IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 1434 / 2008
1456 / 2008
1464 / 2008
1465 / 2008

REDACTED FINDING INTO DEATH WITH INQUEST

(Amended pursuant to Section 76 of the *Coroners Act 2008* on 26 September 2012)

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: RGF

Delivered On:	7 September 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne, Vic, 3000
Hearing Dates:	10,11, 12 and 13 October 2011 and 4 November 2011
Findings of:	JUDGE JENNIFER COATE, STATE CORONER
Representation:	Mr Brian Birrell, Solicitor, on behalf of SB Mr J Ruskin, QC with Mr Chris Winneke on behalf of DEECD Ms Sara Hinchey on behalf of IL
Police Coronial Support Unit	Sergeant Tracy Weir

I, JUDGE JENNIFER COATE, State Coroner having investigated the death of

RGF

AND having held an inquest in relation to this death on 10, 11, 12 and 13 October 2011 and 4 November 2011

at Melbourne

find that the identity of the deceased was RGF

and the death occurred 13 March 2008

at an address provided to the court

from:

1 (a) Firearm injury to the head and neck[1]

in the following circumstances:

Background

1. RGF was born in Shepparton on 29 November 1973 and was aged 34 at the time of his death. He had lived in the Shepparton-Mooroopna area all his life, and was a qualified diesel mechanic.
2. RGF's sister Denise described RGF as a caring person who loved his children very much. His mother also made a statement to police[2] in which she outlined what she knew of RGF's home and work life, and stated that she loved him very much. RGF's brother Stephen described him as a socially popular person.
3. In 1995, RGF commenced a relationship with LF. The couple did not marry, although LF adopted RGF's surname. During their relationship, LF and RGF had three sons together. Prior to their meeting, LF had a daughter from a previous relationship, SB. SB was about six years of age when her mother commenced her relationship with RGF, and he took on the role of stepfather to SB.
4. It was the evidence of LF that in the four years preceding RGF's death, the couple had been living separately in the same home.

[1] Forensic pathologist Dr Paul Bedford: Autopsy report 10 July 2008

[2] Inquest Brief p.134

Circumstances surrounding the death of RGF

5. RGF was initially thought to have disappeared from his home on the evening of 13 March 2008. Over the next few days, LF received a number of messages from his mobile phone, indicating that he had commenced a new relationship. As a result of those messages, LF believed that RGF had left her for another woman.
6. On 4 April 2008, RGF's brother filed a missing persons report. In the course of responding to this report, police obtained a statement from SB on 8 April 2008. She initially denied any knowledge of RGF's whereabouts.
7. On 9 April 2008, human remains believed to be those of RGF were found. SB was formally interviewed on 10 April 2008 in relation to RGF's death. In that interview, she disclosed, with considerable difficulty, that RGF had been sexually abusing her since she was approximately 14 years old. She reported that this had been accompanied with threats of violence, including threats to kill. SB stated that some of these threats were accompanied by the production of a knife.
8. During that interview, SB confessed that on 13 March 2008, she had shot and killed RGF. She stated that on that day, she had been subjected to two episodes of sexual abuse by him. On the second of these occasions, she had tried to resist, however he removed a shotgun from his gun cabinet, loaded it with a single cartridge, pointed the gun at her, and forced her to perform a sexual act. At some point he had his back turned toward her. Without his knowledge, SB had picked up the loaded gun and fired a single shot to the back of his head, killing him instantly.
9. In the interview, SB described being highly distressed and overwhelmed by what had happened. Confused and fearing the prospect of jail, she described how she proceeded to dismember the body and dispose of the remains, whilst fabricating a story that RGF had left his family.
10. In her interview, SB stated that she had not planned to kill RGF, but had acted spontaneously because she just wanted him to go away.
11. She was also asked whether she told anybody about the sexual abuse. She stated that she could not tell anybody because she believed RGF would kill her. She also stated that she hated what was happening and if ever anyone else knew, then she had to accept that it was real.[3]

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[3] See question and answer 629: Record of interview. I note that the only evidence of any disclosure made by SB to any person is contained in the evidence of her friend Tye. At the committal, Tye gave evidence that after he told SB that he liked her, SB told him that nothing could happen because RGF would not allow it. When Tye questioned SB as to what RGF had to do with it, she told Tye, according to his evidence, that RGF had taken photos of her when she was little. Tye stated that when he asked her if she would go to the police SB said she would not because RGF had told her that if she did "*he would stab her straight in the heart.*" Tye stated that he offered to go to the police but SB told him that would "*only make things worse.*"*(Commital transcript at P.759 of the Inquest Brief.)*

12. When SB was asked what kind of threats RGF had made, she stated: "*he'd always say that if ever I told anyone or if I'd ever left or anything, he'd – he'd find me and kill me. He'd always say that he'd shoot me: He said he'd stab me. He's got a knife out a couple of times...*"[4]
13. Further in the interview, SB was asked whether RGF had ever threatened her with a firearm before, to which she answered he had told her before that he would shoot her. When asked what was different about this time she replied: "*He put a bullet in the gun.*"[5]
14. In the wake of that interview on 10 April 2008, SB was arrested and charged with the murder of RGF.
15. SB was committed to stand trial after a number of witnesses were examined at committal.

Supreme Court Proceedings

16. In the Supreme Court on 10 March 2009, a directions hearing was held before the Honourable Justice Cummins in preparation for the trial. At that directions hearing, His Honour drew the prosecutor's attention to the state of the evidence concerning the history of sexual abuse and the nature of the continuing violent threats posed to SB at the hands of RGF. He asked that the prosecution consider its position.

