IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2012 0414

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

(Amended pursuant to section 76 of the *Coroners Act 2008* on 5 October 2015)

I, AUDREY JAMIESON, Coroner having investigated the death of CATHERINE JANE BERNARD

without holding an inquest:

find that the identity of the deceased was CATHERINE JANE BERNARD

born 14 July 1994

and the death occurred on 2 February 2012

at the railway track between Mount Waverley and Syndal train stations, Mount Waverley 3149

from:

1 (a) MULTIPLE INJURIES DUE TO IMPACT BY TRAIN

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Catherine Jane Bernard was 17 years of age at the time of her death. Her parents had separated when she was four years of age, whereupon she moved from Ballarat to Melbourne with her mother, Mrs Deborah Kottek. Mrs Kottek remarried in 2001 and had another child to her new husband, Mr Gerry Kottek. Catherine's father, Mr Michael Bernard, re-partnered in 2003. His new partner and her daughter, who was a few years older than Catherine, moved in with him. This relationship ended in 2006. At Catherine's request, in 2009 she changed schools and commenced at Emmaus College.

2. At approximately 11.10pm on 2 February 2012, the first day of Catherine's year 12 schooling, she attended the railway line running between Syndal and Mount Waverley stations. She telephoned her friend, Hannah, with whom she used to attend school. Catherine told her friend that she loved her, that she was sorry, and asked Hannah to tell her mother, Deborah Kottek, that she loved her. Catherine then moved onto the railway line and began running towards a Glen Waverley-bound train, which was unable to stop in time to avoid a collision. Catherine sustained fatal injuries and died at the scene.

3. Victoria Police, the metropolitan ambulance service and Metro Train Melbourne (MTM) staff attended the scene.

INVESTIGATIONS

4. Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed an external examination on the body of Catherine, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings were consistent with the known mechanism of injury.

5. Toxicological analysis of blood retrieved post mortem identified a trace of paracetamol. No alcohol or other common drugs or poisons were identified. Dr Baker ascribed the cause of Catherine's death to multiple injuries due to impact by train.

6. The circumstances of Catherine's death have been the subject of investigation by Victoria Police on my behalf. No evidence of third party involvement in Catherine's death was identified. Police obtained statements from Mrs and Mr Kottek, Emmaus College Assistant Principal Ms Anne McLachlan, attending police members, MTM Manager of Investigations Laurie Lacorcia and the train driver.

7. Mrs Kottek reported she and Catherine were engaged with the Victims Assistance Program after family violence incidents in 1993 and in 1999. Catherine had two sessions with a private Psychologist (reason unrecorded) but it coincided with Child Protection Service (CPS) initial contact after an incident with Michael Bernard. Access was suspended and an intervention order obtained by Mrs Kottek.[1] CPS closed the case.

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1 Eastern Health Child & Adolescent Mental Health Case Assessment Summary dated 1 December 2012 and authored by Psychiatric Registrar Justin Foster. Child Protection history for Catherine Bernard updated 13 August 2012.

8. In 2007, Catherine's two half brothers were asked to leave the family home.[2] According to Catherine, this was a trigger for increased conflict with her mother.

9. In 2008, Catherine at age 14 years went to live with her father (whom she had a good relationship with) because of the increased conflict with her mother. Catherine reported that after six weeks she returned to live with Mrs Kottek because her mother was not happy with the level of supervision provided by Catherine's father.

10. In 2009, at 15 years of age and during September school holidays, Catherine returned to her father's home in Ballarat but did not experience the usual lift in her mood from being there. On return to Melbourne on 9 October 2009 she took an overdose of temazepam and was taken to the Monash Health Emergency Department (ED). According to the health records, Catherine reported she had a previous suicide attempt three months prior.

11. Catherine told staff her trigger for the overdose included family conflict. After the overdose, Catherine was assessed by Box Hill Child and Adolescent Mental Health Service (CAMHS) and Psychiatric Registrar Dr Justin Foster as having a depressive episode with parent-child relationship problems and she was referred to private Psychologist. Catherine then expressed wanting to live with her father in Ballarat.

12. Catherine disclosed to a junior medical officer whilst in the Emergency Department that she had been "sexually assaulted" by an older step-sister when she was 8 years old. Catherine thought her mother knew of the assault but when told, her mother reported she had not known. According to Mrs Kottek, the staff told her of Catherine's disclosure, which upset Catherine.[3] The medical officer sought advice from a senior doctor who advised a report of the alleged sexual assault was not necessary at that time because the alleged perpetrator no longer had access to Catherine and Catherine and her parents could raise it with the mental health services and/or report it to the police.[4]

13. On 15 November 2009, CPS received a referral voicing concerns about Catherine's decision to go and live with her father in Ballarat. CPS spoke with Michael Bernard and Catherine's

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2 Eastern Health Medical record hardcopy, case Assessment Summary by psychiatric registrar Dr Justin Foster, 1 December 2009, page 2.

