IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 5106

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, CAITLIN ENGLISH, Coroner having investigated the death of KJ

without holding an inquest:
find that the identity of the deceased was KJ
born on 19 August 1994
and the death occurred on 30 November 2012
at train tracks between Mordialloc and Aspendale railway stations
from:

1 (a) MULTIPLE INJURIES DUE TO IMPACT BY TRAIN

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. KJ was 18 years of age at the time of her death. She resided at 59 Denver Street, Bentleigh East, with her aunt and uncle, Ruth and Gary Johnston and their sons.

2. A police investigation was conducted into the circumstances of her death.

3. A brief prepared by Victoria Police for the Coroner includes statements obtained from KJ's mother, uncle, auntie and treating consultant psychiatrist. The brief also includes a report on investigations undertaken by Mr Paul Downes, senior investigator, Metro Trains, Melbourne. I have drawn on all of this material as to the factual matters in this finding.

Family background

4. KJ was born to parents, Tracy Goodman and Steve Johnston. Ms Goodman had two other daughters, Tamika Goodman-Callinan and Jessica Stellmacher.

5. Child protection was involved with KJ between 1994 and 2007.[1]

6. In July 1996, protective intervention was made by the Department of Human Services (DHS) when KJ was almost two years old. According to Amanda Mason of DHS, *"...the girls' mother required hospitalisation and the girls were placed in a foster care placement subject to an Interim Accommodation Order."*[2]

7. KJ's father recommenced caring for KJ in January 1997. He gained a Family Court order for KJ to remain in his care.

8. On 19 May 2001, KJ was the victim of an abhorrent sexual attack when she was abducted and raped, aged 6.

9. Andrew Davies was ultimately sentenced to a 16 year total effective sentence with a non parole period of 12 years for the offending, following a successful sentence appeal in the Supreme Court of Victoria.

10. KJ returned to her mothers care in 2001 when she was 7 years old. Her father relocated to Western Australia.

11. In 2007, KJ went to live with her paternal uncle and aunt, Gary and Ruth Johnston, with community support in place. She resided with them for the next six years.

Mental health history

12. On 14 April 2012, KJ made an attempt to end her own life. KJ had been drinking with friends and indicated to her mother on a telephone call that she intended to jump in front of a train. Police were notified and located her.

13. On 16 April 2012, KJ was referred to the Alfred Child and Adolescent Service (CAMHS).

14. She was admitted to the Stepping Stones Child and Adolescent Mental Health Unit at Monash Medical Centre on the same day under the care of consultant psychiatrist, Dr Kesarios.

15. According to Dr Carolyn Simms, consultant psychiatrist, Monash Crisis Assessment and Treatment Team (CATT), "KJ *described depressive symptoms of several years*

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[1] Summary of child protection history for KJ – COR 2012 005106, Amanda Mason, Department of Human Services, 3 December 2012, 1.

[2] Ibid.

duration which had recently worsened in the context of significant stressors and losses over the preceding year. These included the deaths of her grandfather and her best friend who also suicided in front of a train in August 2011. In addition her dog and cats had also died. KJ *was also aware that the paedophile, who raped her at the age of six, was due for release from jail in 2013.* KJ *had also had bowel surgery for an obstruction in August 2011."*[3]

16. KJ reported a background of self-harm for a number of years. Two weeks prior to her admission she reported that she had taken an overdose of paracetamol.

17. During her admission to the Stepping Stones Unit, KJ was initially prescribed Efexor and Seroquel. This was ceased following an impulsive overdose whilst on leave, in the context of increased emotional distress following conversations with her boyfriend and friends.

18. KJ was treated as an involuntary patient for two days and discharged four days later to attend Alfred CAMHS.

19. On 30 August 2012, KJ was referred by her uncle to the psychiatric triage service, Monash Crisis and Treatment Team as she had been reportedly self-harming. according to Dr Carolyn Simms, *"reported feeling more suicidal since her eighteenth birthday party. She stated she felt she had nothing to look forward to now her birthday had passed. She described ongoing nightmares, seeing the rapist's face and hearing voices telling her he will do it again."*[4]

20. Following medical review, the plan was to provide daily support whilst awaiting private admission. This included monitoring of her mental state and risk.