Director of Public Prosecutions (DPP) withdraws the charge

17. On 27 March 2009, the Director of Public Prosecutions filed a notice that the prosecution was being discontinued in the trial of SB after which she was discharged from court.
18. Whilst addressing the court regarding the decision of the Director of Public Prosecutions to follow this course of action, the Director said as follows:

> "*I have reached the conclusion that there is no reasonable prospect that a jury would convict SB of any offence arising from the tragic events that led to her shooting dead RGF on 13 March 2008 and interfering with his body. I stress Your Honour this decision has been made solely on the basis of a careful consideration of the strength of the evidence in this case and the likely impact on the jury's consideration of that evidence under the new statutory provisions relating to self defence and family violence... I recognise that the physical or sexual and psychological abuse to which SB was subjected since the age of 14 and the circumstances that confronted her immediately*

[4] Record of interview Ans: Qu: 632

[5] Record of Interview Ans: Qu: 638

before she shot the deceased were such as to make it extremely unlikely that a jury would convict her of any offence arising from the death of RGF."[6]

19. After the discontinuation of the trial, an inquest brief was prepared and submitted by the investigating member from the Homicide Squad, Detective Senior Constable Barry Gray.

The investigation and inquest proceedings

20. The investigation into the particular circumstances in which RGF's death occurred raised a number of issues relevant to the coroner's role. The public part of the coronial investigation commenced by way of a directions hearing on 10 February 2011. At that directions hearing, I indicated my view that there were aspects of the circumstances in which the death of RGF occurred which had not been explored in the context of the criminal investigation but were potentially of relevance for the coroner's investigation.
21. I identified the areas of the circumstances of RGF's death which warranted further investigation as (i) the mandatory reporting of child sexual abuse and in particular the training provided to teachers with respect to their statutory obligations, and (ii) the community awareness of child sexual abuse and (iii) what the community understood about how to use the systems available to them and the barriers to reporting. These issues arose in light of evidence that a number of members of the adult community around SB held concerns about the nature of the relationship between SB and RGF, and based on information that two teachers at SB's school appeared to have information about the abusive relationship but had not acted upon it.
22. At a second directions hearing on 18 May 2011, the legal representative on behalf of one of the teachers at SB's school submitted that an inquest should not be held. I ruled against this submission by way of written ruling dated 29 September 2011.[7]
23. The inquest proceeded over four days and took evidence from witnesses from the community around SB including her grandmother, some of her friends and some parents of those friends. There were also witnesses from the Department of Education and Early Childhood Development (DEECD) and teachers from SB's school, Mooroopna Secondary College.
24. The issues raised during the course of the inquest touched upon the areas identified at the directions hearing and are set out in this finding.

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[6] There were over 9000 photographic images located in RGF's shed during the police investigation confirming the nature of the sexual abuse SB had endured.

[7] This ruling can be found on the Court website under Rulings: 29 September 2011

S. 67 Mandatory findings

25. Having investigated the death of RGF, the first two mandatory findings required of the coroner by s.67 of the *Coroners Act 2008* (Vic) being identity and cause of death were not controversial in this case.
26. The evidence was that RGF died on 13 March 2008 at his home address, as a result of a single gunshot injury to his head in the circumstances set out above.
27. However, as noted above, it was the circumstances in which his death occurred that raised the issues set out above for investigation at inquest.
28. It would appear that as a result of the photographic images found, SB's statements of the sexual abuse perpetrated upon her were accepted by the DPP and the Supreme Court. No question has been raised as to the veracity of SB's account of what happened.

Suspicion of harm to SB among her friends

29. SB had three close friends throughout secondary school, Jade, Amy and Chloe. Each of these three girls gave evidence at the inquest. They impressed as intelligent and articulate young women who were very fond of their friend SB and troubled by what they saw of her relationship with RGF. Each of the girls indicated that they had endeavoured to get SB to open up to them on many occasions. However, SB was described as having been resistant to any discussion of this kind.
30. The evidence of the three girls was that they were concerned that RGF was so excessively controlling of SB that he must be hurting her in some way. Over the Easter period of 2005, the girls attended a camping trip with SB and RGF. During this trip, RGF had made them feel uncomfortable on a number of levels including making comments about SB's breasts in their presence. It was the evidence of the girls that this was of obvious embarrassment to SB and in their view was not something a father should say about his daughter.
31. Subsequent to this Easter camping trip, Jade sent an email to SB containing a comment about RGF. It appears that this email was read by RGF, and as a result, the three girls were prohibited from seeing SB anymore outside school hours.[8] This was at the end of Year 10 in 2005. SB had previously told the girls that RGF checked her emails and phone messages.

Suspicions of sexual abuse among adults who knew SB

32. Witness statements contained in the inquest brief indicate that a number of adults known to SB held suspicions and/or concerns about the nature of the interaction between RGF and SB.

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[8] Inquest Brief p.324

33. RGF was described by a number of witnesses as extremely controlling and obsessive in his treatment of SB. The weight of the evidence is that he sought to control where SB went, what she was wearing and with whom she was having contact. The evidence suggests that he tried to limit her contact with peers and prevent her involvement in social events and extra-curricular activities.

34. It was further indicated that observers were often left with the impression that something was 'not quite right' about the manner in which RGF treated SB, and there was plenty of suspicion that RGF may be engaging in some form of sexual misconduct against SB.

35. SB's mother did not give evidence at the inquest. However, her statement documents that she had frequently put to RGF that something was going on between him and SB. In her statement she explained, *"I was very worried that I might have been wrong about [RGF's] relationship with [SB] and I didn't want to tear the family apart over something that [RGF] kept denying and saying that I had a mental problem about and that I was bi-polar."*[9] Further, she added, *"I didn't speak with [SB] about her relationship with [RGF] very often but when I occasionally did she would not respond in any way."*[10]

36. SB's mother did give evidence in the committal proceedings. In the course of giving evidence, LF stated that RGF had started to take more interest in SB in about 2003 after her son was born. She stated that RGF would comment on the size of SB's breasts, and had started to get very controlling about what SB was wearing and where she was going, and started making derogatory comments about SB and intruding on her when she was in the bathroom. She stated that she had the feeling that something was not right between them. She stated that RGF started to exclude her and turn his attention to SB. She stated that he would go everywhere with SB. The effect of LF's evidence was that she was confronting RGF about her suspicions and asking SB what was going on, but was met with derision and abuse from RGF and resistance and denial from SB. There is no evidence that LF sought advice or counsel from anywhere or anyone about these troubling developments.

