IN THE CORONERS COURT OF VICTORIA
AT MELBOURNE

IN THE MATTER OF RGF
CASE NO. 1434/08

RULING ON THE QUESTION OF INQUEST OR NO INQUEST

Background

1. RGF was killed on March 13 2008 as a result of being shot once in the back of his head by SB [redacted] He was 34 years old at the time of his death.

2. The death was reported to the coroner and was also the subject of a criminal investigation by the Homicide Squad.

3. On April 10 2008, SB [redacted] was arrested and charged with the murder of RGF

4. She was committed to stand trial after a number of witnesses were examined at committal.

5. In the Supreme Court on March 10 2009 a Directions Hearing was held before His Honour Justice Cummins in preparation for the trial. At that Directions Hearing His Honour drew the prosecutor's attention to the state of the evidence and in particular to the evidence as to the history of sexual abuse of SB and the nature of the continuing violent threat posed to SB at the hands of RGF and asked the prosecution to consider its position. On March 27 2009 the Director of Public Prosecutions (DPP) filed a Nolle Prosequi (notice that the prosecution was being discontinued) in the trial of SB [redacted] after which she was discharged from Court.

6. In the course of addressing the court as to why the DPP was taking such a course the DPP Mr Rapke QC said as follows: "*I have reached the conclusion that there is no reasonable prospect that a jury would convict Ms SB of any offence arising from the tragic events that lead 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 a jury's consideration of that evidence under the new statutory provisions relating to self defence and family violence.....I recognise that the physical, sexual and psychological abuse to which SB was subjected since the age of 14 and the circumstances that confronted her*

immediately 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 [1]

7. After the discontinuation of the trial, an Inquest brief was prepared by the investigating member from the Homicide Squad Detective Senior Constable Barry Gray and delivered to the court.

8. The contents of that brief were considered by me in the context of the role and purpose of the coroner and the court as set out in the **Coroners Act 2008.**

9. On February 10, 2011 a Directions Hearing was held in this court at which time Mr Birrell sought leave to have his clients, SB and her mother LF granted leave as interested parties. Mr Winneke sought leave to have his client, the Department of Education and Early Childhood Development, included as an interested party. Both applications were granted.

10. The first matter raised at this Directions Hearing was the issue of whether or not an inquest would be held. It was not contentious that s.52 of the *Coroners Act* meant that the holding of an inquest was not mandatory in this case as SB had been charged with an indictable offence connected to the death as detailed above.

11. Mr Birrell on behalf of his clients urged the holding of an inquest. Sergeant Weir assisting, indicated that the investigating member had been in touch with the family of the late RGF and that the family did not express a view either way. Mr Winneke on behalf of his client had instructions to not express a view on this issue.

12. That being so, I indicated my view that there were aspects of the circumstances in which the death of RGF occurred which potentially raised matters that touched upon the purpose of the coroner's investigation, most notably being the potential to contribute to a reduction in the number of preventable deaths. I identified those areas as the area of mandatory reporting of child sexual abuse and the area of community awareness of child sexual abuse.

13. At that first Directions Hearing two persons who had been employed at the secondary school where SB had attended for a number of years and were "mandated notifiers" pursuant to the *Children Youth and Families Act*, were identified as possible interested parties. They were notified and given the opportunity to participate at the next Directions Hearing on May 18 2011.

[1] The DPP was in possession of pornographic images and movies of RGF and SB which, according to the investigating member, appear to have been taken over a four-year period between January 2004 and January 2008 when SB would have been 14 through to 18. Approximately 9743 pornographic still images of SB and/or the deceased were located by investigators hidden in RGF's shed during the Homicide investigation.

The application to discontinue the inquest

14. At the Directions Hearing on May 18 2011, Ms Hawkins appeared on behalf of Ms ILO [redacted] (being one of those persons notified) and requested the opportunity to be heard on the question of inquest or no inquest. Despite having ruled on this issue at the previous Directions Hearing, given that Ms [redacted] had not had the opportunity to be heard, I allowed the re-opening of this question.

15. I requested written submissions on this issue from those interested parties that wished to do so. Written submissions were received on behalf of Ms [redacted], ILO submitting that there was no jurisdiction to hold an inquest. Mr Birrell on behalf of his clients, submitted that not only was there jurisdiction to hold an inquest, that should be done as decided at the previous Directions Hearing.

16. The essence of the submission on behalf of Ms [redacted] was that (a)any alleged failure to make a notification to child protection pursuant to the mandatory reporting requirements was too remote in time to RGF's death **and** (b) that it was only *mere speculation* that even if a mandatory report had been made, that it would have prevented the death of RGF

17. In the course of the written submissions for Ms [redacted] reference was made to various cases on the scope and limits of the coroner's powers including *Harmsworth v the State Coroner* [1989] VR 989 and *Conway v Jerram and Anor [2010] NSWSC 371* to support the submission made as to remoteness and causal connection.