3 Eastern Health Medical record hardcopy, Screening Assessment dated 9 October 2009.

4 Email from Monash Health dated 18 March 2015/ED Record Monash Health.

treating Psychiatrist and found no reasons to prevent Catherine from moving to Ballarat. CPS closed the case.[5]

14. Dr Foster recorded the following as part of the formulation after assessment sessions with Catherine and her family:

> *Catherine's difficulties are likely to continue with ongoing conflict in the family. Her father's passivity secondary to his brain disorder will not provide a counterpoint to her current family life that she desires. Catherine's tendency for all or nothing thinking and her desire for friendship exclusivity makes a supportive friendship group potential ground for future conflict. Catherine's ongoing difficulties at school, including an ongoing desire to change schools leaves stability outside of the family unit difficult.*[6]

2010

15. On 18 January 2010, Catherine began seeing General Practitioner (GP) Dr Fiona Warburton who organised a mental health care plan (GPMHP) to enable free counselling. Catherine saw private Psychologist Rosemary Stark regularly until later in 2010 when Mrs Kottek agreed for her to stop going because Catherine thought it was a waste of time and did not believe Psychologists or counsellors could fix things.[7]

2011

16. On 21 March 2011, Catherine stayed home from school claiming to be sick. Mrs Kottek insisted she see the GP for a medical certificate. Catherine returned home from the GP and took an overdose of paracetamol. Catherine was medically treated at the Box Hill hospital and later transferred to the Adolescent Psychiatric Inpatient Unit (APIU). Catherine told staff her triggers for the overdose included continued conflict with her mother, and that when intoxicated she had "kissed" her boyfriend's best friend (who her girlfriend liked). Catherine thought they all "hated" her since.[8] According to the available information, Catherine had a history of risk taking behaviours including promiscuity and intoxication.

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5 Child Protection history for Catherine Bernard updated 13 August 2012.

6 Eastern Health Medical record hardcopy, case Assessment Summary by psychiatric registrar Dr Justin Foster, 1 December 2009, page 5.

7 Eastern Health Medical record hardcopy, Progress notes (EH389000) dated 24 March 2011.

8 Eastern Health Medical record hardcopy, Progress notes (EH389000) dated 24 March 2011.

17. Catherine told staff she was "annoyed" that she had not died when she took the overdose. Although reporting a low mood, Catherine was social and flirtatious, resisting boundary setting with male co-patients during the 10-day admission. During the admission, Catherine was clear about her dislike of school, and that she felt stupid, but she had plans to attend TAFE/VCAL with a view to nursing/childcare training. She also told staff she was "jealous" of her half-sister Sarah because she believed Deborah and Gerry Kottek had greater affection for Sarah.

18. According to Nurse Brophy, on 26 March 2011 after returning from leave with Mrs Kottek, Catherine:

> *Stated that her mother hardly talked to her, that they argued and Catherine is adamant that they cannot live together. Catherine see's no way out of this, believes she had tried "everything" but her and her mother will never get along. Catherine states that she always feels suicidal, was thinking today about hanging herself in the front yard of the family home but didn't because it would be a bit "brutal". Catherine said she still has plans to suicide one day but first needs to figure out the right way to do it. Catherine did agree that she would be willing to try suggestions from mental health staff to solve the communication problems with her mother – however, she does see her mother as the problem in total.*[9]

19. Catherine was prescribed the hypnotic temazepam during the admission and was discharged home on 30 March 2011 with follow-up at Box Hill CAMHS. Catherine was diagnosed with a major depressive disorder.

20. On 6 April 2011, Catherine and Gerry Kottek saw Psychiatric Registrar, Dr Peter Davies from Box Hill CAMHS. Dr Davies found no evidence of a current major depression and Catherine denied any suicidal ideation or plan. The major issue identified and verified by Gerry Kottek was ongoing conflict between Catherine and her mother. There was another appointment with Catherine and Gerry Kottek on 18 April 2011 and Dr Davies undertook an assessment to determine if Catherine met the diagnostic criteria for borderline personality disorder, which she did not. A safety plan was devised with Catherine and her stepfather Gerry. Meetings with Deborah and Gerry Kottek took place on 2 May 2011, 26 May 2011and 6 June 2011. Mrs Kottek described her daughter as a social butterfly, who preferred to have a best friend but who

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9 Eastern Health Medical record hardcopy, Progress notes (EH389000) dated 26 March 2011.

would be successful as part of a group of friends, however she had a history of "falling out"[10] with friends in this environment, a pattern that continued until her death.

21. In 2011, during a session with Psychiatric Registrar Dr Peter Davies and Deborah and Gerry Kottek, Dr Davies recorded Mrs Kottek's description of the nature of the disclosed sexual assault as "unclear."

22. After 5 May 2011, Deborah and Gerry Kottek reported to Dr Davies that Catherine was refusing to go to school, was becoming increasingly aggressive, but they did not identify any increased risk, however Catherine was making contingent (do what I want or I will kill myself) threats to self-harm. Both Deborah and Gerry Kottek reported exhaustion from Catherine's behaviours, aggression and demands.