37. The mothers of some of SB's friends and SB's maternal grandmother gave evidence that they each held concerns that there were troubling signs that RGF's behaviour towards SB was not normal. For the reasons outlined above, their observations were that his involvement with SB was far beyond normal parental supervision.

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[9] Inquest Brief p.161

[10] Inquest Brief p.161

38. Despite the suspicions and concerns held by a range of people, no person made a report to police or Department of Human Services (DHS) Child Protection, nor sought advice from either of these agencies. The essence of the evidence of witnesses such as SB's grandmother and the mothers of SB's friends was that they did not report to any authority for a range of reasons, which were in summary:
    - They thought they had to have proof before they could report to any authority;
    - They were scared of RGF for themselves and his possible reaction toward SB and her family;
    - They did not have faith in the system to keep them protected;
    - Most did not think of reporting to child protection and when questioned as to the barriers to doing so, stated they would be concerned about the ramifications for SB if they did and for her family; and
    - They held concerns about a report remaining confidential in a regional town.

SB made no reports or disclosures

39. SB informed police after the death of RGF that she had not told anyone, other than the "*bits and pieces*"[11] she told her friend Tye, about her exposure to her step-father's abuse. SB made no reports or disclosures despite various attempts by her best friends and her mother to get her to open up about what they suspected was happening.
40. During her police interview, when asked as to whether she was aware of what she could do about RGF's behaviour, she stated that she could not do anything because he would kill her.[12]
41. A couple of questions on, SB was asked by the police why she did not make a report to police and she stated because she did not want anyone to know. She went on to state that she hated what was happening "*and if ever anyone else knew then I had to accept that it was real.*"[13]
42. SB was also asked why she did not tell her mother. She replied that she was told by RGF not to tell and she did not want anyone to know.[14]
43. SB also stated in that interview that he had used the photographs to blackmail her "*to do stuff*" as he knew that she did not want anyone to see the photos.[15]

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[11] Qu: 749 Record of Interview

[12] Inquest Brief p.636; Qu 624 Record of Interview

[13] Qu: 629 Record of Interview

[14] Qu. 772 Record of Interview

[15] Qu: 687 Record of Interview

44. SB was asked if she ever thought of going to the police for help and she stated that she had, but she thought RGF may just get a fine and then he would attack her.[16]
45. SB stated that RGF had threatened to humiliate her, bash her and kill her and this had kept her silent.[17]

What did the school know?

46. In the course of the criminal investigation into RGF's death, information was provided which raised issues about what teachers at SB's school may have known or suspected about her situation and what they did or did not do. This information came from a range of sources including some of SB's school friends, some of the parents of those school friends and SB's grandmother.
47. First, with reference to SB's school friends, the evidence was that they had held concerns for SB's welfare for some time and their concerns grew following the Easter 2005 camping trip referred to above.
48. The evidence from Chloe, Jade and Amy is that they decided to speak with someone at their school about their concerns in the wake of the Easter 2005 camping trip. According to Chloe, they identified a school counsellor, MG, as an appropriate person to approach. Chloe stated that she was the spokesperson for the three when they went to visit the person they identified as the school counsellor. The other two girls stated that whilst they were present at this meeting, they remained silent.
49. It was the recollection of Chloe that at this meeting, she had informed MG that she thought RGF was hurting SB or was sexually abusing her.[18] The three girls gave evidence in similar terms at the inquest.
50. According to Chloe, MG told them there was nothing she could do about it unless SB came to her directly. Chloe stated that after this meeting, she did not know what else to do. She did not tell SB that they had made this approach and believed that had SB known it occurred, it would have made her "*go into her shell even more*".[19]
51. MG made a statement and gave evidence at the inquest that she did not recall the meeting the girls had described.[20] Her evidence was that she had spent "*many sleepless nights*" going over

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[16] Qu: 768 Record of Interview

[17] Qu. 796 Record of Interview

[18] Transcript 72

[19] Inquest Brief p.440

[20] Statement in Inquest Brief p.346

the matter in her mind. She stated that she did not recall that visit of the three girls Chloe, Jade and Amy and had no recollection of Chloe raising concerns about possible sexual abuse of SB.[21] However, she stated that if such a visit did take place, and she was told by the girls of concerns about sexual abuse, she would have made a note of it and passed the information on to SB's year co-ordinator at the very least.[22] There was no evidence of any note or any referral to the actual school counsellor having been made at that time.

52. Throughout the evidence of MG, she was concerned to make clear that in 2005 she was at the school only as a part-time relief teacher, and had not been teaching full-time for a couple of years. As such, she stated she would not have taken on any on-going counselling or support role with the students. She also stated that she would have made clear that the full-time student welfare co-ordinator was the appropriate person to approach and she would not have just "*fobbed off*" the girls.[23]
53. MG made a second statement in which she stated that if she had received information which, although raising suspicions did not "*enable her to form a view based on reasonable grounds*" that a child had or might suffer harm, that she would communicate that to the Deputy Principal or the Principal.
54. She gave evidence that she had previously made reports of her concerns to DHS Child Protection in the region concerning other children. She gave evidence that she had been to many 'in service' training sessions on mandatory reporting and believed she understood her obligations well. At my request MG did go on to give evidence of the barriers she observed to mandatory reporting and this was consistent with the evidence of others from the school. I shall return to this issue.
55. Another aspect of information provided to a teacher at the school emerged during the criminal investigation. Contained in the statements of some witnesses during the criminal investigation was information that was brought to the attention of one of SB's teachers, known as IL.[24]
56. This teacher had first met SB when she was about 13-years-old, and had taught her in 2003, 2005 and 2006. She was an experienced teacher, having had some 28 years in the profession, and was also a friend of SB's grandmother. Following RGF's death, this teacher made a

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[21] Transcript 546

[22] Transcript 578

[23] Transcript 580

[24] Suppression orders were put in place at the commencement of these court proceedings and remain on foot.

statement to police, dated 12 February 2009.[25] In this, she described her observations of SB and information she had received from the mother of SB's friend Amy. IL stated that in July or August of 2005, she had a general conversation with Amy's mother (Kay), at which time she expressed concern regarding RGF's behaviour towards SB. IL's first statement made during the criminal proceedings contains the following:

