IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 000447

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: DARCEY IRIS

Delivered On:	30 October 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	15 - 16 July 2015
Findings of:	JUDGE IAN L. GRAY, STATE CORONER
Counsel Assisting the Coroner:	Sergeant Sharon Wade, Police Coronial Support Unit, instructed by Ms Erica Capuzza, State Coroner's Solicitor.

I, JUDGE IAN L. GRAY, State Coroner, having investigated the death of DARCEY IRIS

AND having held an inquest in relation to this death on 15 and 16 July 2015

at MELBOURNE

find that the identity of the deceased was DARCEY IRIS FREEMAN

born on 11 February 2004

and the death occurred on 29 January 2009

at the Royal Children's Hospital, 50 Flemington Road, Parkville Victoria 3052
from:

I (a) INJURIES SUSTAINED IN FALL FROM HEIGHT

in the following circumstances:

SUMMARY

1. Darcey Iris[1] was a four-year-old girl who was born in the United Kingdom on 11 February 2004. She was about to turn five years old and begin primary school at the time of her death. Darcey had an older brother aged six at the time, and a younger brother aged two. She was described as an independent and determined child.

2. Darcey was one of three children to Ms Peta Barnes and Mr Arthur Freeman. Mr Freeman and Ms Barnes met in Australia and moved to the UK shortly after their marriage in 1999. The children were all born in the UK and the family returned to Australia in June 2006. Ms Barnes and Mr Freeman separated in 2007 and later divorced. A dispute over parental care arrangements for the children ensued, which resulted in final orders being made at the Federal Magistrates' Court (now the Federal Circuit Court).

3. Up until 28 January 2009, the children had spent three days with each parent, with the exception of an extended period from July to November 2008 when Mr Freeman was in the United Kingdom.

[1] The family of Darcey Iris requested that she be referred to as such during the inquest and in my finding.

4. On 28 January 2009, Ms Barnes and Mr Freeman attended the Federal Magistrates' Court (as it then was) in Melbourne where orders were made with the consent of both parents (known as consent orders), directing that both parents retain equal shared parental responsibility for any long-term decisions about the care, welfare and development of the children. However, the previous living arrangements (made by previous consent order) were altered so that the children would reside with Mr Freeman for three days every second week, and one Thursday afternoon or early evening in the alternate week. In making these arrangements, consideration was given to Darcey's needs during her first year of school.[2] This was following a psychological assessment and family report prepared by Clinical Psychologist Dr Jennifer Neoh, as ordered by the Court.

5. Dr Neoh's report noted a past history of family violence perpetrated by Mr Freeman against Ms Barnes. Ms Barnes had also previously disclosed the history of violence to her general practitioners (GPs).

6. Based on the available information, it is not clear when Ms Barnes sought to alter the parental care arrangements (i.e. whether this occurred in March 2008 while Mr Freeman was overseas or prior to his departure).[3] Regardless, Ms Barnes believed that the three-day time period with each parent was no longer suitable, and she had sought to increase the amount of time the children lived with her.

7. The Order also concerned property matters, including that Ms Barnes pay Mr Freeman $15,000.[4] It appears that Mr Freeman was unhappy with the financial aspects of the Order.[5]

8. After the Court proceedings, Mr Freeman spoke with friends by phone. He was described as being unhappy with the outcome of the court case, and felt that the psychological assessment and report prepared by Dr Neoh had been a negative one for him and positive for Ms Barnes.[6] However, he made plans for the following evening to meet with friends in St Kilda.[7]

9. It does not appear that Mr Freeman expressed overt anger or threats to harm either Ms Barnes or the children during these conversations. Mr Freemen spent the evening of the court proceedings with his parents, Mr Peter and Ms Norma Freeman, in Aireys Inlet where Darcey and her brothers had been while the court proceedings took place. Mr Peter Freeman described

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[2] Exhibit 10, statement of Dr Jennifer Neoh, coronial brief page 54.
[3] Exhibit 10, report prepared by Dr Jennifer Neoh, coronial brief page 59.
[4] Exhibit 10, consent order, coronial brief page 390.
[5] Exhibit 2, summary of evidence prepared by S/Sgt Damian Jackson, page 4.
[6] Exhibit 10, statement of Mr Anthony Luscome, coronial brief page 84.
[7] Exhibit 10, statement of Mr Gregory Jarman, coronial brief page 79.

his son as being '*very distressed*' about the outcome, particularly regarding the role of Dr Neoh in recommending the parenting arrangements, and stated that Mr Freeman had felt he was '*set up*'.[8]

CIRCUMSTANCES OF THE DEATH

10. On the morning of 29 January 2009, Darcey was to begin her first day of 'Prep' at St Joseph's School in Hawthorn. Mr Peter Freeman states that he assisted his son to organise the children for school that morning, and was concerned that his son was '*very stressed*'.[9] Mr Peter Freeman offered to accompany his son, however his offer was refused and Mr Freeman and the three children left the residence at about 7.30am to travel to Melbourne. Some time after 7.35am, a vehicle later believed to be Mr Freeman's was observed by a witness driving erratically at a fast pace on the Anglesea Road, tailgating other vehicles.