21. KJ overdosed on 3 September 2012. She was admitted to Dandenong Psychiatric Centre voluntarily under the care of consultant psychiatrist, Dr Dharmagee.

22. KJ according to Dr Simms, *"described being distressed by auditory and visual hallucinations of the rapist..."*[5]

23. On 7 September 2012, a meeting was held and KJ was discharged to await private admission with her guardians. It was considered that the acute risk had diminished.

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[3] Statement of Dr Carolyn Simms, 20 January 2012, 1.

[4] Ibid, 2.

[5] Ibid, 3.

24. During October 2012, KJ was admitted to the Albert Road Clinic but was reported to have discharged herself after one week.

25. On 29 October 2012, KJ overdosed on a combination of cough medicine, Panadol, Neurofen, travel sickness medication, bleach and vodka.

26. A friend contacted an ambulance and KJ was seen by Emergency Psychiatric Services at Monash Medical Centre.

27. On assessment according to Dr Simms, KJ *"described having overdosed in the context of 'everything having got too much'. She reported ongoing traumatic symptoms related to past abuse, stating she sees the man who raped her."*[6]

28. KJ felt comfortable returning home and accepted follow up with the Monash Crisis Assessment and Treatment Team. Her uncle, Garry Johnston was present when the plan was made and she was discharged.

29. KJ was discharged from the Monash Medical Centre Crisis Assessment and Treatment Team's care on 5 November 2012. It was felt the current crisis had resolved. KJ denied suicidal ideation and was happy to follow up with Dr Needwell and engage with a private psychiatrist. KJ had no further contact with Southern Health Mental Health Services Program.

30. KJ's auntie, Ruth Johnston described several stressors which KJ faced prior to her death;

"At the start of the 2012 school year the work load of year eleven was difficult. She seemed ... anxious about little things. The next significant thing was when her father rang...[out of]... the blue and told her straight out that the man that attacked her was getting out. She was both furious and upset over being told this. I tried to convince her he was only up for parole next year being 2013...She started having nightmares and started seeing him in her room at night."[7]

31. In the week leading up to her death KJ visited her sister in Ballarat. Her uncle, Gary Johnston described that *"It went down hill when she visited her sister in Ballarat. She*

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[6] Statement of Dr Carolyn Simms, 20 January 2012, 3.

[7] Statement of Ruth Johnston, 2.

was there for a few days and had overdosed while up there. I don't know what triggered it."[8]

Events Proximate to Death

32. Dr Ronald Schweitzer was KJ's treating general practitioner for six years. He stated as follows:

"Whilst KJ *had had constant thoughts of suicide, these thoughts had become stronger over the preceding few months after she had been informed...that the person who had sexually assaulted her when she was six years old...would be coming up for parole next year. Since receiving this information,* KJ *significantly deteriorated."*[9]

33. On 30 November 2012, KJ saw Dr Schweitzer at his East Bentleigh Medical Group practice.

34. She reported that she had taken tablets and alcohol two days prior in an attempt to end her life. She reported feeling depressed at her sisters house and recurring nightmares about the offender who raped her. Dr Schweitzer noted that she stated that, *"[t]he nightmares – he's there, he's going to come and kill me and I deserve what I got. It scares me because I'm scared he'll come and find me."*[10]

35. Dr Schweitzer organised a review for two weeks time and suggested that her auntie and uncle take the lead in her not going to her sisters for Christmas as this presented as a source of anxiety.

36. Dr Schweitzer summarised his support to her during his treatment of her as follows;

"Commencing her on anti depressant medication, Counselling and supporting her (with the assistance of her supportive Aunt and Uncle), Referring her to the CAT Team at the Alfred, Having her admitted to Stepping Stones, Referring her to a psychologist (Ms Gillian Needleman) under the Better Access to Mental Health Program, Referring her to the Delmont Private Hospital and the Albert Road Clinic".[11]

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[8] Statement of Gary Johnston, 13 February 2013, 1.