> *"We talked about the Year 10 formal and whether or not [RGF] was going to let [SB] go. Kay told me that [RGF] had been shopping with [SB] and bought a dress for her and that seemed a bit odd for a step-father to take his step-daughter dress shopping. Kay said to me that she thought [RGF] was doing her [SB]. I asked her why she thought that and she told me that the girls [SB's friends] had voiced concerns to her."*[26]

57. During the conversation, the teacher stated that she was informed that RGF had travelled to Melbourne with SB, and he had let SB drive even though she did not have a licence, and they had been drinking. Her statement further indicates that she was informed that RGF had gone away on a camp over Easter with the girls and SB's mother had not been present. The teacher stated that she "*got the feeling that something had happened on the camping trip that the girls must have mentioned to Kay.*"
58. According to IL, they discussed what action might be taken. IL had suggested speaking to the school principal or welfare co-ordinator, and also suggested that the girls speak to someone that they were comfortable with. Further, IL's first statement notes: "*We also discussed the fact that there was no proof that there was some type of sexual relationship between [RGF] and [SB].*"[27]
59. Approximately two days after this discussion, IL tried to take up her concerns with SB's friend Amy. Both Amy and IL provided evidence that Amy told IL that she did not know anything.[28] IL stated that she got the feeling that Amy was trying to hide something that she did know, but was reluctant to "*betray*" SB.
60. Some time in 2005 or early 2006, IL stated that she spoke with SB's grandmother, who was a friend of IL. IL stated: "*I told Lynn [SB's grandmother] that a parent had told me something about [SB] and I was a bit worried about what I had been told by this parent. I told Lynn that*

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[25] Inquest Brief p.349

[26] Inquest Brief p.349

[27] Inquest Brief p.350

[28] Inquest Brief p.350

the parent had thought that there was a sexual relationship between [SB] and [RGF]. Lynn told me that she had concerns of her own."[29]

61. SB's grandmother told IL that she had raised her concerns with SB's mother and as a result, SB's mother stopped talking to her and severed the relationship between SB and her grandmother.
62. IL stated she had only observed RGF and SB together on one occasion. She had been out shopping and saw SB walking hand in hand with an older man. She had not known it was RGF at that time. She stated however, that they were walking like the way a couple would walk together rather than a teenage step daughter and step -father.[30] Final submissions for IL stated that it was only after the sexual abuse had been uncovered that she was made aware that the person SB had been with on this occasion was RGF.
63. At the commencement of the coronial investigation, IL sought to be excused completely from giving evidence in this inquest on the grounds of being exposed to a disciplinary proceedings which may affect her livelihood. She was excused for the reasons set out in a separate ruling.[31] She did however, make a second statement.[32]
64. In her second statement made on 31 October 2011 in the course of the inquest, she stated that she had received training in mandatory reporting and was familiar with the school policies and how to report and felt that what was in place at the school was "*sufficient for dealing with the risk.*"
65. IL explained in her second statement that she would not have hesitated to make a referral about SB if she held any concerns. She did not make a referral. She stated that she concluded that what she had been told was "*only gossip*".[33] She also stated in her second statement that it was only with the benefit of hindsight, when making a statement to the police after RGF had died, did she think Amy was hiding something, rather than what she thought at the time.
66. In her second statement IL described SB as a very intelligent and likeable girl who was well groomed and polite and an excellent student. She also stated that she did not even form a suspicion at the time that SB was being sexually abused. The evidence is that IL did not make any referral to any authority or raise any issue at the school.

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[29] Inquest Brief p. 250

[30] Inquest Brief p. 65

[31] November 4 2011

[32] October 31 2011

[33] Second statement of IL Exhibit 26

67. The Acting Principal of the school, Lynn Emmerson, also gave evidence at the inquest. Ms Emmerson had taught SB and was at pains to state that SB and her friend Chloe had been taught a subject by Ms Emmerson that addressed issues of sexual abuse and how to report it to authorities and what support services were available to young people.

68. In reflecting on the events that had occurred, Ms Emmerson stated that she had been puzzled and disappointed as to why SB and her friends had not utilised the information they had been provided during their school subjects to make a report or to seek assistance from one of the support services they had learnt about.

69. Ms Emmerson was largely focused on SB's intelligence and understanding of the subject matter, and described her as appearing well balanced, committed to completing her work and not appearing distressed at all. She also stated that SB had been one of the top students.[34] Ms Emmerson did express an understanding of the difference between theoretical knowledge and the ability to apply it in personal circumstances when answering a question from Mr Ruskin of Counsel.[35] To this end, she reflected on the likely impact of abuse upon SB, the potential difficulties in making a disclosure, such as fear of the consequences, feeling like a failure, and not wanting to expose the family to investigation. She also expressed her understanding of the barriers for SB's friends, such as fear of the consequences for SB.

Conclusions as to what the school knew

70. This inquest was not an investigation into whether or not an individual or individuals failed in their statutory duties as mandated reporters and were therefore in breach of the *Children Youth and Families Act 2005*.[36] Indeed, a coroner must not include in a finding any statement that a person is or may be guilty of an offence.[37]

71. In making submissions on how to assess the facts in this case relevant to the actions of the school and its teachers, Counsel on behalf of the Department of Education and Early Childhood Development (DEECD) cautioned not to let "*the wisdom of hindsight become the guide.*"[38]

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[34] Transcript 433

[35] Transcript 474

[36] The current legislative requirements for mandatory reporting make clear that a registered teacher in Victoria is a mandated reporter. Section 184 of the *Children Youth and Families Act* 2005 (Vic) sets out the test for when a mandated reporter is required to report and in what circumstances. The section provides that a teacher who, in the course of practising his or her profession or carrying out the duties of his or her office, position or employment forms the belief on reasonable grounds that a child has or is likely to suffer, significant harm as a result of sexual abuse must make a notification after forming that belief.

[37] Section 69 *Coroners Act* 2008

[38] Final written submission: 16 December 2011.

This is an appropriate submission to make and always a proper caution to be exercised by a fact finder.