23. Dr Davies prescribed the antidepressant escitalopram[11] to stabilise her mood rather than treat a depression. The information available suggests Catherine took the medication sporadically and sourced them from other medical practitioners. I note her post-mortem toxicology showed she was not taking the medication at the time of her death.

24. Catherine continued to see Dr Davies regularly[12] and there was a family session on 20 June 2011. Deborah and Gerry Kottek told Dr Davies there was increasing separation between Catherine and the family for the past month, with friends taking priority. It was thought Catherine misconstrued their interest as intrusive rather than genuine interest. Dr Davies suggested the impetus for change is more likely to come from the adults and suggested ways to address it. A further family session booked for 11 July 2011 was cancelled by Gerry Kottek. Dr Davies contacted Gerry to reschedule and was told Catherine had disappeared to a friend's house following an argument with her mother. This occurred after Catherine had spent the previous week with her father in Ballarat.

25. The records of individual sessions with Dr Davies note an improvement in Catherine's reported mood. She had stated she had a good parental relationship with Gerry, but could not see any hope of improvement in her relationship with her mother. Catherine asked for the dose of

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10 Eastern Health Medical record hardcopy, case Assessment Summary by psychiatric registrar Dr Justin Foster, 1 December 2009, page 4.

11 Escitalopram (Lexapro) is a selective serotonin reuptake inhibitor/ antidepressant for moderate to severe generalised anxiety disorder and moderate to severe social anxiety disorder and depression.

12 On 17 June 2011, 24 June 2011, 11 July 2011, 15 July 2011, 22 July 2011, 1 August 2011,8 August 2011, 22 August 2011 and 30 August 2011.

escitalopram to be increased but Dr Davies suggested waiting until the next appointment. At the session on 15 July 2011, Catherine had moved out of home to live with the family of a friend 'Chris' and planned to move out permanently. Dr Davies documented Catherine's removal of consent for him to speak about her with her parents, "*Asks me not to have any further contact with mother or stepfather Gerry.*"[13] The escitalopram dose was increased. Catherine was diagnosed with a major depressive episode – in remission and parent-child relational problems.

26. By the 22 July 2011 session, Catherine had moved home while waiting for a permanent option. She had an option at Youth for Christ supported accommodation in South Vermont. On 1 August 2011, Catherine had accepted a room at Youth for Christ and planned to move soon, but had not told her parents and also requested Dr Davies not tell them either. Dr Davies noted Catherine was worried about the move and sad about having to move out of home. She reported occasional suicidal thoughts but no plan.

27. Catherine had engaged with the school counsellors, Ms Camille Baker, Ms Madeline Sibbing and Ms Chrissy Ballas who were involved in supporting her mainly through her identified social needs, such as accommodation and Centrelink.[14]

28. On 8 August 2011, Dr Davies reviewed Catherine and reported she was more settled in Youth for Christ. Catherine reported her parents had unenrolled her from Emmaus College and were not paying school fees, but the Emmaus College was prepared to waive the fees to enable Catherine to complete VCE. Catherine ended the session after she became emotional when discussing moving out of home.

29. On 22 August 2011, Catherine reported she had settled into the accommodation and her mood had improved.[15] She reported occasional thoughts of suicide but no intent or plan. She stated she had had contact with her mother but did not intend on returning home, even after her mother apologised for the conditions at home prior to her leaving, stating she felt it was "too little too late".[16] Catherine provided the accommodation support contacts to Dr Davies and gave permission for him to speak to her school.

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13 EMR Eastern Health, page 28.
14 Coronial brief pages 162-184 & 208-240.
15 Supported by entries made by Dr F Warburton on 16 August 2011 (brief page 44), 9 September 2011 (brief page 44).
16 EMR Eastern Health, page 17.

30. On 30 August 2011, Catherine told Dr Davies she was more at home at the accommodation and felt increasingly cheerful. Dr Davies recorded her as being brighter and more cheerful. Catherine had phone contact with her mother, remained angry with her but expressed sadness about the perceived loss of her parents and being overwhelmed by her level of freedom. She told Dr Davies she might consider future contact with her mother but was not ready to take that step at that time. She felt supported by her brother and boyfriend Aidan.

31. Catherine did not attend the next scheduled appointment but agreed to attend the following week when Dr Davies telephoned her. She reported she was alright. On 19 October 2011, Dr Davies spoke with school counsellor Ms Madeline Sibbing who reported Catherine's school attendance was intermittent. Dr Davies identified Catherine's current main issue was adapting to her new level of independence. On 5 December 2011, Dr Davies completed a comprehensive risk assessment and provided information on crisis contact with Catherine.

