin.
[9] The principal metabolite of heroin.
[10] Often found as an impurity of heroin.
[11] Information obtained from the Department of Health indicates that there was a permit to treat Elizabeth with methadone and/or buprenorphine for opioid dependence.

long-term health. Recognition of the impact of strangulation by police and services is critical for understanding the risk posed to a victim's safety and their health needs.[12]

27. Given the long-term impacts that non-fatal strangulation can have on an individual's health, I queried with Dr Fronczek whether there had been evidence of non-fatal strangulation at autopsy.

28. Dr Fronczek advised that a post-mortem CT scan was undertaken, along with other examinations, and confirmed that there was no evidence of strangulation:

> *At autopsy, there was no evidence of any injuries that may have caused or contributed to death. There were no injuries about the neck. I do note the hospital admission of ~11 days before passing. Possible injuries that may have been present at the time of admission, may have disappeared or changed. However, I note that no neck injuries are described in the received medical records.*

CPU REVIEW

29. The evidence available to me indicated that Elizabeth experienced family violence throughout her life, including in the lead-up to her death. Accordingly, I requested that the Coroners Prevention Unit (**CPU**)[13] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**)[14].

30. I make observations concerning service engagement with Elizabeth as they arise from the coronial investigation into her death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in my observations, and Elizabeth's death.

31. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour, and this carries an implicit danger in prospectively evaluating events through *'the potentially distorting prism of hindsight'*. I make observations about services who had contact with

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[12] Safe and Equal, *Understanding Non-fatal Strangulation,* available online at: https://safeandequal.org.au/wp-content/uploads/NFS_TipSheet_A4_FINAL_01.pdf

[13] 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.

[14] 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.

Elizabeth to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Alfred Health

32. Elizabeth was engaged with Alfred Health for mental health treatment prior to her death.

33. A review of the medical record indicates that Elizabeth made several disclosures of violence to Alfred Health throughout her treatment. Records indicate that her risk of violence was queried by clinicians, that she was offered referrals to support services and that staff communicated with Victoria Police in relation to her experience of violence.[15]

34. The CPU advised me that they did not hold concerns in relation to Elizabeth's engagement with Alfred Health, and I accept that advice.

The Orange Door

35. Elizabeth was referred to the Orange Door following reports of family violence on 30 January 2022 and 8 October 2022. In both instances, the service attempted to contact Elizabeth to no avail and closed their engagement as a result.

36. The CPU advised me that they did not hold concerns related to the Orange Door, and I accept that advice.

Victoria Police

37. There were 15 reports to Victoria Police of family violence between Elizabeth and Mr Beaton between 2012 and her death. The CPU's review focussed on the two incidents that occurred during 2022, being most proximate to fatal incident.

<u>Family violence incident on 30 January 2022</u>

38. On 30 January 2022, Elizabeth approached security services at her apartment building and advised that Mr Beaton had assaulted her. She was noted to be bleeding from her nose at the time.[16]

39. Police attended and spoke to Elizabeth who stated that she and Mr Beaton had engaged in a verbal dispute, after which she produced a knife and threatened to stab him. Mr Beaton

[15] Alfred Health Medical Records of Elizabeth Ferris.
[16] L17 records for Elizabeth Ferris, p. 9-10.

grabbed her, disarmed her and punched her to the face. CCTV footage then shows Elizabeth attempting to prevent Mr Beaton from leaving the apartment block by blocking his exit.[17]

40. At the time of police attendance, Mr Beaton had left the scene. Elizabeth was transported to the Alfred hospital with a suspected broken nose.[18]

41. At the time of the incident, a limited Family Violence Intervention Order (**FVIO**) was in place with Elizabeth listed as the Affected Family Member (**AFM**). In response to this incident, however, police applied for an FVIO with limited conditions with Mr Beaton listed as the AFM and Elizabeth as the respondent.[19]

42. The incident was assessed as high risk and Elizabeth was subsequently arrested and interviewed. She was bailed to appear at Court on 16 February 2022.[20]

Misidentification of the predominant aggressor

43. The CPU considered that Victoria Police may have misidentified Elizabeth as the predominant aggressor on 30 January 2022.