72. As to the meeting with MG, I note that none of the girls described this meeting in their first statements to the police. This evidence first emerged at the committal proceedings. There may be many reasons as to why that could have happened. At committal Jade and Amy stated they had not spoken with any teacher about their concerns about SB. When questioned at the inquest about this apparent disparity, both Jade and Amy stated they took the question literally and answered honestly because neither of them had actually spoken at the meeting they say occurred with MG. I found nothing implausible about those answers.
73. Ultimately, it is difficult to come to an exacting conclusion about the nature and form of any conversation that occurred between MG and SB's friends. This is particularly so as the application of the Briginshaw[39] standard does not allow for inexact proofs.
74. I am satisfied on the evidence that the Easter 2005 trip had a very unsettling effect upon SB's friends and left them feeling troubled enough to want to do something to help SB. I am satisfied that the girls discussed with each other what they could or should do for SB. I am also satisfied on the evidence that the girls decided to approach MG at the school as someone known to them as an approachable person who had been a school counsellor.[40]
75. What is not capable of being established to the appropriate standard is what was actually said during that meeting and when and where and in what circumstances it took place. The girls were trying to remember what was said years after it had taken place. They did not mention it in their statements to police in 2008, three years after the 2005 meeting. The committal proceedings commenced in January 2009. It was during these proceedings that the evidence as to the meeting with MG first emerged, four years after the 'meeting' took place. Relying on memories in the wake of the inevitable number of conversations and discussions that must have taken place between this friendship group over these years, and especially in the wake of the horrible events of RGF's death, creates a level of uncertainty that does not provide a sufficient basis upon which to make a firm finding about what was said at that meeting.
76. Whilst I cannot come to a concluded view to the required standard about what was said by the girls to MG and in what circumstances, what can be concluded is that these three girls had

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[39] The standard of proof required in coming to a Finding in these circumstances is on the balance of probabilities using the test set down in *Briginshaw v Briginshaw* (1938) 60CLR 336

[40] This is consistent with the evidence of Amy's mother and consistent with the evidence of IL that Amy's mother was telling IL that the girls were worried about SB and what RGF was doing to her. This conversation took place, according to IL, in July or August 2005, prior to the Year 10 formal.

correctly formed the view that RGF was badly mistreating their friend SB, even though SB steadfastly refused to discuss it with them.

77. I found MG to be a co-operative and forthright witness with the court and deeply troubled by the possibility that she may have missed an opportunity to intervene in this situation. She was an experienced and highly regarded teacher at the school and an experienced school counsellor.

78. As for the evidence with respect to what information IL had and what she made of that information, that evidence is contained in two statements made by IL. In examining these two statements, the context in which each one of them was made is relevant. The first one was made in the context of a pending criminal trial of SB for the unlawful killing of RGF. IL was making a statement in which she was offering some context to SB's actions. The second statement was made for the purpose of this inquest. It focused upon the actions and thoughts of IL herself, and her obligations to respond to what may have been sufficient information to at least raise concerns or questions about SB's welfare.

79. Through her counsel, IL submitted that the information she had received from Amy's mother and SB's grandmother was only speculation. She stated that she would have made a referral if she had formed a reasonable belief that SB was being abused. In her second statement, IL stated that she did not even form a *suspicion* that SB was being sexually abused at that time.

80. However, that is not the impression that one gets left with when reading IL's first statement. IL was sufficiently worried about what she had heard from Amy's mother to raise it with SB's grandmother and when she did so, she got affirmation from SB's grandmother that she too was worried. Further, IL sought to engage Amy after her discussion with Amy's mother. Her first statement in which she states that she had noticed SB walking with an older man "*hand in hand*" like a couple, left a sufficient impression on her that she put it in her first police statement.

81. The student wellbeing coordinator at Mooroopna Secondary College at the time of these events was Ms Michelle Trudgen. She made a statement and gave evidence at the inquest. [41] Her evidence was that any level of concern about a student at the College would cause her to open a file on that student.[42] It was her evidence that she advised teachers that if they were worried or even wondering about a student, then they should put in a referral to the student well being co-

[41] Exhibit 14b

[42] Transcript P 375

ordinator and not take on the role of being investigator or be concerned about what may or may not happen in the wake of a referral.[43]

82. Ms Trudgen also gave evidence that if the mother of a student at the school told her she believed her daughter's school friend was being sexually abused, she would make a written report about that information and meet with the suspected victim. Her evidence was that if the suspected victim did not want to talk to her, she would provide the student with information about KidsHelpline or other agencies.[44]
83. During cross-examination, when Ms Trudgen was provided with the accumulation of information that IL had about concerns being expressed about SB, Ms Trudgen's evidence was that she would have considered herself required to make a report to DHS.
84. In conclusion, with respect to IL, to at least raise a concern with the student wellbeing co-ordinator to exercise her discretion, would have been the actions of a prudent teacher. As Ms Trudgen said, it is not for the teacher who receives the pieces of information to engage in an investigation. It is not the teacher's role to establish proof of abuse having occurred. IL had concerning information she should have passed on to the school to engage its systems' response.

Procedures in place at Mooroopna Secondary College

85. There was considerable material produced in the course of this investigation as to the system in place at SB's school for responding to child protection concerns. The evidence spanned from SB's period at the school up until the present day.
86. In 2004, a new student wellbeing co-ordinator was appointed to the school, Ms Michelle Trudgen. Ms Trudgen stated that she remembered knowing who SB was when she was at the school, but that she did not recall ever speaking to her and stated that she had never come to her attention as a student who was identified as being at risk of harm. There is no evidence to the contrary.
87. Ms Trudgen gave evidence that in 2004, 2005, 2007 and 2008 there were formal mandatory reporting training sessions provided to staff at the school. She stated that the training was provided either by herself or by others. She stated that in 2005 she arranged for the manager of Child Protection at Shepparton DHS to present the mandatory reporting training. She stated on another occasion it was provided by a student welfare officer from another school in the region. She also stated that the school had regular forums in which they would discuss 'at risk' children.

