IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 003600

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:	Samantha Joy Fraser
Date of birth:	22 July 1980
Date of death:	23 July 2018
Cause of death:	1(a) Hanging in the setting of multiple blunt force injuries.
Place of death:	19 Seagrove Way, Cowes, Victoria, 3922
Keywords:	Homicide; family violence; family violence intervention order

INTRODUCTION

1. On 23 July 2018, Samantha Joy Fraser was 38 years old when she died at her home in Cowes, Victoria. Samantha was the mother of three young children when she passed away, and was a beloved daughter, friend, and sister. Samantha was killed by her estranged husband, Adrian Basham, who was convicted of her murder on 21 April 2022. Adrian received a sentence of life imprisonment, with a non-parole period of 30 years.

Background

2. Samantha and Adrian met in about 2005 and were married in March 2007. They had three children together, born in 2009, 2011, and 2013. Samantha worked as a psychologist and Adrian previously worked in construction in Western Australia, on a fly-in-fly-out basis. At the time of Samantha's death, Adrian was unemployed.

3. Throughout 2015 and 2016, Samantha began to disclose incidents of family violence perpetrated by Adrian towards her to her friends and family. She made several attempts to separate from Adrian, and finally left him on 16 April 2017. Both during the relationship and after she separated, Samantha told friends and professionals that she was terrified of Adrian. She changed the locks on the doors and windows of her home and had security equipment installed.

4. Samantha swore two police statements that detailed allegations of rape during the marriage, and in August 2017, Adrian was charged with nine counts of rape. He was due to face a contested committal hearing on 30 July 2018. Samantha was due to give evidence at the contested committal hearing.

5. A final family violence intervention order (**FVIO**) was granted at the Wonthaggi Magistrates' Court on 12 January 2018 to protect Samantha from Adrian. The order was granted for a period of two years and occurred after numerous directions and contested hearings, including a cross application lodged by Adrian, which he later withdrew. This FVIO was active, current, and served at the time of Samantha's death. It prevented Adrian from contacting Samantha or attending her work or home addresses.

THE CORONIAL INVESTIGATION

6. Samantha'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 Detective Senior Constable Luke Farrell to be the Coroner's Investigator for the investigation of Samantha's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Samantha Joy Fraser including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[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.

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

Identity of the deceased

11. On 23 July 2018, Samantha Joy Fraser, born 22 July 1980, was visually identified by her friend, Wayne Foster.

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

Medical cause of death

13. Forensic Pathologist Dr Sarah Parsons, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 24 July 2018 and provided a written report of her findings dated 21 November 2018.

14. The post-mortem examination revealed evidence of blunt force trauma to the face, neck, upper and lower limbs, in keeping with an assault. Sections of the bruises taken did not show any evidence of healing or Perls' positive haemosiderin deposition and were in keeping with recent bruises.

15. Dr Parsons opined that given the injuries identified, it was possible that the deceased had been knocked unconscious and hung from the rope, however it was also possible that the deceased had hung herself following an assault.

16. Toxicological analysis of post-mortem samples identified the presence of diazepam and its metabolite nordiazepam, and caffeine. Ethanol (alcohol) was not detected.

17. Dr Parsons provided an opinion that the medical cause of death was *hanging in the setting of multiple blunt force injuries.*

18. I accept Dr Parsons' opinion as to the cause of death.

Circumstances in which the death occurred

19. At 8.52am on 23 July 2018, Samantha left her home in Cowes to drive her three children to school. Meanwhile, Adrian travelled by motorcycle from San Remo, where he was staying with a friend, to Cowes. He parked his motorcycle near Samantha's home and waited until Samantha left home. About three minutes after Samantha left with her children, Adrian approached the home and hid whilst he awaited Samantha's return.

20. Following the school drop-off, Samantha attended a nearby café with some friends, before returning home at 11.22am. After driving into the garage, Adrian entered the garage and assaulted Samantha, which resulted in multiple injuries. Adrian then tied a noose around Samantha's neck before hanging her from the garage door and staging the scene to make it look like Samantha had taken her own life.

21. That afternoon, when Samantha failed to collect her children from school, staff at Cowes Primary School requested police attend to conduct a welfare check. Police arrived at Samantha's home at about 5.05pm, forced entry to the premises and located Samantha deceased in the garage.

22. The Homicide Squad were immediately notified and commenced an investigation into Samantha's death. Adrian was charged with Samantha's murder on 2 August 2018 and was remanded in custody. Adrian pleaded not guilty to the charge of murder and claimed that Samantha took her own life.

23. Following a trial in the Supreme Court of Victoria, Adrian was convicted by a jury of Samantha's murder on 21 April 2022. In Her Honour's sentencing remarks, Justice Taylor found that the offending fell into the worst category of murder and was premeditated.

FURTHER INVESTIGATIONS AND CPU REVIEW

24. As Samantha's death was the result of family violence, and occurred in circumstances where there was a reported history of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3] The CPU considered the family violence related services involved with Samantha and Adrian prior to her passing.

Victoria Police

[2] 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.