11. At 8.09am, Mr Freeman telephoned a friend in the United Kingdom, Ms Elizabeth Lam. They had a short conversation during which Mr Freeman cried and told Ms Lam that he had lost his children, and that everywhere he turned there were angry women. Ms Lam became concerned that Mr Freeman might take his own life. The conversation ended when Ms Lam's phone battery went dead.

12. At about 8.54am, Ms Barnes, who was at Darcey's school with her mother, telephoned Mr Freeman and asked him where Darcey was. Mr Freeman told her to say goodbye to her children and hung up. Ms Barnes telephoned him again and Mr Freeman told her she would never see her children again. Ms Barnes tried to telephone her solicitor, then reported the matter to police.

13. At about 9.15am, Mr Freeman stopped his vehicle in the inbound emergency lane of the West Gate Bridge, Spotswood with his hazard lights on. Mr Freeman asked Darcey to climb from the rear of the vehicle into the front seat. Mr Freeman lifted Darcey out of the vehicle and carried her to the rail (which was about waist-high at the time), before throwing her from the bridge. Several witnesses observed the events. Mr Freeman returned to his vehicle and drove to the base of the bridge. He stopped briefly at his eldest son's request, who asked his father repeatedly to go back to get Darcey as she could not swim.

14. Mr Freeman then drove to the Commonwealth Law Courts on William Street, Melbourne. On his arrival, he was highly distressed, non-responsive and crying. Police were contacted and Mr Freeman was arrested.

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[8] Exhibit 10, statement of Mr Peter Freeman, coronial brief page 90.
[9] Ibid.

15. Darcey was found at the base of the bridge by attending paramedics and police following 000 calls from witnesses. Police and paramedics attempted to revive her and she was transported by air to the Royal Children's Hospital. Darcey did not survive her injuries and was confirmed deceased at 1.35pm that day.

CRIMINAL INVESTIGATION

16. Darcey's death was clearly as a result of homicide and as such was subject to a criminal investigation. This Court awaited the conclusion of Mr Freeman's criminal proceedings before undertaking the coronial investigation.

17. Mr Freeman was charged with Darcey's murder and, after a trial lasting 19 days, was convicted. At trial, Mr Freeman denied remembering what he had done but accepted that he had caused Darcey's death. Mr Freeman attempted to establish that he was mentally impaired at the time of the offence, however this defence was ultimately rejected. On 11 April 2011, Mr Freeman was sentenced by the Honourable Justice Coghlan to life imprisonment with a non-parole period of 32 years. Mr Freeman sought leave to appeal his sentence to the Court of Appeal and then to the Full Bench of the Court of Appeal, but was unsuccessful.

PURPOSE OF A CORONIAL INVESTIGATION

18. The primary purpose of the coronial investigation of a reportable death[10] is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[11] An investigation is conducted pursuant to the *Coroners Act 2008* (Vic) (Coroners Act). The practice is to refer to the medical cause of death incorporating, where appropriate, the mode or mechanism of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

19. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory authority or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[12] This is generally referred to as the prevention role of the coroner.

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[10] Section 4 of the Coroners Act requires certain deaths to be reported to the coroner for investigation.
[11] Section 67 of the Coroners Act.
[12] Sections 72(1), 72(2) and 67(3) of the Coroners Act regarding reports, recommendations and comments respectively.

20. This finding is based on the totality of the material the product of the coronial investigation of Darcey's death, including the brief of evidence compiled by the Coroner's Investigator, Senior Sergeant Damian Jackson, and the results of the forensic medical and scientific investigation. All of this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

21. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or may be guilty of an offence.[13]

22. The unexpected and violent death of a child is devastating and is particularly shocking when perpetrated by a family member, given the family unit is expected to be a place of safety and protection. My purpose in holding this inquest was to explore whether any lessons could be learnt that might prevent similar deaths in the future. This prevention role is a broader function of the modern coronial system.

FINDINGS AS TO UNCONTENTIOUS MATTERS

23. In relation to Darcey's death, most of the matters I am required to ascertain were uncontentious from the outset. Her identity, the date, place and medical cause of her death were never at issue. I find, as a matter of formality, that Darcey Iris Freeman, born on 11 February 2004, aged 4, and died at the Royal Children's Hospital, 50 Flemington Road, Parkville Victoria 3052 on 29 January 2009.

MEDICAL CAUSE OF DEATH

24. Similarly the medical cause of death was not in dispute. An autopsy of Darcey's body and post mortem CT scanning were performed by Senior Forensic Pathologist Dr Matthew Lynch, who formed the opinion that the cause of her death was '*injuries sustained in fall from height*'.[14] Dr Lynch noted the estimation of a period of fifteen minutes of immersion prior to Darcey's extraction from the water.

[13] Section 69 of the Coroners Act.
[14] Report of Dr Lynch dated 8 April 2009.