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[43] Transcript p 377

[44] Transcript p 390

88. She stated that the school had a number of written policies and documents touching upon student welfare and teacher's responsibilities and mandatory reporting. She stated that she believed significant efforts were made by herself, the Principal and the Assistant Principal at the school to ensure that all staff were aware of their obligations under the mandatory reporting requirements of the *Children Youth and Families Act 2005*.
89. Mr Gary Golding was the Principal from July 1997 through to December 2006. He confirmed the evidence of Ms Trudgen and stated he was well aware of his mandatory reporting obligations and that teachers at the school were provided training by either informal sessions or formally each year by Ms Trudgen.[45] He also stated that there were continual reminders at regular meetings of student welfare issues and of mandatory reporting obligations.
90. Mr Gary Fletcher commenced at Mooroopna Secondary College in the third term of 2004 as the Assistant Principal. He was appointed as the Principal of the college at the commencement of 2007 and continued in that position until the end of term three 2009. In his statement he described an initiative introduced by Ms Trudgen in or about 2004 wherein a student wellbeing 'referral process' was initiated. He described that process as a confidential one, which enabled teachers to refer any concerns that they had in relation to a child, even if those concerns did not amount to reasonable beliefs of sexual and/or physical abuse, to the student wellbeing coordinator or Principal.
91. In those circumstances, the student wellbeing coordinator would generally then speak to the student about the concerns raised and ask appropriate questions to determine whether or not there were reasonable grounds for holding a belief that the child was at risk.
92. Mr Fletcher went on to state that it had always been his view and the view that he had conveyed to staff at the school that, if in doubt, a notification should be made to DHS.[46] He too stated that members of staff were: (i) regularly reminded of their obligations regarding mandatory reporting; (ii) the referral process within the school; and (iii) presented information at both informal and formal professional development training sessions about mandatory reporting.
93. Each of the teachers who provided evidence in this inquest as to the system in place at Mooroopna Secondary College described it as one which was both caring and thorough with respect to the training provided to teachers about their mandatory reporting obligations.
94. Ms Emmerson, the Acting Principal at the school, gave evidence about the instruction given to students concerning their own wellbeing. Ms Emmerson stated that she had personally taught

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[45] Inquest Brief p. 484

[46] Statement of 19 July 2011

SB a subject which gave information to students about where to go and what to do if they needed assistance. Ms Emmerson was questioned as to whether or not these events had resulted in a reassessment of how the school's course could be enhanced to address the shortfall between an adolescent's intellectual understanding and the real life inhibitors to reporting or disclosing abuse. It was difficult to extract any clear evidence from Ms Emmerson that the very problem, so dramatically highlighted in SB's situation, had been appropriately addressed via some skilled analysis of this issue.

Actions of DEECD subsequent to the death of RGF

95. Following discontinuation of the criminal proceedings in connection to the death of RGF, DEECD commissioned an investigation into the school's mandatory reporting systems and training, including general consideration as to what the DEECD was doing with respect to its mandatory reporting obligations.

96. This investigation was undertaken by *Work Logic Consulting Pty Ltd,* a private consultancy firm, and resulted in a written report being provided to the DEECD which contained a series of recommendations.

97. For the purpose of the coronial investigation, a copy of the *Work Logic* report was requested. DEECD objected to its provision, claiming legal professional privilege over its contents. However, the court later learnt that a public media statement about this investigation and the resulting recommendations had been made in November 2009. Specifically, a statement had been made by Mr Paul Barber, the Deputy Manager of the Media Unit of the DEECD on 23 November 2009, in response to a question from a journalist from the Shepparton News.[47] This statement contained confirmation that there had been an independent investigation commissioned which found that no teacher had breached their mandatory reporting obligations and that the independent investigator made four recommendations for consideration by the DEECD.

98. It was disappointing that earlier and proper disclosure of the material from *Work Logic* did not occur, given that legal professional privilege over this part of the material had clearly been waived two years earlier. Had proper and appropriate disclosure been made to the Court, the coronial investigation could have avoided a considerable amount of public time and effort being wasted.

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[47] Exhibit 19

99. In any event, the *Work Logic* recommendations set out in the published statement were as follows:

> **Recommendation one**
>
> *That the Department consider requiring Government schools to provide to teachers a minimum number of hours in mandatory reporting training each year. The annual compliance checklist would be a good vehicle for the Department to check that schools are providing to teachers the minimum number of hours' training in mandatory reporting each year.*
>
> **Recommendation two**
>
> *That schools are encouraged to utilise the 'Safe From Harm' training (or to develop its equivalent) so that the standard of training is high and likely to be consistent across all schools*
>
> **Recommendation three**
>
> *That the Department revise the Victorian Government Schools Reference Guide to clarify teachers' obligations with respect to enquiring into suspicions or concerns about a student at risk*
>
> **Recommendation four**
>
> *That the Department consider whether graduate teacher's knowledge of mandatory reporting is sufficient, and if not, write to the Victorian Institute of Teaching (VIT) and/or Universities in this regard.*

100. The statement to the media containing these recommendations concluded with the following: "*These recommendations were accepted by the Department and will be put into place by the commencement of the next school year.*"[48]

101. In a letter to the Court dated 6 October 2011 and in final written submissions,[49] descriptions of various actions that have been taken in response to the *Work Logic* review and recommendations are set out. These are summarised below.

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[48] Exhibit 19

[49] Final written submissions of DEECD: 16 December 2011

Minimum mandatory reporting training

102. In response to recommendation **one** above, DEECD decided to commit to minimum content rather than minimum hours of training in mandatory reporting. The evidence provided to the Court is that on 18 May 2010, all staff in government schools were required to attend a comprehensive training session on mandatory reporting obligations. According to the material, Principals of all government schools are now required to provide one briefing session per semester to all staff at the school on mandatory reporting obligations. All new staff are required to attend a comprehensive training session to ensure that they are aware of their mandatory reporting obligations. A range of materials has been prepared including manuals, online PowerPoint presentations and step by step instruction sheets. Schools are required to report on their adherence to this commitment annually, utilising the School Compliance Checklist.[50]

Consistency in the training materials

103. In response to recommendation **two**, DEECD stated that the mandatory reporting training of staff in government schools has been updated and is now based on a resource titled '*Protecting the safety and wellbeing of children and young people.*' This resource includes a PowerPoint presentation for both new and existing school staff and was released to schools on 18 May 2010. Further materials aimed at ensuring consistency in the information given on mandatory reporting have been placed on line. A resource entitled '*Guide to managing a disclosure of child abuse*' has been adapted from the original '*Safe from Harm*' kit and has been available online for all Victorian schools from 1 March 2011.