44. The term predominant aggressor is at times substituted for the term primary aggressor, and:

> *seeks to assist in identifying the actual perpetrator in the relationship, by distinguishing their history and pattern of coercion, power and controlling behaviour, from a victim survivor who may have used force for the purpose of self-defence or violent resistance in an incident or series of incidents. The predominant aggressor is the perpetrator who is using violence and coercive control to dominate, intimidate or cause fear in their partner or family member, and for whom, once they have been violent, particularly use of physical or sexual violence, all of their other actions take on the threat of violence.*[21]

45. The Victoria Police *Code of Practice for the Investigation of Family Violence* in place in January 2022 provided guidance on identifying the predominant aggressor. It listed several indicators for police to consider, including respective injuries, likelihood or capacity of each

[17] Ibid.
[18] Ibid.
[19] Ibid.
[20] LEAP record for incident 30/01/2022.
[21] Family Safety Victoria, MARAM Practice Guides: Foundation Knowledge Guides (February 2021), 124.

party to inflict future injury, whether either party has defensive injuries, which party is more fearful, and patterns of coercion, intimidation and/or violence by either party.[22]

46. The *Code of Practice* directed that when police members are unclear about who the predominant aggressor is, the AFM should be nominated *'on the basis of which party appears to be most fearful and most in need of protection'.*[23]

47. While Elizabeth admitted to wielding a knife and threatening Mr Beaton during the incident on 30 January 2022, Mr Beaton ultimately perpetrated physical assault, causing injuries requiring hospitalisation.

48. The CPU noted that this incident should also be considered in the broader context of Elizabeth and Mr Beaton's relationship. Police had previously responded to 13 incidents of family violence where Elizabeth was most frequently identified at the AFM and had reported physical and verbal violence perpetrated against her by Mr Beaton. In addition, an interim FVIO was already in place which established Elizabeth as the AFM and Mr Beaton as the respondent.

49. Police misidentification of women as primary aggressors is an ongoing issue in Victoria and other Australian jurisdictions and has serious repercussions for victims.[24]

50. Research indicates that when women use violence in heterosexual intimate relationships, the violence tends to be a consequence of their own victimisation and as a violent resistance to a pattern of controlling, coercive and violent behaviour used against them.[25] It is important therefore that the primary aggressor is selected by police on the basis of a pattern of coercive and controlling behaviour, and that police do not adopt an incident-based approach to investigation which does not take patterns of coercion and control into account.[26]

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[22] Victoria Police, Code of Practice for the Investigation of Family Violence (2014) 3nd Edition V2, 17.

[23] Ibid.

[24] Women's Legal Service Victoria, 'Snapshot of Police Family Violence Intervention Order Applications' (2018), 1; Women's Legal Service Victoria, "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family violence incidents in Victoria (Policy Paper One, July 2018), 1; No To Violence, Predominant Aggressor violence reforms Primary prevention system architecture (Report, 2022) 10-1; Parliament of Victoria Legislative Council, Legal and Social Issues Committee Inquiry into Victoria's Criminal Justice System Volume 1 (March 2022), 243 < lclsic-59-10-vic-criminal-justice-system.pdf (parliament.vic.gov.au)>.

[25] Women's Legal Service Victoria, "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family violence incidents in Victoria (Policy Paper One, July 2018), 2-3; Family Safety Victoria, MARAM Practice Guides, Foundation Knowledge Guide: Guidance for Professionals Working with Child or Adult Victim Survivors, and Adults Using Family Violence (2021) 112.

Identification and Victim Misidentification (Discussion Paper, November 2019), 6; FVRIM, Monitoring Victoria's family

[26] Heather Nancarrow et al, 'Accurately Identifying the "Person Most in Need of Protection" in Domestic and Family Violence Law' (Research Report Issue 23, ANROWS, November 2020), 27; Women's Legal Service Victoria, "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family violence incidents in Victoria (Policy Paper One, July 2018) 4.

51. The Family Violence Reform Implementation Monitor (**FVRIM**) December 2021 report *Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor* (**'the FVRIM report'**) explored the reasons for victim survivors being misidentified as perpetrators and made several recommendations to address the issues identified.