25. Dr Lynch stated that the post mortem examination revealed evidence of bruises and abrasions consistent with a 'fall' from height and significant internal injuries. Dr Lynch also stated that there was evidence of marked brain swelling and features of hypoxic brain injury. Dr Lynch noted that the *clinical* view was that Darcey had suffered significant hypoxic brain injury in the setting of immersion. Post mortem toxicological analysis of ante mortem specimens did not reveal the presence of ethanol (alcohol) or any other common drugs or poisons.

CORONIAL INVESTIGATION AND INQUEST

26. Darcey's death was included in the Court's Victorian Systemic Review of Family Violence Deaths (VSRFVD).[15] The criteria for inclusion in the Review are:

    a. the death was caused, directly or indirectly, by an offender through the application of assaultive force or by criminal negligence;

    b. the relevant parties (deceased and offender) were or had been (at any point in time) in an intimate or familial relationship as defined by the *Family Violence Protection Act 2008* (Vic); and

    c. the death occurred in the context of family violence (including evidence of a history of family violence between the deceased and offender as defined by the Family Violence Protection Act, pending or actual separation or child custody dispute).

27. The following witnesses gave viva voce evidence at the inquest:

    - Senior Sergeant Damian Jackson, coroner's investigator
    - Ms Peta Barnes, Senior Next of Kin
    - Professor Kelsey Hegarty, Royal Australian College of General Practitioners (RACGP)
    - Ms Beth Allen, Department of Health and Human Services (DHHS).

28. The issues for examination at inquest were:

    - GPs' understanding of mandatory reporting obligations relating to reports of child abuse, and the adequacy of training and resources provided to GPs regarding disclosures by patients of child abuse and family violence. Further, whether the RACGP works with the

[15] The VSRFVD provides assistance to Victorian coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focussed recommendations aimed at reducing the incidence of family violence in the Victorian community.

DHHS Child Protection to ensure training and guidelines in the area of mandatory reporting of child abuse are appropriate and effective.

- Risk assessment in Federal Circuit Court proceedings and whether the changes in family court guidelines for staff and parties to proceedings adequately address their mandatory reporting obligations. In reflecting on the circumstances of the Freeman and Barnes' families' involvement in Court proceedings, whether any areas for improvement could be identified.
- The obligations, if any, for lawyers practising in the family law and family violence jurisdictions to report disclosures by their clients of actual or possible child abuse or family violence, and consideration of any professional or ethical barriers.

29. In a letter to the Court, Ms Barnes identified several matters that she wished the Court to consider during the investigation and inquest. As a result, I sought information prior to the inquest from the Emergency Services Telecommunications Authority (ESTA), the Family Court of Australia, the Law Institute of Victoria, the Victorian Bar Council, the DHHS and the RACGP.

General practitioners and mandatory reporting obligations

30. Ms Barnes stated that after her separation from Mr Freeman, she consulted with her GP at the time and described her fears of what Mr Freeman could do to the children. Specifically, Ms Barnes stated that she had told her GP (hereafter referred to as GP A) that she was concerned Mr Freeman could kill the children and that he was vengeful enough to kill the children to get back at her.[16]

31. I requested a statement from GP A, who stated that Ms Barnes disclosed '*ongoing problems with an angry irritable husband*' who shoved and pushed her, and was overly irritable with the children. GP A stated that Ms Barnes was teary and worried about the future of the relationship. GP A asked if Ms Barnes could have Mr Freeman come to see them to help the couple work through these issues.[17] On 28 June 2008, GP A learned that Ms Barnes and Mr Freeman had separated. Ms Barnes reported worrying about her eldest son and Darcey as she said they were showing signs of stress. GP A did not treat the children specifically in relation to this.[18] GP A also saw the children with Mr Freeman several times for routine vaccinations and childhood

[16] Exhibit 3, statement of Ms Peta Barnes, coronial brief pages 129-30.
[17] Exhibit 10, Statement of GP A dated 19 July 2013, coronial brief page 444.
[18] Ibid.

illnesses. GP A stated that they did not recall having any concerns nor did they witness any concerning behaviour from the children or Mr Freeman.[19]

32. On 10 December 2008, Ms Barnes consulted another GP at the same practice (hereafter referred to as GP B). This was the only occasion on which she saw GP B.[20] GP B stated that Ms Barnes presented with symptoms of a generalised anxiety disorder in relation to the loss of her job and concerns about Mr Freeman's violent behaviour. GP B stated that '*[a]t this consultation she expressed a fear that he would harm her children. She also said that she had discussed this with her attorney*'.[21]

33. GP B said that their impression was that Ms Barnes was seeking help with her anxiety symptoms and would continue to follow up with her attorney, and that this was advisable. GP B telephoned Ms Barnes on 11 December 2008 to provide follow-up support. Ms Barnes did not answer so GP B left a message for her; Ms Barnes did not return the message or return for a follow up visit.[22]