32. According to two screen prints from Facebook, on 8 and 9 December 2011, Catherine (account name of 'Rip Catherine Jane Bernard') had exchanges with her then boyfriend Aiden and several friends. It was apparent from the exchanges Catherine took offence to being told by Aiden he could do better. Aiden apologised and explained it was a joke.[17]

33. According to Mrs Kottek, after Catherine left home and when Mrs Kottek became aware of Catherine living at Youth for Christ accommodation, Catherine had a boyfriend (Aiden), was happy and was working at a café.[18] Catherine spent time with the family over Christmas and attended a family function. According to Mrs Kottek, Catherine told her she lost her job and was having problems with Aiden, and that she was getting drunk with two friends (who Mrs Kottek did not trust).[19]

34. By January 2012, Catherine reportedly had a new boyfriend Alex, was finding it financially difficult to live on Centrelink payments and saw Deborah Kottek "a bit".[20] Michael Bernard, however says Catherine visited him in January for a weekend with her boyfriend 'Chris' and seemed happy.[21] According to Mrs Kottek, she unsuccessfully tried to ring Catherine about two weeks prior to her death.

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17 Facebook screen-print, printed 1/03/2012.
18 Coronial brief of evidence, page 10.
19 Ibid.
20 Ibid, page 11.
21 Ibid, page 14.

35. On 27 January 2012, there were exchanges between Catherine's friends (Aiden and Alex) on Facebook but no direct contact with Catherine. The information available in this respect is limited. The exchanges suggest Catherine had had sexual intercourse with a boy by the name of Jason. The exchanges suggest Aiden had begged her not to, was hurt and angry and would not speak with her.[22]

36. Catherine did not attend the next appointment or any thereafter and Dr Davies formally discharged her on 28 December 2011 after he received no response to his repeated attempts to contact her by telephone, and to the letter sent to Catherine encouraging her to make contact and if not, that CAMHS would discharge her and for her to see her GP for ongoing prescriptions.

37. According to Mrs Kottek, she spoke with Catherine five days before she died, objected to the message Catherine had on her phone and told her she wished Catherine did not see her friends Ngoc and Hannah. Catherine told her mother she never wanted to see her, to leave her alone and that she would get another phone.[23] Apparently Catherine sent a short text message to her mother the following morning and Mrs Kottek apologised to her via text message.

38. On 2 February 2012, Catherine returned to school in Year 12. At 8.30pm, Catherine telephoned Michael Bernard. He described her: "*She sounded very upset and down but I managed to get her talking and sounding like she was OK.*"[24] According to her father, Catherine told him she was being bullied at school and on Facebook. According to the coronial brief of evidence summary, at 11.10pm, Catherine telephoned her friend Hannah, told her she loved her, that she was sorry, and asked her to tell her mother she loved her.[25] It appears that immediately after the telephone call, Catherine ran along the railway towards and oncoming train.

Metro Trains Melbourne

39. On 2 February 2012, the train driver was rostered to driver the 10.29pm Flinders Street to Glen Waverley passenger train, having commenced his shift at 6.23pm. The driver was scheduled to complete his shift at 12.11am. The driver had the previous day completed a 4.31pm to 12.15am shift. He was not on any medication at the time that would have affected his driving

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22 Facebook screen-print, printed 1/03/2012.
23 Coronial brief of evidence, page 14.
24 Coronial brief of evidence, page 14
25 I note there were no statements obtained to confirm this information.

capabilities. The train departed Flinders Street station on time. Both the brake and whistle worked effectively.

40. The track between Mount Waverley and Syndal stations is generally straight with a slight uphill gradient. The maximum designated track speed in this section is 95kph, however when driving the Xtrapolis type train (which was being driven at the time), the maximum track speed is 90kph.

41. The train was fitted with automatic headlight operation which activates low beam headlights, which were on at the time of the incident, consistent with operational requirements. The driver estimated the train speed prior to the collision at 80-85kph.

42. The train had travelled approximately one third of the way to Syndal Station when the headlights picked up Catherine's presence approximately 50 to 80 metres ahead. The driver sounded the whistle and immediately engaged the emergency brakes. The driver observer Catherine running towards the train.

43. Following the incident, the train driver contacted Metro Train Control and reported the incident, and was informed Control would contact emergency services. Emergency services arrived and the driver underwent a preliminary breath test, which returned a negative result. The train's data logger confirmed the train had been travelling at 85kph when the brake was activated in the emergency position.

44. There is neither artificial lighting nor a pedestrian crossing at the incident location. The weather was fine and dry and visibility was clear.

Coroners Prevention Unit

45. The Coroners Prevention Unit (CPU)[26] reviewed the circumstances of Catherine's death on my behalf. The CPU specifically looked at the mental health treatment received by Catherine.

46. Of note is that investigating member, Senior Constable Melissa Wood states Catherine's friends Hannah and Ngoc and boyfriend Chris, with whom Catherine had most contact with

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26 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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

prior to her death have not provided statements. This has limited the information available regarding the days proximate to Catherine's death.