Clarification of the extent of teachers' legal obligations

104. In response to recommendation **three**, DEECD obtained legal advice and updated the training materials for presenters. This involved including a phrase contained in the section mandating teachers to report "*in the course of practising his or her profession*" to mean that a teacher's duties extend beyond their actual hours of duty. That is, if a teacher acquired information about possible abuse outside his or her official hours of duty, that teacher is still obligated to make a notification, regardless of whether or not the information came to him or her outside the school.[51]

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[50] The Court was advised that the School Compliance Checklist was implemented across all government schools in February 2007, to enable policy, legislative and regulatory requirements to be better managed and monitored. It is mandatory that all schools self assess against the compliance items. The level of compliance is monitored by the Office of Government School Education, through the nine regional offices and particularly the regional network leaders who work with the schools to assist them in planning for and facilitating compliance.

[51] Exhibit 13a: P 15 "*Mandatory Reporting: Professional Learning for School Staff*"

Pre-service teacher training

105. In response to recommendation **four**, in its final written submissions, DEECD noted that it did not control the content of training provided to undergraduate teachers. However, DEECD set out the various steps it has taken to ensure that all persons coming into the teaching profession are properly educated with respect to their mandatory reporting obligations and as part of their professional development requirements for continued teacher registration.

106. Whilst evidence was given about various steps taken in this regard and more material being produced in various and more sophisticated forms, there was no clear evidence that mandatory reporting training currently forms part of the registration requirements for teachers.

Evaluation of the effectiveness of mandatory reporting training

107. The inquest also heard evidence from Mr Denis Torpy, a senior representative of the DEECD. He gave evidence of DEECD policies and guidelines in connection to mandatory reporting. He advised that there has been no formal evaluation of the efficacy of the current training being delivered, apart from some self-guided questions. His evidence was that some form of evaluation is currently being considered and developed, although not yet decided at the time of the close of evidence and submissions.

COMMENTS

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

108. Given the circumstances in which RGF's death occurred, this investigation was assisted by the Victorian Systemic Review of Family Violence Related Deaths (VSRFVD).[52] With the assistance of that review, there are a number of important observations that can be made in connection to the family violence aspects present in this case.

Vigilance in the absence of obvious risk factors for abuse

109. One of the important findings to come out of this investigation is the need to be constantly vigilant and challenge our assumptions about whether or not abuse is occurring and a child is at risk. By its very nature, childhood sexual abuse is an insidious crime. Those who perpetrate it typically go to great lengths to avoid detection and ensure that the victims do not reveal what is happening to them.

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[52] Positioned within the Coroners Court of Victoria, the VSRFVD provides assistance to Victorian coroners to investigate the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related incidents. This contributes to the development of a broader knowledge base for dissemination to the community and agencies working in the area of family violence.

110. The evidence in this case was that it was the view of a number of adults, including teachers at the school, that the absence of the usual indicia of child sexual abuse formed part of the rationale for coming to a view that it was not occurring. SB was described as bright, capable and a focused student, who had integrated well with her peer group. Further, witness statements noted that bruising or injuries had not been observed upon SB.[53] As a result, it appears that many of the public signs of RGF's controlling and abusive behaviour towards SB were not given proper attention and significance.

111. Understanding the often observed and well-documented indicia of child abuse is important. However, as starkly demonstrated in this case, the apparent ***absence*** of these signs is not in and of itself confirmation that serious long term abuse is not occurring.

112. When there are other features of a situation that are arousing suspicions or causing concern, and particularly among multiple parties as was the case here, further consideration as to what may be happening is necessary. In respect to how this applies to the school environment, small pieces of information can take on greater significance when they are brought together and provided to a skilled person.

113. The submission of DEECD notes that there is "*now a greater emphasis on encouraging teachers to consult with others (and in particular the school leadership team, amongst other professionals) to ease the burden upon teachers who may be in doubt as to whether they should make a report.*"[54] It is hoped that consultation of this kind will enable a more in depth consideration of cases such as this one, where there has been some degree of concern raised, but the child presents without apparent 'signs' of abuse.

Barriers to reporting and disclosure

114. In the last couple of decades, much sophisticated analytical work and thinking has gone into examining the range of known barriers to the reporting of child sexual abuse, not just for mandated reporters, but among the peers of the victim, the victim's family, the wider community, and most importantly, the victim.

115. The evidence in this investigation contains compelling information worthy of in depth consideration for all who seek to protect young people from sexual abuse. An examination of what the barriers were and why those barriers resulted in no intervention being made on behalf of SB is essential. An effective intervention may not only have stopped the abuse of SB, but prevented the death of RGF and all that flows from his death for so many people around him.

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[53] Inquest Brief p.351

[54] Final written submissions of DEECD: 16 December 2011

Barriers for the victim

116. All the evidence from SB's teachers was that she was an excellent student. The evidence was that she had been able to respond very capably and convincingly to the intellectual component of the information being imparted to her by her teachers about what supports were available to a young person in her situation. However, despite numerous enquiries from her friends and family, SB remained silent as to what was happening to her.

117. In light of this evidence, DEECD should obtain some expert assistance to re-think how the course content or delivery of subjects directed at equipping students with both information and support could be enhanced. The evidence in this case underlines the shortfall between a bright, competent adolescent's intellectual understanding, and the real life inhibitors to reporting or disclosing abuse. No clear evidence emerged in this case, despite some enquiries, that this problem so dramatically highlighted in SB's situation, is being appropriately re-considered.