34. GP B stated as follows:

> *With the benefit of hindsight, I would not do anything differently. As I understood things, Ms Barnes was addressing the issue of her children's safety fears with her attorney. The attorney seemed the appropriate person to address those concerns. The only avenue available to me would have been to make a report to the Department of Human Services, but I had no reasonable belief that the children were at risk of imminent harm. To the extent they were with their mother they were safe. Insofar as their father, Mr Freeman, was concerned, I had previously seen Mr Freeman with his children when [he] had brought them in to The Medical Clinic for immunisation. During that consultation the children were poorly behaved yet Mr Freeman behaved with the utmost calm and ensured they were duly immunised. At no time was I concerned that he was in any way a violent character with regard to his children, and so I do not think I would have had sufficient grounds to make a report to DHS.*[23]

35. A third GP at the practice (hereafter referred to as GP C) that had seen the family over a year earlier also provided a statement. GP C stated that Ms Barnes attended on 23 and 27 March 2007. GP C stated that Ms Barnes reported that police had attended their home following an argument between Mr Freeman and Ms Barnes and that '*whilst Ms Barnes expressed a general concern regarding the children's welfare at that time, I do not recollect her stating any specific*

[19] Exhibit 10, Statement of GP A dated 19 July 2013, coronial brief page 444.
[20] Exhibit 10, Statement of GP B dated 3 July 2013, coronial brief page 447.
[21] Ibid.
[22] Ibid.
[23] Ibid.

reasons for this'. GP C further stated '*[a]s the police had attended this domestic dispute, I was under the impression that if this matter required any follow up, that they would institute this*'.[24]

36. GP C treated each of the children in 2007 and 2008 for minor ailments and Mr Freeman usually accompanied them to these appointments. GP C stated that the children '*always appeared well cared for and not distressed in his presence, nor did they have any signs of physical injuries. Therefore, there was no indication for referral to a service provider such as DHS on these visits*'.[25]

37. The DHHS states in its online publications that the Victorian Child Protection Service is '*specifically targeted to those children and young people at risk of harm or where families are unable or unwilling to protect them*', and that its main functions are to:

    a. *investigate matters where it is alleged that a child is at risk of harm*
    b. *refer children and families to services that assist in providing the ongoing safety and wellbeing of children*
    c. *take matters before the Children's Court if the child's safety cannot be ensured within the family*
    d. *supervise children on legal orders granted by the Children's Court*
    e. *provide and fund accommodation services, specialist support services, and adoption and permanent care to children and adolescents in need.*[26]

38. Some professionals such as doctors, nurses, midwives, police, school principals and school teachers are legally obliged to report suspected child abuse.[27] In addition, any person who believes on reasonable grounds that a child needs protection can make a report to the Victorian Child Protection Service. Child Protection will assess and, where necessary, further investigate if a child or young person is at risk of harm.[28]

39. Professor Kelsey Hegarty (Prof Hegarty) provided a statement to the Court and gave evidence on behalf or the RACGP.[29] Prof Hegarty is a GP and an academic expert in family violence, in particular intimate partner violence. Her qualifications are set out in her report at Exhibit 5 and

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[24] Exhibit 10, Statement of GP C dated 19 July 2013, page 450.
[25] Ibid pages 450-1.
[26] State Government of Victoria, *Child Protection*, 30 October 2014, Department of Health and Human Services, <http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection>.
[27] *Children, Youth and Families Act 2005* (Vic), section 182(1).
[28] State Government of Victoria, *Child Protection*, 30 October 2014, Department of Health and Human Services, <http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection>.
[29] In her statement, Prof Hegarty explained that the RACGP membership covers the vast majority of GPs in Victoria (5,848 of 7,800 in 2014) and that training for GPs is undertaken at two levels – vocational training and continuing professional development.

her career summary at Exhibit 6. They demonstrate significant experience and expertise in the field.

40. Prof Hegarty was asked to provide an opinion about the training and resources provided to GPs regarding disclosures by patients of child abuse and family violence, GPs' understanding of mandatory reporting obligations relating to reports of child abuse and whether the DHHS works with the RACGP to ensure training and guidelines in this area are appropriate and effective.

41. Prof Hegarty stated that the RACGP believes that '*the guidelines and training for primary care to manage all members of the family when abuse is happening requires an integrated model of education to be available for general practitioners to develop and update their learning in this area*'.[30] Prof Hegarty further stated that women and children need to have a safe response at three levels:

> *First line response: patients need to be responded to at any initial disclosure with good communication skills of active listening and non judgemental support. Safety assessment response: families need to have their safety assessed at the time of disclosure. They then can be guided to appropriate ongoing care, which might include the general practitioner seeing the patient for ongoing support, referral to advocacy services or crisis support. Pathway to safety: GPs need an understanding of specialist services and access to resources and referrals in local areas to assist them in keeping women and children safe.*[31]