Nature of disclosure of childhood sexual abuse

i. Contact with Catherine Bernard on 9 October 2009

47. The Monash Health Director of Paediatric Emergency Medicine (name unknown) provided information on mandatory reporting in the ED.[27] Mandatory reporting of children who are victims of abuse has been supported at Monash Health (previously Southern Health) by policy and procedure for many years. The Director of Paediatric Emergency Medicine also reviewed Catherine's presentation to the ED on 9 October 2009 and made the following observations:

    a. Catherine disclosed to a member of the junior medical staff that she had been sexually abused at some point in the preceding years;

    b. the alleged abuser no longer had exposure to Catherine or her family;

    c. the junior medical staff member consulted with the supervising member of the senior medical staff and was incorrectly advised that these allegations did not need to be reported to Child Protection;

    d. as Catherine had presented for another matter and had been assessed as requiring a mental health admission, it was determined that no further assessment or consultation was required for the alleged abuse at that time;

    e. given that Catherine was in a safe environment in the ED, there was no urgent requirement to make a report whilst the patient was in the ED;

    f. there was an expectation that the matter of the alleged abuse would be reviewed with Catherine while she was an inpatient;

    g. as no inpatient bed was available, Catherine stayed in the ED overnight and was re-assessed in the morning by the mental health team as being suitable for management in the community; and

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27 Email from Monash Health dated 18 March 2015.

h. it does not appear that the matter of the alleged abuse was followed up by the ED or mental health staff the following day.[28]

ii. Mandatory reporting

48. Section 162 of the *Children, Youth and Families Act 2005* (Vic) relevantly states one of the grounds for a child being in need of protection:

> (1) (d) the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;

49. Section 184 of the *Children, Youth and Families Act 2005* (Vic), in relation to mandatory reporting relevantly states:

> (1) A mandatory reporter who, in the course of practising his or her profession or carrying out the duties of his or her office, position or employment as set out in section 182,[29] forms the belief on reasonable grounds that a child is in need of protection on a ground referred to in section 162(1)(c) or 162(1)(d) must report to the Secretary that belief and the reasonable grounds for it as soon as practicable—
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> (a) after forming the belief; and
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> (b) after each occasion on which he or she becomes aware of any further reasonable grounds for the belief.[30]

50. Monash Health Medical Centre and Eastern Health clinical staff were aware of Catherine's disclosure of childhood sexual abuse[31] by an adolescent female. Catherine was 15 years old when she made the disclosure. The practitioners may have formed a reasonable belief there was no current risk, however at 15 years of age, the issue of 'reasonable belief' is influenced by the Department of Health's[32] clear advice. The Victorian Department of Health's

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28 Email from Monash Health dated 18 March 2015.

29 I note a 'mandatory reporter' under section 182 includes a registered medical practitioner.

30 *Children, Youth and Families Act 2005*, accessed at http://www.legislation.vic.gov.au. I note a penalty of 10 units applies to this provision.

31 Defined as infancy to 17 years of age.

32 As it then was.

Vulnerable babies, children and young people at risk of harm, Best practice framework for acute health services[33] states:

> *Research shows that the potentially profound effects of serious sexual assault on a child or young person are not always obvious and disclosure of the abuse is often delayed. A child or young person who has experienced past serious abuse, including sexual abuse, should be considered at risk of harm even if no obvious concerns are apparent.* [34]

iii. Impact of childhood sexual abuse

51. Childhood sexual abuse (CSA) has established implications for the mental health of victims. CSA is associated with an array of deleterious outcomes, including problems related to mental health, interpersonal functioning and substance use. Studies of community samples have consistently shown a substantial association between reports of CSA and suicide attempts and other self-destructive behaviour in young people and adults.[35]

52. The research on the longer-term impact of child sexual abuse indicates that there may be a range of negative consequences for mental health and adjustment in childhood, adolescence and adulthood. Not all victims experience these difficulties – family support and strong peer relationships appear to be important in buffering the impact.[36]

iv. Timing of disclosure of CSA

53. According to the National Child Protection Clearing House Practice Brief, children and young people can disclose CSA at any time[37] and older children may indirectly attempt to disclose or cope with their abuse through risk-taking behaviours. This can include self-harming, suicidal

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33 Victorian Government, Department of Health, 2006 *Vulnerable babies, children and young people at risk of harm, Best practice framework for acute health services*. 060303, August 2006, <http://health.vic.gov.au/childrenatrisk> accessed 9 December 2014.

34 Victorian Government, Department of Health, 2006 *Vulnerable babies, children and young people at risk of harm, Best practice framework for acute health services*. 060303, August 2006, <http://health.vic.gov.au/childrenatrisk> accessed 9 December 2014, page 8.

35 M Cutajar, P Mullen, J Ogloff, S Thomas, D Wells & J Spataro, 'Suicide and fatal drug overdose in child sexual abuse victims: a historical cohort study' (2010) *The Medical Journal of Australia* 192(4) 184-187.

36 J Cashmore, R Shackel, 2013. 'The long-term effects of child sexual abuse', Child Family Community Australia, Information Exchange, CFCA Paper No.11 2013.Page 1.