[9] Ibid.

[10] Letter of Dr Ronald Schweitzer, 7 February 2013, 1.

[11] Ibid.

37. On the same day as her appointment with Dr Schweitzer, she went shopping with her uncle for her friend's birthday present. According to her auntie, *"...she seemed in really good spirits..."*[12]

38. KJ asked her auntie and uncle if she could stay at her friends house which they were comfortable with. Her uncle dropped her off at approximately 5.30pm and she spoke to her auntie at approximately 9.30pm when she still sounded in good spirits.

39. At approximately 11:34pm, the 10:45pm Frankston train was travelling south between Mordialloc and Aspendale rail stations when the leading carriage struck KJ approximately 880 metres south of the Mordialloc Train station.

40. KJ was walking with a friend when she ran from the eastern side and according to witness Bill Mitsos, she *"leapt into the air onto the railway line"* and was hit by the train.[13] Mr Mitsos described that there was another girl present who had attempted to stop KJ from leaping in front of the train unsuccessfully.

41. Mr Benjamin Ter Haar Metro trains driver stated as follows;

"I saw two people beside the track about a train length or a bit more in front of me...The two people were standing to the left of the track. They were less than five metres away from the track so I blew the whistle to let them know that a train was coming. As soon as I blew the whistle, one person ran towards the track. They ran from my left to right. They ran quickly up the ballast (crushed stones) at the side of the track. I thought that the person was just going to run across the tracks to get to the other side but when they reached the track that I was travelling on, they turned to face the train and ran straight towards me. I immediately put the train brake into the emergency position and blew the whistle..."[14]

42. The train driver sounded the train whistle and applied the emergency brakes but could not avoid a collision. The site of the collision is opposite Attenborough Road approximately 166 metres south of the Station Street level crossing which is approximately 880 metres south of Mordiallic.

43. According to Mr Downes, *"the rail reserve is approximately 25m wide, bordered by Station Street to the east and Nepean Highway to the west. A 1200mm high, cyclone wire fence*

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[12] Statement of Ruth Johnston, 13 February 2013.

[13] Statement of Bill Mitsos, 3 December 2012, 2.

[14] Statement of Benjamin Ter Haar, 7 February 2013, 2.

separates the rail reserve from the Nepean Highway. The eastern border of the rail reserve is unfenced although shrubs and trees form a partial barrier. Short grass and trees grow along both sides of the rail reserve. The vegetation blocks the streetlights and so the track area is quite dark at night."[15]

44. KJ sustained major injuries and died at the scene.

45. Police, Ambulance and Fire authorities attended.

46. A preliminary breath test was conducted on the driver which read negative for alcohol.

47. The general prevailing maximum speed limit over the section of track between Mordialloc and Frankston is 95km per hour.

48. The train datalogger recorded the train travelling at a speed of 67km per hour at the time the emergency brakes were applied. The train datalogger indicates the emergency brake application was initiated at approximately 23:35:22 hours for a total of 22 seconds and travelled 231 metres while the train slowed from 67km per hour to a full stop. The total breaking distance was 231 metres.

49. Mr Downes concluded that KJ *"was on the rail reserve without authority at a place where there was no designated pedestrian crossing...I consider that the proximity of the train to [KJ] when she stood on the track in front of the approaching train provided insufficient time and distance within which the driver might halt the train and avoid a collision... The train datalogger indicates that the train was operated well within the prevailing line speed limit."*[16]

Post Mortem Examination

50. A post mortem inspection report was completed by Forensic Pathologist Dr Melissa Baker at the Victorian Institute of Forensic Medicine on 3 December 2012. Dr Baker formulated the cause of death. I accept her opinion.