42. Prof Hegarty referred to the RACGP's manual titled 'Abuse and Violence: working with our patients in general practice' (known as the White Book). The White Book was updated in July 2014 and is publicly available on the RACGP website. Prof Hegarty stated that the RACGP has also developed an education package for GPs in the area of family violence. This includes an online learning module and a support and information line for GPs through the 1800RESPECT service, so that GPs can access information on difficult issues in family violence.[32] Prof Hegarty stated that the RACGP would welcome a collaborative approach with key stakeholders to seek further funding to develop an online learning module on child abuse in the context of partner violence, and specific guidance in collaboration with the DHHS on when GPs should refer to Child Protection in the context of partner violence.[33]

43. At inquest, Prof Hegarty was presented with the evidence of the three GPs who saw Ms Barnes and made statements. None of those disclosures resulted in reports being made to the DHHS under the mandatory reporting guidelines. Prof Hegarty stated that in two cases, the disclosures

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[30] Exhibit 5, report of Professor Kelsey Hegarty dated 15 July 2015, coronial brief page 1139.
[31] Ibid page 1139.
[32] Ibid page 1140 and transcript page 26.
[33] Exhibit 5, report of Professor Kelsey Hegarty dated 15 July 2015, coronial brief page 1140.

were of partner violence and that there is no mandatory reporting requirement for partner violence.[34] Prof Hegarty also stated that instances of a child witnessing family violence are also not required to be reported under the mandatory reporting guidelines in Victoria.[35]

44. Regarding Ms Barnes' disclosure of her fears that Mr Freeman might harm the children to GP B, Prof Hegarty stated that this sort of disclosure must be taken seriously and formed the view that '*it would have been good to have some risk assessment of ... what was going on with the family ... around that disclosure*'.[36] Prof Hegarty referred to the Common Risk Assessment Framework (CRAF)[37] of which she stated GPs might or might not be aware, and explained that elements of the CRAF are set out in several sections of the White Book (this would not have been available to GPs before the 2014 update).[38] However, Prof Hegarty did not believe that a mandatory report should have been made in the case of this disclosure.[39] I accept Prof Hegarty's evidence and agree that, based on the evidence before me, the nature of the concerns raised to GP B did not necessitate the making of a mandatory report.

45. Prof Hegarty agreed that it appeared that the involvement of other professionals might have allayed some of the concerns of the GPs and meant that they then did not report. Prof Hegarty stated that it was common that GPs would think that the legal system and police would protect children in such situations.[40]

46. Regarding whether GPs understand that they are 'stand-alone' mandatory reporters even where other services are involved, Prof Hegarty stated that whilst she believed that it was clear to GPs that they are mandatory reporters and cannot rely on other services, the RACGP could consider

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[34] Transcript page 17. Prof Hegarty described 'partner violence' as fears that a patient's partner might commit violence rather than the patient themselves committing violence, as distinct from 'intimate partner violence' or violence perpetrated by one partner against another.

[35] Transcript page 17.

[36] Ibid page 18.

[37] Ms Beth Allen explained at transcript page 52 that the Common Risk Assessment Framework '*has been designed for anyone working with ... [w]omen who are experiencing family violence. It's a gender-based tool. It recognises that it's most commonly women impacted by family violence. It's been designed in such a way that it reflects that there are multiple and many professionals from, if I call them various classes of professionals that can come into contact with women who are experiencing family violence, and so it's crafted in three sections to reflect the skill level that each of those professional groups may have in respect to their work with family violence. So the first section of the CRAF is a guided risk assessment tool that helps those that are probably less commonly in touch with families who experience family violence. So it's the very basic elementary skills that they may require to give consideration to whether a woman is experiencing violence*'.

[38] Transcript pages 18-9.

[39] Ibid page 35-6.

[40] Ibid pages 21-2.

adding some further guidance to the White Book on this matter, specifying that GPs are mandatory reporters even where other services are involved.[41]

47. Prof Hegarty also spoke of the added complexity where both partners are being seen by the same GP and family violence has been disclosed, or with families with children when the GP is seeing the whole family, and that in such situations GPs should not be seeing both partners.[42] Prof Hegarty indicated that the RACGP is keen to develop further guidelines specifically on these matters. Currently, the RACGP guidelines follow the equivalent DHHS guidelines.[43]

48. Prof Hegarty was asked whether there is a referral service that a GP can provide to a patient if they disclose family violence which does not meet the threshold for mandatory reporting. She responded by explaining that there were several issues, being that some patients are not prepared to acknowledge that they are experiencing family violence, and under-resourcing of such services. Speaking from her own experience as a GP, Prof Hegarty stated that she preferred to refer to a domestic violence crisis service in such instances.[44]

49. Regarding GPs' knowledge of available services, Prof Hegarty stated that in her experience training GPs, they do not appear to have significant knowledge, especially as concerns the Child FIRST[45] service. The Child FIRST service is now addressed in the White Book.[46]

50. Prof Hegarty firmly recommended that training in some form of simple safety risk assessment and safety planning in the context of family violence be made compulsory for GPs. Prof Hegarty explained that currently, the only compulsory training for GPs is for cardiopulmonary resuscitation (CPR).[47] Prof Hegarty explained that it is not RACGP policy to make such training compulsory and that this view was her own.[48]