37 C Hunter, 2011. Australian Institute of Family Studies, Responding to children and young people's disclosures of abuse. National Child Protection Clearing House Practice Brief. Page 2. Accessed at: https://www3.aifs.gov.au/cfca/publications/responding-children-and-young-people%E2%80%99s-disclosures-abu.

behaviour, eating disorders and other types of risk exposure.[38] Once a child has disclosed CSA, a child or young person then requires access to support, advocacy and assistance to recover from the trauma of being abused.[39]

54. Some of the reasons thought to result in delayed disclosure by a child are pressure or threats from the perpetrator, expected consequences of telling, pressure from the child's family, fear of a negative reaction from parents or family, fear of not being believed, feelings of embarrassment, shame and self-blame and specifically for males, fears of stigmatisation and fear of being labelled as homosexual.[40]

55. Childhood sexual abuse can affect the child's capacity to establish and sustain relationships in their life, including with their families.[41] According to Deborah and Gerry Kottek and Drs Davies and Foster, Catherine had parent-child relationship conflict especially with her mother and was impacted by the long-standing acrimonious relationship between her mother and father. Family conflict occurs in the absence of CSA and there is evidence of parent-child conflict also occurred with Catherine's siblings.

v. Clinical treatment of a patient who has experienced sexual abuse

56. Trauma when it occurs in the "*childhood context which has particular impacts on the development of sense of self and is a negative impact on attachment with caregivers*"[42] is considered significant trauma and consideration should be given to the trauma as a possible source of symptoms/problems. According to the Centre Against Sexual Assault (CASA):

> *Treatment of [adult] survivors of childhood sexual assault incorporates a number of therapeutic approaches which reflect the major theoretical schools of therapy, emotional, cognitive and behavioural. Experiential or exploratory techniques focus on accessing emotions, re-experiencing the trauma and integrating these with the adult self. Cognitive therapy aims to identify the survivor's distorted cognitions of themselves, others and the world and attempts to replace these with more accurate and realistic*

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38 Ibid.
39 Ibid.
40 Ibid.
41 ASCA website. Impact of Childhood Abuse. Accessed at: http://www.asca.org.au/About/Resources/Impact-of-child-abuse.aspx.
42 L Wall & A Quadara, 2014. Acknowledging complexity in the impacts of sexual victimisation trauma. Australian Centre for the Study of Sexual Assault. Issues No 16 2014. Accessed at http://www3.aifs.gov.au/acssa/pubs/issue/i16/02.html.

cognitions. Behavioural therapies focus on enhancing the survivor's behavioural repertoire through the acquisition of more adaptive behavioural responses, coping strategies and learning new skills.[43]

57. The review of the available evidence suggests there was no focus on Catherine's experience of sexual assault or any resultant effects. It is unclear if this was because it was not seen to be an issue, it was attended to but not documented or because Catherine did not want to discuss it. The literature suggests once a disclosure is made, the child is more likely to disclose during formal investigation.[44] I consider the absence of any reference to the discussion of Catherine's experience of CSA is suggestive of it having not occurred.

vi. Dr Justin Foster

58. A further statement was obtained from Dr Foster on 17 April 2015, the treating Psychiatric Registrar at Eastern Health proximate to Catherine's death.

59. Dr Foster's was asked to address whether he gave consideration to the reporting requirements of the *Children, Youth and Families Act 2005* following a conversation with Catherine's father Michael Bernard on 3 December 2009.

60. Dr Foster's noted a session on 18 November 2009 with Deborah and Gerry Kottek where:

> "*Deborah informed me that she had made a notification to Child Protection about a variety of issues which included the previous sexual abuse. Other issues discussed with Child Protection included Catherine's schooling, her previous self harm and the overdose, the current EH CYMHS assessment and Deborah's difficultly in contacting her daughter who at the time had moved up to Ballarat to live with her father Michael.*"

61. On 18 November 2009 and after the meeting, Dr Foster spoke with Child Protection worker, Maureena at Box Hill Child Protection. She confirmed Deborah Kottek had made a notification but he was unsure if it included sexual abuse. Dr Foster believed Michael Bernard, Catherine's father had been told by Child Protection of the previous sexual abuse, although he had not documented this when he spoke to him on 3 December 2009.

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43 Centre Against Sexual Assault – South Eastern. http://www.secasa.com.au/pages/working-with-adult-survivors-of-child-sexual-assault/.

44 C Hunter, 2011. Australian Institute of Family Studies, Responding to children and young people's disclosures of abuse. National Child Protection Clearing House Practice Brief. Page 2. Accessed at: https://www3.aifs.gov.au/cfca/publications/responding-children-and-young-people%E2%80%99s-disclosures-abu.

62. Dr Foster believed a notification had been made to Child Protection and that it included previous sexual abuse however the report from Child Protection does not reflect a notification of this kind had been made.