51. Therapeutic concentrations of fluoxetine and citalopram were identified in the toxicology report.

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[15] Statement of Paul Downes, Metro Trains Investigation Report, 20 March 2013, 4.

[16] Statement of Paul Downes, Metro Trains Investigation Report, 20 March 2013, 11.

Coroners Prevention Unit

52. As part of my investigation I referred this matter to the Coroners Prevention Unit[17] (CPU) to ascertain whether any research had been conducted regarding Victorian suicides among people who were the victims of sexual assault.

53. The CPU identified 72 confirmed suicides between 1 January 2009 and 31 December 2011 where there was evidence the deceased was a victim of sexual assault. In a further 10 deaths, the deceased's intent could not be determined.

54. An analysis of the 72 suicides showed that the majority of both males and females were sexually assaulted as children and suicided as adults. Amongst both males and females, most suicides occurred more than five years after the sexual assault occurred.

55. The findings suggest that sexual assault might not be an immediate proximal stressor for suicidality, but rather its impact as a suicide stressor on the individual develops over time.

56. This is consistent with the existing research in this area which shows that victims of sexual assault (and particularly child victims) are at increased risk of suicidality over the course of their lives. The development of post traumatic stress disorders and /or depressive disorders (which are independently associated with elevated suicide risk) over the course of the months and years following the sexual assault might assist in explaining why suicidal behaviour emerges some time after the assault itself.

COMMENTS

Pursuant to s 67(3) Coroners Act 2008, I make the following comments connected with the death:

Inquiries made as part of this investigation revealed that the offender whose release from jail KJ feared, Andrew Davies, in fact died in custody in 2007. Tragically, the fear that the prospect of his imminent release provoked in KJ was unfounded.

Information is now available to victims about offenders who have been found guilty of charges against them. On 30 August 2004 a Victims Register was established within Corrections Victoria which provides information about offenders to victims who apply to be placed on the Register.

[17] The CPU is a specialist service created for coroners in order to provide them with assistance during the course of an investigation. The CPU reviews particular types of deaths and assists the coroner in developing prevention-focused recommendations.

Information provided includes an offender's earliest possible release date and notice if the offender dies during their sentence. Since 2007 the Registry has been managed by the Victims Support Agency.

The offender, Andrew Davies, was found guilty of abduction and rape after a County Court trial in 2002. His case went on appeal and was not ultimately finalised by the Court of Appeal until 21 April 2005. Despite this being after the establishment of the Victims Register, KJ was not registered, although she would have been entitled to apply.

The death of KJ is one of many Victorian suicides in circumstances where the deceased had been sexually assaulted in the past. The trauma of this experience was undiminished by time and ultimately that experience, and the belief of the offender's imminent release from jail, has been contributing stressors in her suicide.

The Australian Institute of Family Studies 2013 report, *The long-term effects of child sexual abuse* notes: 'To date, the strongest links have been found between child sexual abuse and the presence of depression, alcohol and substance abuse, eating disorders for women survivors, and anxiety related disorders for male survivors. An increased risk of re-victimisation of survivors has also been demonstrated consistently for both men and women survivors. Some more recent research has also revealed a link between child sexual abuse and personality, psychotic and schizophrenic disorders, as well as a heightened risk for suicide ideation and suicidal behaviour.'

RECOMMENDATIONS

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

1. That Victims Support Agency should consider publicising the role of the Victims Register to the general public so that victims whose cases pre-date its establishment are aware of its existence and the services available.
2. Policy makers, funders and service providers in the field of victim support consider how ongoing safe and effective support can be made available to people who have been sexually assaulted, to reduce the incidence of deaths in these circumstances.

Finding

I find KJ died from the multiple injuries sustained from the impact by train in circumstances where she intended to take her own life.

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

Ms Tracey Goodman

Mrs Ruth Johnston

Senior Constable Michael Fullarto

Victims Support Agency

Dr Ronald Schweitzer

Signature:

CAITLIN ENGLISH
CORONER
Date: 13 April 2105