51. Prof Hegarty also referred to the successful implementation of the GP Mental Health Care Plan and recommended the introduction of a similar Medicare-funded 'Family Safety Plan'.[49] Prof

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[41] Transcript page 22.
[42] This matter was addressed by former State Coroner Judge Jennifer Coate in COR 2007 0860 Finding into the death of Lynette May Phillips dated 10 December 2012.
[43] Transcript pages 22-3 and 25.
[44] Ibid page 27.
[45] There are 24 Child and Family Information, Referral and Support Teams (Child FIRSTs) across the state. Each Child FIRST provides a central referral point to a range of community-based family services and other supports within each of the Child FIRST catchment areas. Professionals involved with vulnerable children, young people aged 0 to 17 years and their families, including families with an unborn child, may report or refer a concern to either Child Protection or the Child FIRST intake service.
[46] Transcript page 29.
[47] Ibid pages 30-1.
[48] Ibid page 31.
[49] Ibid pages 31-2.

Hegarty explained that family violence is underlying mental health issues for women, men and for children, and that the number of GPs requesting training in this area is increasing.[50]

52. Finally, Prof Hegarty expressed that GPs often expect, but do not receive feedback after making a report to Child Protection as to the outcome of their report. Prof Hegarty acknowledged that there had not been previous consultation between the RACGP and DHHS on this matter and that this would be a positive step.[51]

53. Ms Beth Allen, Assistant Director Child Protection Unit, DHHS, provided a statement to the Court and gave evidence at inquest. Ms Allen's evidence covered the obligation of GPs to report child abuse, the relationship between DHHS and the RACGP, and the training and guidelines that DHHS provides to the RACGP regarding the mandatory reporting of child abuse.

54. In her statement, Ms Allen explained that section 28 of the *Children Youth and Families Act 2005* (Vic) (CYF Act) provides that anyone in the community may make a confidential report to the DHHS about a child if the person has a significant concern for the wellbeing of the child.[52] The DHHS can then provide assistance, advice or refer the matter to a family service (usually Child FIRST) or community based service, or make a determination that the report is a 'Protective Intervention Report'. This is a report that requires investigation to assess whether the child has or is at risk of suffering harm. At this stage, Child Protection may initiate a protection application in respect of the child, or will work with the child's family (if they are willing to cooperate) to resolve the concerns.[53]

55. Ms Allen also stated that under the CYF Act, it is an offence for a mandatory reporter who, in the course of practising their profession or carrying out their duties, forms the belief on reasonable grounds that a child is in need of protection on grounds referred to in section 162(1)(c) (physical abuse) or 162(1)(d) (sexual abuse) of the CYF Act, to not report that belief and the reasonable grounds to the DHHS. A defence to that offence is that a mandatory reporter proves that they honestly and reasonably believed that all of the reasonable grounds for their belief had been the subject of a report made by another person.[54]

[50] Transcript page 32.
[51] Ibid page 37.
[52] *Children, Youth and Families Act 2005* (Vic), section 28. Exhibit 8, Statement of Ms Beth Allen dated 15 June 2015, coronial brief page 735.
[53] Exhibit 8, Statement of Ms Beth Allen dated 15 June 2015, coronial brief page 736.
[54] Transcript page 737.

56. Other kinds of harm such as harm due to emotional or psychological abuse cannot alone trigger the mandatory reporting requirement, and the degree of harm from physical or sexual abuse must be *significant* in order to meet the threshold for mandatory reporting.[55]

57. At inquest, Ms Allen was asked whether the requirement that the risk of harm be 'significant' was too high and whether a mandatory reporting obligation should be triggered where the reporter forms the belief that the child requires protection from *harm* from physical or sexual abuse. Ms Allen responded that in her view, the threshold is not too high and stated that it is important to note that in Victoria, any person in the community or any professional can make a report if they hold any concern for a child's wellbeing. This is separate to the mandatory reporting regime.[56] Ms Allen explained that for those professionals where reporting is mandated, the purpose is to '*[compel] those professionals to make those reports that are most serious and essentially apply a penalty if they do not do so*'.[57]

58. Ms Allen further stated that in Victoria, unlike many other jurisdictions, there are generally two pathways for reports to the DHHS; one for lower level concerns, for example about parents' ability to cope or to provide for the child's needs; the other is the Child Protection system where the State intervenes when children are experiencing significant harm and parents are unable to protect them from harm.[58] In all but the cases of mandatory reporting, which must be reported to the DHHS Child Protection, any other person or professional can make a decision about whether or not they believe that there is a wellbeing concern or a concern about the protection of children, and they can choose to report to either Child Protection or Child FIRST. If it is deemed that the reporter has chosen the incorrect option for the circumstances, either Child Protection or Child FIRST can report or refer the matter to the other.[59]

59. Ms Allen was also asked whether the nature of 'harm' in the CYF Act should be consistent with the Family Violence Protection Act, that is, not limited to physical or sexual abuse but should include psychological and emotional harm. Ms Allen responded that emotional and psychological harms are in fact included and well-recognised as forms of child abuse consistent with the Family Violence Protection Act, but that they are not grounds on which mandatory reporting must occur.[60]

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[55] Transcript page 743.
[56] Ibid pages 46-7.
[57] Ibid page 47.
[58] Ibid pages 47-8.
[59] Ibid page 48.
[60] Ibid pages 49-50.