63. The email with Dr Foster's letter also included information from Chief Counsel Eastern Health (Dr Foster's current employer), Sue Allen, regarding medical staff training for mandatory reporting requirements:

> "*In relation to the training requirements of medical staff regarding mandatory reporting in 2009 and since, I understand that all medical schools in Victoria incorporate a Law & Ethics component throughout their medical training (and have done so since at least 2009) which would cover this topic...At Eastern Health, the interns undergo an induction program and weekly education sessions throughout their internship, and this topic is usually covered in one of those sessions.*"

vii. Child Protection

64. The Department of Heath confirmed via email dated 13 August 2012 that Child Protection involvement had ended more than 12 months prior to her death. Child Protection were involved with Catherine during 1999 in relation to her father and in 2009 following a report concerning Catherine's mental health and recent overdose.

65. The Child Protection history for Catherine Bernard updated 13 August 2012 and compiled by Ms Amanda Mason has no record of CPS being aware of the disclosure of childhood sexual abuse by Catherine.

viii. Monash Health

66. Monash Health was asked to provide information regarding the organisation's activities related to mandatory reporting. The service provided the following documents:

    a. 2009 documents available to all staff working in the ED in October 2009

        i. Southern Health Vulnerable Babies, Children & Young People at Risk of Harm, Risk Assessment & Management, September 2007;

        ii. CP-VC03: Guidance Information: Management of Vulnerable Babies, Children and Young People, v1.0, September 2008; and

iii. Flowchart for the management of vulnerable babies and children in the Emergency Department, Southern Health, August 2009.

b. Current documents

i. Vulnerable Children/Unborn Babies Policy, 31/8/2012, last updated 25/7/2014; and

ii. Vulnerable Children Procedure, 31/8/2012, last updated 8/4/2014.

67. The policies and procedures that applied at the time of Catherine's death appear to support the notion that notification should have occurred. The more recent Vulnerable Children/Unborn Babies Policy and Vulnerable Children Procedure are more detailed and provide greater guidance to staff. The definition of "reasonable grounds" is a useful addition, although it does not refer to direct disclosure by a child or young person.

68. The Monash Health Director of Paediatric Emergency Medicine provided information on current systems and requirements for staff training on polices and procedures at Monash Health:

a. current procedures are available on Monash Health's Web based clinical procedure warehouse system called PROMPT and are available and applicable to all Monash Health staff;

b. education in this area has been an ongoing endeavour with staff trained to be vigilant in considering if a child might have presented to the ED as a result of abuse;

c. senior medical staff are expected to be very familiar with the procedure. They are updated through the Monash Health Morbidity and Mortality process which occurs every three months;

d. Paediatric Registrars receive updates on the vulnerable children pathway approximately every three months. This involves a representative from the Victorian Forensic Paediatric Medical Service (VFPMS) presenting to the registrars and conducting a discussion. Most of Monash Health's Paediatric Registrars will have some experience or a heightened sense of awareness of the issues having worked at the Royal Children's Hospital before working with Monash Health;

e. mandatory reporting is a component of undergraduate medical teaching and is a core topic in the Australasian College for Emergency Medicine (ACEM) curriculum and the Royal Australasian College of Physicians (RACP). The topic is covered on a rotational basis in Monash Health's ACEM and RACP emergency programs;

f. nursing staff complete a 'mandatory reporting' package; and

g. ED staff have access to online pathways and rapid access to VFPMS clinicians and Monash Health Paediatricians for advice.

ix. Facebook

69. According to the Alannah and Madeline Foundation, bullying occurs "*...when an individual or a group of people with more power, repeatedly and intentionally cause hurt or harm to another person or group of people who feel helpless to respond. Bullying can continue over time, is often hidden from adults, and will probably continue if no action is taken.*"[45] Bullying does not include a single episode of social rejection or dislike, single episode acts of nastiness or spite, random acts of aggression or intimidation or mutual arguments, disagreements or fights. [46]

70. The limited amount of information available regarding the Facebook exchanges is not suggestive of bullying. Both exchanges are related to comments by friends to activities that had taken place. It was not systematized, repeated nor random.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. Monash Health did not make a report to Child Protection and they also did not provide any information about the existence of specialist services that Catherine and/or her parents may have been interested in pursuing. This is most likely because the assumption was it would be followed up by mental health services. There is nothing in the evidence available to me to suggest anyone at any time, across all services and either parenting group, considered referral to a specialist service. The assumption that mental health services have the expertise in evidence-based therapies for childhood sexual abuse therapies is perhaps unfounded.

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45 Alannah and Madeline Foundation, accessed 25 March 2015 at: <http://www.amf.org.au/parents/whatisbullying/>
46 Alannah and Madeline Foundation, accessed 25 March 2015 at: <http://www.amf.org.au/parents/whatisbullying/>

2. A review of recent literature regarding youth suicides reveals there is a complex interrelation of factors. Self-esteem issues[47] and stressful life events are associated with suicide. The triggers are specific to the individual and often in spite of what other people view as quite insignificant events, can be a source of intense personal stress to the youth:

> *Stress can contribute to suicide. A young person or teenager may experience an overwhelming and immediate stress or they may have stress that builds up over a long time.*[48]

3. The stress may arise from the normal outcomes of situations outside of the youth's control, from underlying illness, from poor coping skills and impulsivity of the youth.[49] There is evidence of parent-child conflict reported to be a trigger in up to 50% of cases.