52. Victoria Police have previously advised the Court that they are implementing the findings and recommendations from the FVRIM report and are developing a Family Violence Predominant Aggressor Practice Guide for officers to refer to in the course of their duties.

53. Then-State Coroner Judge John Cain, in his *Finding Into Death Without Inquest of FCP*,[27] discussed at length the issue of misidentification of the predominant aggressor. He noted recommendation 5 of the FVRIM report, for Victoria police to *"Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possible for other targeted cohorts) before it is committed to Victoria Police's LEAP database."*

54. In the matter of FCP, Victoria Police submitted that they had satisfied this recommendation. However, Judge Cain noted that specialist family violence agencies were not involved in the actual reviews of Family Violence Reports where a woman is identified as a respondent but rather were only consulted as part of the design process. Judge Cain made the following recommendation, '*for Victoria Police to implement FVRIM recommendation 5 in the spirit in which the was intended'.*[28]

> *That Victoria Police fully implement recommendation 5 of the FVRIM December 2021 report, Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor, specifically to "Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possible for other targeted cohorts) before it is committed to Victoria Police's LEAP database."*

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[27] COR 2020 001981 Finding into Death of FCP without Inquest, available online at: <https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202020%20001981%20Form%2038%20-%20Finding%20into%20Death%20without%20Inquest_deidentified.pdf.>

[28] This recommendation was also made in COR 2022 002405 Finding into Death of DCF without Inquest, available online at: https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202022%20002405%20Form%2038%20-%20Finding%20into%20Death%20without%20Inquest_de-identified%20_Redacted%20.pdf

The review of Family Violence Reports should occur by police and members of the specialist family violence sector together.

55. Victoria Police advised the Court that it is considering options to address the intent of the coroner's recommendation. They acknowledged the need for ongoing reform to address predominant aggressor misidentification, but stated:

> *Victoria Police has significant concerns regarding the operability of the proposed review process, as recommended by the Family Violence Reform Implementation Monitor. Specifically, Victoria Police is concerned with the potential safety risks associated with any delays in information being committed to the LEAP database, noting resource constraints across the sector which may impact the timely review of FVRs/L17s.*[29]

56. In response to the challenges of correctly identifying the predominant aggressor, Victoria Police introduced the 'Predominant Aggressor Program of Work' in December 2022. As part of the ongoing program of work, Victoria Police developed and published the Predominant Aggressor Practice Guide (**PG**) and updated the Victoria Police Manual – Family Violence (**VPM FV**) guidance for police members investigating family violence incidents. The PG addresses the following:[30]

    a) makes specific reference to factors which may increase the risk of misidentification;

    b) provides guidance to police officers to consider potential biases and how these may contribute to expectations around what a victim is 'supposed' to look and/or act;

    c) provides guidance as to the potential for misidentification based on the victim's presentation or behaviour in relation to having mental illness, the influence of alcohol or other drugs, and perceived or actual aggression towards police;

    d) speaks to 'bi-directional' violence and requires police officers to consider where the use of violence may be in the context of self-defence or violent resistance (noting this

[29] Chief Commissioner of Police, Robert J. Hill APM's response to recommendations dated 16 May 2025, <https://www.coronerscourt.vic.gov.au/sites/default/files/2025-07/2022%205430%20Response%20to%20recommendations%20from%20Victoria%20Police_FCP.pdf>.

[30] Victorian Government Solicitor's Office correspondence on behalf of the Chief Commissioner of Police to the Court dated 21 April 2026.

is distinct from violence driven by ongoing, coercive or controlling behaviour perpetrated by the predominant aggressor);

e) supports members to consult a supervisor if there is uncertainty; and

f) when misidentification is determined to have occurred, processes for rectification, including, where appropriate, withdrawal of resulting family violence intervention order applications and/or criminal charges.