60. Ms Allen explained the importance of the Child Protection regime maintaining an appropriate level of protection and services for those matters that are not the highest level of risk. Ms Allen spoke of the aim, being to:

> *develop and manage a system that allows for the best possible response to be provided to children and families as quickly as possible. And so the two pathways or doors allows us to do that. If we were to require mandatory reporting of every form of emotional or psychological abuse, my view would be that the child protection system would be inundated with everything from low level concerns about perhaps a child being sad at school and their parents not protecting them from bullying, as one perhaps minor example, through to the more severe. What we want to try and do is unpack those and ... ensure that the services are commensurate and reflect the needs of the child so that ... the state's not intervening and looking at potentially removing children from parents' care when the situation or the report involves relatively lower level concerns.*[61]

61. Ms Allen also explained that emotional or psychological abuse are the primary types of reports to Child Protection, and that where there are concerns about emotional and psychological concerns for children reported, they would typically involve family violence.[62] Ms Allen further stated that '*generally it's fair to say that most professionals and community members understand when children are being exposed to substantial emotional and psychological abuse and they refer that to Child Protection frequently*'.[63]

62. I accept and support Ms Allen's position on this issue.

63. Regarding the CRAF and its application for children, Ms Allen stated that '*the CRAF in its current form [does not] speak very well or reference children very well*'.[64] Ms Allen stated that there is a minor mention in one section of the CRAF called the 'aide memoire' that refers to the considerations to be given to children. The CRAF does not go into great detail or prompt the user to give detailed consideration to impacts on children. Ms Allen stated that it is recognised in the family violence sector currently that further work should be done in this regard.[65] Nevertheless, Ms Allen stated that the CRAF, whilst being a useful tool for GPs, does not, in her view, replace the need for GPs and other professionals who encounter patients who are experiencing family violence to be routinely undertaking quality training.[66] [67]

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[61] Transcript page 50.
[62] Ibid.
[63] Ibid pages 50-1.
[64] Ibid page 53.
[65] Ibid page 53.
[66] Ibid pages 53-4.
[67] In my finding into the death of Luke Geoffrey Batty dated 28 September 2015 (COR 2015 000855), I recommended that the State of Victoria undertake empirical validation of the CRAF to ensure it can robustly assess risks of family violence, particularly in relation to children. I am of the view that the circumstances surrounding Darcey's death are not

64. Regarding Prof Hegarty's evidence that, anecdotally, GPs often state that they do not receive feedback from the DHHS when they make a report to Child Protection, Ms Allen stated that the expectation of and advice to the DHHS staff is to always respond to the professional reporters informing them of the outcome of their report. The DHHS will advise the reporter that they have either provided advice and assistance to the family, or that Child Protection intends to investigate. The DHHS cannot inform reporters of the outcome of an investigation, unless it deems that they have an ongoing role, for example, if a GP is going to be part of the planning and supports available to a family.[68]

65. In response to Prof Hegarty's comments about possible improvement of the DHHS resources for GPs concerning post-separation family violence and child abuse, Ms Allen stated that the DHHS has recently developed a case practice model guide titled 'Working with Families where an Adult is Violent.' Ms Allen stated that the guide is available to anyone working with children and families where family violence might exist, and the guide covers in detail issues of prevalence, when and how to engage with perpetrators, and in particular the significance of the post-separation period and how practitioners should be mindful of 'red flags' at that particular time. Ms Allen described the guide as '*an excellent resource for GPs*'.[69]

66. Ms Allen concluded by stating that in recent years, the DHHS has learned a lot more about family violence than is covered in its materials that are currently available, and is '*committed to supporting any other professional groups to understand both the dynamics of family violence and reporting obligations, and how best to bring children and families to the right door*'.[70] Ms Allen also stated that the DHHS would happily share publications or training that would improve reporting obligations and understanding for other professionals.[71] I commend the DHHS for its work and its eagerness to make improvements in this area.

Risk assessment in Federal Circuit Court proceedings and changes to family court guidelines

67. I asked that Dr Neoh provide further detail on her attendance on 28 January 2009 at the Federal Magistrates' Court hearing, to describe the process involved in giving her evidence, and the manner in which it was tested by Counsel for each of the parties.

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such that a similar recommendation regarding the CRAF should be made in this case, but I note that the State of Victoria is currently considering my recommendation and that its response might have implications for victims of family violence and those working with them. I will not deal further with the CRAF in this finding.

[68] Transcript page 57.

[69] Ibid page 58.

[70] Ibid pages 59-60.

[71] Ibid page 62.