[3] 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

25. The CPU team identified some concerns with the actions and responses of Victoria police, however noted that the family violence service system in Victoria has undertaken significant reform since that time, and many deficiencies in the service response have now been addressed.

26. The CPU noted that Samantha reported numerous breaches of the FVIO in 2017, however the Victoria Police response was inconsistent. This was acknowledged by Victoria Police within their Family Violence Related Death Service Delivery Review (**FV-SDR**) for this matter. At least one issue was related to the limited investigative experience of the police officer who received the FVIO breach report.

27. The CPU commented that the FVIO breaches were reported in 2017 and noted that Victoria Police has since undertaken significant changes in its processes and procedures relating to family violence. The establishment of Family Violence Investigation Units (**FVIUs**) and the embedding of qualified investigators in all FVIUs since Samantha's death has improved Victoria Police's response to family violence incidents and FVIO breaches.

28. The CPU did not identify any further prevention opportunities in relation to Victoria Police, which have not been addressed by recent reforms or the FV-SDR recommendations.

29. I accept the CPU's advice.

Magistrates Court of Victoria

30. The CPU noted that Samantha may have faced several barriers when applying for an FVIO through the court system, including:

    a) Different police prosecutors/legal representation at each hearing.

    b) Infrequent or no legal representation other than Victoria Police, including when Samantha was unhappy with the result of an intervention order hearing in August 2017.

    c) Different Magistrates for each hearing.

    d) Exposure to Adrian at court, which posed issues regarding safety, intimidation, and stress.

    e) Out of court negotiations over-utilised to minimise court time.

31. The CPU team noted that since Samantha's death, Specialist Family Violence Courts have been expanded across Victoria and are now located at Ballarat, Broadmeadows, Dandenong, Frankston, Geelong, Heidelberg, Latrobe Valley, Melbourne, Moorabbin, Ringwood, Shepparton and Sunshine Magistrates' Courts.

32. The CPU emphasised the importance of continued investment and specialisation for legal assistance to victims of family violence. The CPU recommended that community legal services are adequately funded and resourced to attend all Magistrates' Courts where FVIOs are heard, to reduce victim's reliance on police representation.

33. I also note Coroner Ingrid Giles' recent Finding into the death of Ms BCJ (COR 2020 3368) in which Her Honour made the following recommendation:

> *With the aim of promoting public health and safety and the administration of justice, I recommend that the Victorian Government ensure that all Specialist Family Violence Courts in Victoria have adequately-funded and resourced specialist legal and non-legal specialist family violence services on site to engage with both affected family members and respondents in an intervention order hearing to provide both legal and non-legal advice and support, including where Victoria Police is the applicant for an intervention order.*

34. I endorse Coroner Giles' recommendation.

Care and treatment provided by general practitioner to Samantha

35. Samantha consulted with a general practitioner (**GP**) eight times between April 2017 and June 2018. Some of the appointments were not in line with best practice, for example:

    a) Seeing both Samantha and Adrian at the same time, after the GP became aware that Adrian was a family violence risk to Samantha.

    b) Referring Samantha and Adrian to the same psychologist for counselling.

    c) Failing to respond appropriately to a disclosure by Samantha of potential child abuse.

36. In responding to family violence, GPs are guided by the Royal Australian College of General Practitioners (**RACGP**) manual 'Abuse and Violence: Working with our Patients in General Practice' (**'the White Book'**). The White Book has recently been updated and now includes more comprehensive information in relation to working with men who use intimate partner

abuse and violence, including a list of risk factors associated with the use of intimate partner violence. It also includes information about the Family Violence Information Sharing Scheme (**FVISS**) and the Multi-Agency Risk Assessment Management (**MARAM**) framework. The RACGP have also developed a series of resources for GPs including webinars and a dedicated 'Family Violence GP Education Program'.

Care and treatment provided by private psychologist to Adrian

37. Adrian consulted with a psychologist on eight occasions in 2018. During these sessions, the clinician became aware that Adrian demonstrated several indicators which should have reasonably caused them to believe that he was a high-risk perpetrator of family violence. This included controlling behaviour, obsessive and jealous behaviour and allegations of sexual abuse.

38. The psychologist's inability to identify multiple indicators that Adrian was perpetrating family violence and continued to present a risk to Samantha may relate to the absence of mandatory family violence training for private psychologists, and the fact that private psychologists are not prescribed under the MARAM framework, including under the perpetrator-focused MARAM guides.

39. I note my previous recommendations in the Finding into the death of Fatima Batool (COR 2018 3266), which are extracted below. I made the same recommendation in the Finding into the death of Alicia Little (COR 2017 6543).

> *With the aim of promoting public health, preventing deaths and supporting medical practitioners to address family violence, I recommend that the National Federation Reform Council (**NFRC**) review the current registration standards required of medical practitioners with a view to updating CPD requirements for General Practitioners. A specific portion of CPD training undertaken by General Practitioners should be dedicated to family violence to reach an occupation-specific level of family violence understanding and referrals for further support where a patient is identified as experiencing or suspected to be experiencing family violence.*
>
> *I recommend that similar measures be taken to introduce family violence mandatory CPD for registered psychologists and psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where*

a patient/client is identified as experiencing or suspected to be experiencing family violence.