Barriers for the community

118. In February 2012, the report of the Protecting Victoria's Vulnerable Children Inquiry was tabled in Parliament.

119. As part of that Inquiry, submissions were received from parents of victims of sexual abuse. These submissions noted that preventative information and guidance about sexual abuse is not readily available in the Victorian community. It was submitted that greater information is needed for children, parents, youth groups and professionals to build capacity and knowledge of sexual abuse within the community.[55]

120. Among the recommendations of that inquiry, was that the DEECD develop a wide-ranging education and information campaign for parents and caregivers of all school-age children on the prevention of child sexual abuse.[56]

121. The facts of this case provide stark evidence underlining the need for the uptake of this recommendation. Those adults in SB's network who held suspicions and concerns might have adopted a different course of action had they been equipped with appropriate information and a greater understanding of child sexual abuse; what options were available to report; and what services were available to discuss concerns and provide confidential information and advice.

122. The evidence as to the barriers identified for not reporting are outlined above. The women who gave evidence at inquest impressed as caring and capable women who were concerned for

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[55] Hon. Phillip Cummins, Dorothy Scott & Bill Scales, *Report on the Protecting Victoria's Vulnerable Children Inquiry* (2012) volume 2, p. 102.

[56] Ibid at volume 1, li.

SB's welfare but, for the reasons set out, did not report, despite their concerns. This confirms more work must be done to address these issues, including the need to address the specific barriers encountered in rural locations.

Barriers for teachers

123. Mandatory reporting is underpinned by a broader community view that the need to protect children from abuse and neglect is an important and necessary task. Whilst any person can report concerns they hold for the welfare of a child to DHS Child Protection or the police, certain professionals, including teachers, are mandated to do so.

124. The weight of the evidence at the inquest from teachers at Mooroopna Secondary College was that they had been given clear instruction as to their obligations with respect to mandatory reporting. The effect of the evidence was that once they reached a level of concern or suspicion a report would be made. At the least, a referral to the student wellbeing coordinator for follow up would be made where any concerns were held. It was submitted that the internal referral system at the school was effective. This process was coupled with regular staff meetings where staff concerns about students at risk were discussed.

125. Importantly however, the evidence of Michelle Trudgen in the context of this case was that she would like teachers to be more 'curious' and proactive when receiving information about welfare concerns for children. Her position was that once a suspicion or concern was raised, that it was not satisfactory to conclude that because the accumulation of the information passed on to that teacher did not meet the standard, that was the end of a teacher's role.

126. These matters are clearly complex. They are further compounded by the 'barriers' to reporting. As described in the evidence of Ms Trudgen, teachers can experience a range of inhibitors to making reports to DHS Child Protection that go beyond the complexities of the legislative framework. Her experience was that while teachers feel the responsibility of mandatory reporting very keenly, they often hold concerns about the 'ramifications' upon the family, such as the possibility of a child being removed. Furthermore, issues such as being confronted with angry parents who hold the teacher responsible for child protection involvement; being fearful of being required to attend court proceedings; concern that their identities will be revealed; and fear of being wrong or having made an unwarranted intrusion to the possible detriment of family and child are common concerns.[57] These are accepted as both real and understandable barriers that need to be considered.

[57] Transcript 408-409

127. As previously stated, these issues are complex, and cannot be easily dealt with by the handing over of information or having an 'online' engagement with a teacher who will thereafter be able to explain the legal test for forming a reasonable belief.

128. The very frank and thoughtful comments provided by the teachers who gave evidence in this inquest as to the barriers for them reporting, including the additional complexity of living in a rural community, must be listened to and incorporated, not only into the training and on-going professional development provided to teachers, but the proper support and guidance given to teachers by their employer. Teachers are not engaged to be social workers or investigators. The pressures and demands upon them in the course of their employment are enormous. They simply must be supported by their employer in their mandated protective role for children. It is unacceptable that teachers face individual prosecution in their employment for failing to report if they are not being appropriately trained and supported to fulfil this requirement.

Evaluation of the effectiveness of mandatory reporting training and support

129. As part of the coronial investigation, DEECD advised that they had not conducted or commissioned any evaluation of the ***effectiveness*** of mandatory reporting training provided to teaching staff using the '*Safe from Harm*' package, or the more recently introduced, '*Protecting the Safety and Wellbeing of Children and Young People'* package. This would seem like an important step to take, in order to identify any potential gap that may exist between the objectives of the training and the effectiveness of it.

130. Completion of the Schools Compliance Checklist is not an evaluation of whether or not the training is effective in achieving what it sets out to do. The effectiveness of training must also be a consideration which goes beyond self-evaluation. Assessing whether or not such complex legal requirements and judgments on teachers are being well-understood and effectively applied is a considerable task, but surely one that is of central importance to the DEECD given the ramifications for both its teachers and the young people entrusted into their care.

Concluding comments

131. The conducting of the *Work Logic* review and my access to its recommendations obviated the need to further address the areas which were the subject of those recommendations. However, based on the evidence examined in this matter, I make the following recommendations:

RECOMMENDATIONS

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

Recommendation one

132. That the Department of Education and Early Childhood Development (DEECD) complete and introduce an on-going evaluation of its mandatory reporting training provided to teachers, in order to monitor its efficacy in achieving its stated aims.

Recommendation two

133. That the Department of Education and Early Childhood Development (DEECD) ensure that its on-going professional development obligations to its teachers address the identified barriers to the reporting of child abuse.

Recommendation three

134. That the Department of Education and Early Childhood Development (DEECD) accept and implement Recommendation 10 of the Protecting Victoria's Vulnerable Children Inquiry contained in *Chapter 7: Preventing Child Abuse and Neglect.* Specifically, that the DEECD develop a wide-ranging education and information campaign for parents and caregivers of all school-aged children on the prevention of child sexual abuse.

I direct that a copy of this Finding be provided to the following for action:

Mr Richard Bolt, Secretary, Department of Education and Early Childhood Development

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published on the internet in REDACTED form (consistent with the Suppression Order made on 10 February 2011).

I further direct that a copy of this Finding be provided to the following for information:

Mr Brian Birrell for SB

Landers and Rogers for IL

Meridian for DEECD

Detective S/C Barry Gray, Investigating Member

Secretary, Department of Human Services

Signature:

Judge Jennifer Coate

Date: 7 September 2012