57. Victoria Police have also updated their training packages around family violence including an interactive program which focuses on a case study and is delivered face to face by Family Violence Training Officers. The session aligns with the PG and updates have been made to Victoria Police information technology systems to allow members to rectify the labelling of parties on a Family Violence Report where misidentification has occurred and this work is scheduled to commence in mid-2026.[31]

58. Victoria Police are currently participants in the Predominant Aggressor Working Group (**PAWG**), which is a whole of Victorian Government working group convened to improve sector-wide responses to misidentification of the predominant aggressor. The PAWG is co-chaired by Family Safety Victoria and the Department of Justice and Community Safety and has developed a work plan, informed by a range of materials and evidence, which aims to consider system improvements that support the effective identification of the predominant aggressor, and appropriate rectification where misidentification is found to have occurred.[32]

59. The CPU acknowledged that Victoria Police have undertaken significant work noted above to address the issue of police misidentification of the predominant aggressor. However, the CPU noted that they continue to identify instances of misidentification in police responses to family violence.

Family violence incident on 8 October 2022

60. Police were attending at Elizabeth's apartment complex for an unrelated matter on the evening of 8 October 2022 when they heard a male voice yelling *'I'm going to call the CAT team on you'*. At around the same time, the attending unit received a job over the air for a family

[31] Ibid.
[32] Ibid.

violence incident at Elizabeth's apartment. Body worn camera footage of the police attendance was provided to the Court.

61. Attending police spoke to Elizabeth who told them she and Mr Beaton had argued about how he does not respect her apartment and makes a mess. She told officers that Mr Beaton had said she was crazy and threatened to call the CAT team and have her *'locked up'*. She further disclosed that he had stolen her keys in the past and had forced entry to her apartment.

62. Elizabeth told police that she did not want Mr Beaton in her apartment anymore but that he had nowhere else to go and he kept *'sucking her back in'* and threatening her. In response, police told Elizabeth that she should *'be harder on [Mr Beaton] and not let him in'*.

63. Police confirmed that an FVIO was in place with limited conditions and asked Elizabeth if she wanted Mr Beaton excluded from the property. She told them she had had an Order before but had *'got sucked back in'* and did not want to *'waste [their] time with all the paperwork'*. Police told Elizabeth she *'shouldn't feel like that'* and advised her they would complete a family violence report for *'the argument'* and refer both Elizabeth and Mr Beaton to support services.

64. Police confirmed with Elizabeth that she would not answer the door to Mr Beaton should he return and confirmed that she would and should call the police if he did so. They confirmed that it was a *'verbal argument'* only and that Elizabeth was aware of how to apply for an FVIO if she wished to do so in the future. Police then left the location.

65. After the incident, police referred Elizabeth and Mr Beaton to support services. The Family Violence Investigation Unit reviewed the matter and advised the attending member to follow up with Elizabeth within seven days. This did not occur.

The Imperfect Victim

66. When attending a family violence incident, police members are required to undertake a risk assessment to better understand the victim's level of risk. This assessment should inform the risk management strategies police may take to promote victim safety.

67. Elizabeth made several disclosures of violence to police on 8 October 2022. It appears though that they did not undertake a risk assessment with her and repeatedly referred to the incident as *'verbal only'*, in effect minimising the impact of her disclosures. The CPU noted with particular concern the failure to query Elizabeth's claims that Mr Beaton had previously forced

entry into her apartment, particularly given members had observed that the security door to her property was broken.

68. The *Code of Practice for the Investigation of Family Violence* in place in October 2022 states that whilst victims of violence may be hesitant for police to pursue civil routes, police should base this decision on *'risk assessment and whether the safety, welfare, property or pets of the victim appear to be endangered'*.[33]

69. The CPU considered that there was sufficient information for police to determine that pursuing civil protection (that is, the issuing of a Family Violence Safety Notice) for Elizabeth was warranted. Even in the absence of a risk assessment, police were aware of several factors that increased her risk of ongoing violence and decreased her ability to seek assistance.

70. It is well established that victims of crime are often measured against an idealised standard of victimhood, typically to the detriment of those who are seen to depart in significant ways from notions of the ideal.[34] Women who are the victims of family violence often 'encounter conditional help'[35] which disadvantages many women, especially those who fight back, have a criminal and/or mental health history or abuse alcohol or other drugs.[36]

71. The CPU held concerns that the police response on 8 October 2022 may have also been impacted by harmful biases around her criminal and socioeconomic background, her mental health, and some of her challenging behaviours. I note that the body worn camera footage from the incident, where the members are recorded speaking about Elizabeth, saying *'oh, she's…'* while making an off-screen gesture causing another member to laugh, and saying *'I know her very well'* and sighing. Later in the footage, police members commented that the social housing building that Elizabeth resided in was *'fucking feral'*. In another instance, one member is recorded saying *'bloody Liz… she's a troublemaker'* and referring to Mr Beaton as a *'feral fucking thing'*.