4. Education of primary care hospital staff in identifying and responding to the requirements for mandatory reporting under the *Children, Youth and Families Act 2005* (Vic) provides an opportunity to offer victims of childhood sexual abuse the help and support they might need, an opportunity which was, on the evidence before me, lost in Catherine's case.

5. The improvements made to the Monash Health policies, procedures and staff training will improve staff knowledge and increase the safety of children and young people who disclose or are believed to be experiencing, or have experienced childhood sexual abuse. At the very least, it is reasonable for an Emergency Department where a disclosure of sexual abuse has been made, regardless of the victim's age, to provide information on services that may be of use to the victim and/or their families, including specialist sexual assault services such as Centres Against Sexual Assault.

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47 A George and H Van Den Berg, 'The influence of psychosocial variables on adolescent suicidal ideation', (2012) *Journal of Child and Adolescent Mental Health* 24 (1), pp. 45-57.

48 Better Health Channel http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Youth_suicide_prevention_the_warning_signs.

49 M Steele and T Doey, 'Suicidal Behaviour in Children and Adolescents Part 1: Etiology and Risk Factors' (2007) *The Canadian Journal of Psychiatry*, 52 (6), 21.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. With the aim of preventing future lost opportunities to provide its patients and/or their families with the appropriate information in an attempt to link them with supportive services, I **recommend** Monash Health Emergency Department develop for patients, victims and/or their families who disclose to their staff or that their staff are aware have made a recent disclosure, of sexual assault, information providing details of Victorian specialist sexual assault or other appropriate services.

   Another opportunity lies in mental health practitioners, especially Psychiatrists' understanding the impact of childhood sexual abuse and best practice in clinical treatments.

2. With the aim of promoting increased awareness amongst treating Psychiatrists of best practice in clinical treatments of childhood sexual assault victims, I **recommend** the Royal Australian and New Zealand College of Psychiatrists provide advice to its members and in its training program regarding best practice in responding to disclosure and clinical treatments for the impacts of childhood sexual abuse, including the available Victorian specialist services.

FINDINGS

I find that the identity of the deceased was Catherine Jane Bernard, born on 14 July 1994 and the death occurred on 2 February 2012 at the railway track between Mount Waverley and Syndal train stations, Mount Waverley.

There was no evidence that Emmaus College was aware of the allegations of childhood sexual assault made by Catherine. Emmaus College appears to have provided Catherine with engagement and support via school counsellors. I accordingly find that the engagement and support provided by Emmaus College was appropriate.

On the evidence before me, it appears there was a misguided response by staff at Monash Health to Catherine's allegations of childhood sexual assault. It does not appear that staff adequately turned their minds to the mandatory reporting provisions in the *Children, Youth and Families Act 2005* (Vic), specifically the 'reasonable belief' grounds, which are guided by the Victorian Department of Health's *Vulnerable babies, children and young people at risk of harm, Best practice framework for*

acute health services. The failure of staff to report was also inconsistent with Monash Health's policies and procedures in place at the time. The apparent lack of appropriate referral or provision of specialised supportive services information represents a lost opportunity for Catherine to engage with specialised clinicians in this area. I cannot however find a causal link between these shortcomings and Catherine's death.

I commend the improvements made to the Monash Health policies, procedures and staff training. Education of the importance of the reporting of such a disclosure necessitates that clinicians do not feel that they have to assess whether the disclosure is factual or indeed where it may lie within the plethora of other factors affecting the behavioural and mental health of the child.

The investigation identified a number of apparent precipitating factors that might have influenced Catherine's decision to adopt the course of action she ultimately chose, including ongoing mental health issues, allegations of childhood sexual assault, complex familial and social relationship issues and previous attempts at self-harm.

Although the text on Facebook does not suggest bullying, this does not rule out the possibility of Catherine being distressed by her behaviours, their consequences and the reaction of her friends, especially on the first day back at school, the day of her death. Catherine had a history of responding to personal distress with self-harming and/or suicide attempts.

I accept and adopt the medical cause of death as identified by Dr Melissa Baker and find that Ms Catherine Jane Bernard died from multiple injuries due to impact by train in circumstances where I am satisfied that she intended to take her own life.

I direct that these findings be published on the Coroners Court of Victoria's website.

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

Mrs Deborah Kottek

Ms Susan Van Dyk on behalf of Monash Health

Ms Sue Allen on behalf of Eastern Health

Ms Penelope Vye, Manager, Centre Against Sexual Assault House

Mr Jason Newman, Gilchrist Connell Lawyers, on behalf of Emmaus College

The Royal Australian and New Zealand College of Psychiatrists

Professor Jeremy Oats, Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Dr Mark Oakley Browne, Chief Psychiatrist

Mr Michael Averkiou, Department of Transport

Metro Trains Melbourne

Senior Constable Melissa Wood

Signature:

AUDREY JAMIESON
CORONER
Date: **5 October 2015**