18. The evidence currently contained in the inquest brief is that SB had been a school student at Mooroopna [redacted] from 2003 until completing her VCE in 2007. That is, she had been a full time student at the school up until a few months before the death of RGF

19. The inquest brief contains a transcript of the evidence given in the committal proceedings. A combination of that transcript and statements contained in the inquest brief, raise the issue as to whether or not some school staff may have had a suspicion or belief or knowledge of the sexual abuse of SB . The evidence produced in the investigation to date touching upon this aspect of the circumstances surrounding the death of RGF . remains unsettled and unclear.

20. The inquest brief is also replete with statements that a number of individuals in the community generally, both friends and family, held suspicions and concerns about the nature of the relationship between RGF and SB, but for a range of reasons were uncertain about what they should or could do about the suspicions and concerns they held.

21. As stated at the Directions Hearing, it is these two areas of the circumstances in which the death of RGF occurred, that have been identified as relevant to this inquiry and by inference I formed the view that these two aspects of inquiry were **not** too remote from this death **and** causally connected.

22. In coming to this view, I turned to the parameters of the coroner's investigation as set out in s.67 of the *Coroners Act 2008*, but in particular s. 67 (1) (c) which requires the coroner to find the circumstances in which the death occurred. In coming to a view about what that means in this case, it is necessary to first consider what it means generally.

23. In my view, to find the meaning of these words, I should look to the *Coroners Act* 2008 and the role and purposes of the jurisdiction as set out by Parliament. In doing so, I am assisted by the Preamble to the Act. In coming to this view, I relied on the recent decision of His Honour Justice Beach in *Thales*.[2] This decision is not only 22 years after *Harmsworth*, it is a decision which considers the new **Coroners Act 2008**, and of course, *Harmsworth* does not. *Harmsworth* was decided under the previous legislative framework.

24. In *Thales*, His Honour Justice Beach appeared to accept that a coroner could not **investigate** for the sole or dominant purpose of making a comment or recommendation, but His Honour noted at Para 68, "what comment or recommendation might be permissible as a result of the evidence that has yet to be called is not capable of determination at this stage". In my view, *Thales* requires a coroner to interpret the meaning of "circumstances in which the death occurred" in the context of the whole Act. Thus, if the coroner finds circumstances in which the death occurred that are not too remote and are causally connected, which, upon initial investigation, raise significant and substantial matters relating to public health and safety or the administration of justice, that may contribute to a reduction in preventable deaths, the investigation of the coroner is within jurisdiction.

25. In this case, I do not accept that either of the aspects of this investigation as described to date in the directions hearing can be said, at this stage, to be too remote or not causally connected to the circumstances in which the death occurred. An examination of the transcript of the Supreme Court proceedings (extracted above) resulting in the DPP entering a nolle prosequi of SG ___ for the killing of RGF provides the prima facie evidentiary causal link between the death of RGF and the evidence as to the sexual abuse of SB

26. Given the nature and extent of the material uncovered by the police in the course of the homicide investigation, I do not accept the submission that it would be *mere speculation* to suggest that had a mandatory report been made by the school or indeed any report been made to either police or DHS resulting in an investigation, that would not have had an impact on the course of events leading to the death of RGF . Indeed, at this stage, there is a prima facie evidentiary basis which raises a reasonable likelihood that had police conducted an investigation into allegations of sexual abuse of SB at an earlier time, the tragic outcome may have been completely different and RGF may well still be alive.

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[2] See Thales Australia Ltd v Coroners Court and Ors [2011] VSC 133 Paragraphs 68 and 69

27. For this reason, the evidence as to what was or was not said to mandated notifiers in the course of the years that SG was at [redacted] and what they knew or ought to have known about their reporting obligations and what the school and the Education Department had in place to assist mandated notifiers to understand their obligations is relevant and not too remote.

28. The evidence on these issues remains uncertain and unclear. There are no rules set down or legislative tests or guidelines set out to guide how and when a coroner exercises his or her discretion to hold an inquest. However, it is generally accepted that where there is uncertainty or conflict in **relevant** evidence accumulated in the course of the investigation, the use of the judicial forensic process at inquest is a proper and appropriate way to endeavour to find the facts.

29. For the reasons set out above, I am satisfied that this area of evidence is relevant, and prima facie forms part of the circumstances in which the death occurred and furthers the purposes of the coroner's jurisdiction.

30. I should add that the submissions on behalf of Ms [redacted] did not address the second basis upon which the inquest is proceeding. This second area was described at the Directions Hearing as "community awareness of child sexual abuse". This issue arises out of the evidence in the inquest brief of a significant number of adults who appear to have had concerns about SG but for reasons that need to be explored at inquest did not report to police or the Department of Human Services. No party, including those representing Ms [redacted] has taken issue with this being a legitimate area of exploration for the coroner.

31. For the reasons set out above I am satisfied it is appropriate to conduct the inquest.

Judge Jennifer Coate
State Coroner
September 29, 2011

Coroners Court of Victoria