40. The Prime Minister of Australia, Anthony Albanese, provided a response to the above recommendations. In response to the recommendation in *Batool*, the Prime Minister noted:

> *In response to your recommendations I have asked the Hon Mark Butler MP, Minister for Health and Aged Care, to work with the Health Ministerial Council (HMC) in developing options to enhance family, domestic and sexual violence training in the health workforce. These options are to include your recommendation of mandatory family violence CPD components for GPs, psychiatrists and psychologists.*

41. The response received in the matter of *Little* largely mirrored that of *Batool.*

42. I note and commend the work already undertaken by the RACGP to provide a dedicated family violence education program to GPs. However, I note there are still opportunities for the Australian Psychological Society (**APS**) and the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) to implement mandatory family violence CPD programs for private psychologists and psychiatrists. I therefore recommend measures be taken by the APS and RANZCP to introduce family violence mandatory CPD for registered psychologists and psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where a patient/client is identified as experiencing or suspected to be experiencing family violence.

CPU review of relevant literature

43. The CPU noted research undertaken by Australia's National Research Organisation for Women's Safety (**ANROWS**) which identified three 'pathways' to intimate partner homicide. The three pathways include the 'fixated threat', the 'persistent and disorderly' and the 'deterioration/acute stressor' pathways. The 'fixated threat' pathway includes many behaviours and factors identified in the present case.

44. The CPU noted some research suggests the use of GPS tracking technology to be an effective intervention for some perpetrators who fit the 'fixated threat' typology, however this requires them to have already come to the attention of authorities, who would put this measure in place. However, in the present case, whilst there were numerous and significant incidents of family violence, there was no indication that the threat was escalating prior to the fatal incident. This gave the impression that the risk was adequately managed or mitigated by the controls already

in place. The CPU further noted a recent Victorian Law Reform Commission Inquiry into Stalking, which found that electronic monitoring is considered controversial and was unlikely to keep people safe.

45. The CPU opined that the risk factors of Samantha re-partnering and the pending court date for sexual assault charges against Adrian did not appear to have been identified as risks. These factors are similarly not listed as risk factors in the MARAM. The CPU suggested that Family Safety Victoria (**FSV**) may wish to consider the available evidence and potentially add re-partnering and pending court date for criminal charges brought by the victim as risk factors to be considered in the MARAM. The CPU noted that this is not a unique issue and has been noted in several other coronial investigations.

46. I support and endorse the CPU's recommendation.

CPU review of pilot programs

47. The CPU referenced the current pilot program underway in the Bayside, Peninsula and Barwon areas for adults who perpetrate family violence and pose a serious risk to victims. The CPU opined that this pilot program may address a gap in the service system for serious perpetrators who are unsuitable for current programs such as Men's Behavioural Change Programs. The CPU suggested that FSV may wish to consider how this program may respond to fixated threat perpetrators, such as Adrian.

48. I support and endorse the CPU's recommendation.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Samantha Joy Fraser, born 22 July 1980;

    b) the death occurred on 23 July 2018 at 19 Seagrove Way, Cowes, Victoria, 3922, from *hanging in the setting of multiple blunt force injuries.*; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

(i) I endorse the recommendation by Coroner Giles in BCJ (COR 2020 3368): *With the aim of promoting public health and safety and the administration of justice, I recommend that the* ***Victorian Government*** *ensure that all Specialist Family Violence Courts in Victoria have adequately-funded and resourced specialist legal and non-legal specialist family violence services on site to engage with both affected family members and respondents in an intervention order hearing to provide both legal and non-legal advice and support, including where Victoria Police is the applicant for an intervention order.*

(ii) That **Family Safety Victoria** consider the available evidence and consider including re-partnering and pending criminal date for criminal charges brought by the victim as risk factors to be considered in the MARAM.

(iii) That measures be taken by the **APS** and **RANZCP** to introduce family violence mandatory CPD for registered psychologists and psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where a patient/client is identified as experiencing or suspected to be experiencing family violence.

(iv) That **FSV** consider how the pilot program currently underway in Bayside, Peninsula and Barwon areas may respond to fixated threat perpetrators.

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

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Trevor and Janine Fraser, Senior Next of Kin

Australian Psychological Society

Brigitte Linder (C/- Meridian Lawyers)

Chief Commissioner of Police (C/- Victorian Government Solicitor's Office)

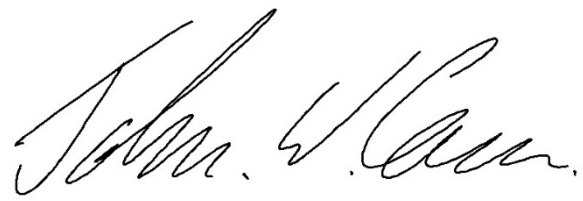
Family Safety Victoria

Royal Australian and New Zealand College of Psychiatrists

Victorian State Government

Detective Senior Constable Luke Farrell, Coroner's Investigator

Signature:



Judge John Cain
State Coroner
Date: 6 November 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.