72. The use of terms such as 'troublemaker' and 'feral' reflects deeply ingrained prejudicial assumptions and socio-spatial stigmatisations. These labels are not only reductive but dehumanising. Such discourses, especially when used by people in a position of power, such

[33] Victoria Police, Code of Practice for the Investigation into Family Violence (Edition 4, Version 1) (August 2022), 45.
[34] Julie Stubbs and Jane Wangmann, 'Competing conceptions of victims of domestic violence within legal processes' in D Wilson and S Ross (eds) Crime, victims and policy (Palgrave Macmillan, 2015).
[35] Sally Merry, 'Rights Talk and the Experience of Law: Implementing Women's Human Rights to Protection from Violence' (2003) 25(2) Human Rights Quarterly, 353.
[36] Ibid.

as police, reinforce biased perceptions and work to inform who is and is not worthy of support and protection. Whilst difficult to conclude with certainty, it is possible that the biases held by attending members on 8 October 2022 informed their decision not to pursue civil protections for Ms Ferris.

73. Elizabeth's history of mental ill-health and drug use, in addition to her forensic history[37] likely marginalised her within the community and worked to establish her expectations for how she would be treated by services and police. These expectations were likely reinforced by police responses to the January and October 2022 incidents and consequently limited Elizabeth's access to additional measures to increase her safety from family violence.

74. The effective prevention of family violence and family violence related deaths is contingent upon a service system and policing framework that possess a nuanced and critically informed understanding of how marginalisation shapes individuals' experiences of violence. Prevention is reliant on these systems recognising the intersecting impacts that structural and social disadvantages such as poverty, mental health and insecure housing, can have on a victim's experience of violence and their willingness and capacity to seek assistance.

75. Despite recognition of these complexities in Victoria Police policy and significant reforms aimed at improving police practice, members continue to demonstrate poor understandings of family violence and the experiences of marginalised communities.

76. I agree with the assessments of the CPU with regard to the police response to the family violence incidents on 30 January 2022 and 8 October 2022, although as I have already found, I do not consider the actions or inactions of police caused or contributed to Elizabeth's death.

77. Rather, I consider that these concerns may represent missed opportunities to better engage and support Elizabeth and Mr Beaton, and to hold Mr Beaton to account for the family violence perpetrated towards Elizabeth.

FINDINGS AND CONCLUSION

78. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[38] Adverse findings or comments

[37] Alfred Health Medical Records of Elizabeth Ferris, 476.

[38] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the

against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Elizabeth Susan Edwina Ferris, born 12 January 1978;

    b) the death occurred on 26 November 2022 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from hypoxic ischaemic encephalopathy complicating cardiac arrest in the setting of presumed drug toxicity; and

    c) the death occurred in the circumstances described above.

80. Having considered the available evidence, I am satisfied that Elizabeth's death was likely the unintended consequence of her use and abuse of drugs.

81. Although I have made criticisms of the Victoria Police response to family violence incidents involving Elizabeth in the year prior to her death, I do not find that they caused or contributed to her death.

COMMENTS

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

82. I support and reiterate Judge John Cain's recommendation in the matter of LFQ –

> *That Victoria Police fully implement recommendation 5 of the FVRIM December 2021 report, Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor, specifically to "Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possible for other targeted cohorts) before it is committed to Victoria Police's LEAP database."*

reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

The review of Family Violence Reports should occur by police and members of the specialist family violence sector together.

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

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.

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

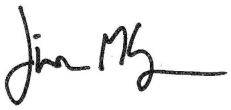
Jason Beaton, Senior Next of Kin

Victoria Police

Alfred Health

Senior Constable Rebecca MacInnes, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 07 May 2026

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.