68. Dr Neoh stated that she attended the Court and gave evidence. She was questioned by both counsel for Mr Freeman and Ms Barnes about the information in her assessment and report. Dr Neoh was informed in Court that the parties were mostly agreed about arrangements for their children, such that the children should spend most of the time with their mother. Dr Neoh further stated that the dispute centred on whether the children should spend an evening or overnight in the alternate week with their father. Many of the questions also concerned Darcey's capacities and development over what was expected to be her first year of school.[72]

69. I sought information from the Family Court of Australia about its family violence policies. The Honourable Chief Justice Bryant of the Family Court of Australia provided comprehensive information to the Court.

70. Her Honour confirmed that both the Federal Circuit Court and the Family Court have jointly established a Family Violence Committee, the membership of which is comprised of Family Court judges, Federal Circuit Court judges, family consultant and other relevant personnel. The Committee has been responsible for the preparation and release of the Family Violence Best Practice Principles (now in their third edition) and the development of the Family Violence Plan 2014-2016. Her Honour stated that this commits both courts to a comprehensive set of actions that support clients experiencing family violence. Both documents are publicly available on both Courts' websites.[73]

71. Her Honour further advised that amendments to the *Family Law Act 1975* (Cth) which came into effect on 7 June 2012 included a detailed definition of family violence, prioritisation of considerations of safety in arriving at decisions that are in the best interests of children, and the imposition of obligations on both courts to take prompt action in cases where all allegations of violence or abuse or the risk of violence or abuse are raised.[74] The Court[75] also places obligations on parties and their advisers to tell the Court about family violence.

72. Her Honour provided me with further information to the Court by way of a letter dated 7 July 2015. By way of general comment, Her Honour stated that '*every Court encourages parties to resolve their disputes without the need for litigation if possible*'.[76] Her Honour further explained that the Family Law Act provides that whether an Order is made by consent (as was the case with Mr Freeman and Ms Barnes) or after a final hearing, the Judge must regard the best

[72] Exhibit 10, statement of Dr Jennifer Neoh dated 10 July 2015, coronial brief page 1141-2.
[73] Exhibit 10, letter from Chief Justice Diana Bryant AO dated 6 March 2015, coronial brief pages 686-7.
[74] Ibid page 687.
[75] The Family Court and Federal Circuit Court.
[76] Exhibit 10, letter from Chief Justice Diana Bryant AO dated 7 July 2015, coronial brief page 689.

interests of the child as paramount importance. Her Honour emphasised that '*judges and Registrars should not and do not make orders by consent unless they are satisfied from the material before the court that those arrangements are in the best interests of the child*'.[77]

73. Regarding family violence, Her Honour stated that the Family Law Act is explicit about the way in which family violence is dealt with and decided. Her Honour referred to the fact that a Family Violence Committee had been formed, which had developed Family Violence Best Practice Principles, as demonstrable of the fact that Judges in the jurisdiction understand family violence. I accept that assessment.[78]

74. Her Honour stated that the Family Court does not condone nor encourage lawyers to press their clients to settle matters where it is inappropriate and to discourage clients from raising relevant family violence when they should.[79] Her Honour reproduced the following from a presentation she delivered at the Family Law Section Conference in 2014:

> *I understand that parties feel pressures to settle but without an indication that they are uncomfortable about an order the court is not to know. So I think it is vitally important that practitioners understand that when dealing with matters of family violence of which there are many, they must be careful. The court and the Act provide for matters to be raised and they should be. No one should ever suggest that it is not appropriate in any way and I would hope that there are no participants at this conference who have given that advice. It is however a common complaint and care must be taken to ensure that if practitioners believe a party is feeling pressured to settle and they do not wish to then that issue must be raised either with them and/or with the court.*[80]

75. This is a pertinent point. I accept and endorse Her Honour's comments, and I thank Chief Justice Bryant for her assistance in this investigation.

Lawyers practising in the family law and family violence jurisdictions

76. I requested that the Law Institute of Victoria (LIV) and the Victorian Bar Council provide comments on how disclosures of family violence are shared with, or used by lawyers and others in the Family Court and Federal Circuit Court contexts and further education and training of family lawyers in matters involving family violence. Ms Katie Miller, President of the LIV, provided a response to the Court.

[77] Exhibit 10, letter from Chief Justice Diana Bryant AO dated 7 July 2015, coronial brief page 689.
[78] Ibid.
[79] Ibid page 690.
[80] Ibid page 689.

77. Ms Miller advised, as Her Honour Chief Justice Bryant did, that reporting mechanisms already exist in the courts to alert authorities when a party has been or is at risk of being abused, subjected to or exposed to family violence.[81]

78. Ms Miller also stated that members of the LIV Family Law Section report '*that information sharing mechanisms currently available in the Family Court system are under utilised and greater education and training would be beneficial*'.[82] Ms Miller stated that the LIV acknowledges that more should be done to enhance information sharing processes and awareness of existing processes between the Courts, the DHHS, police and lawyers from different jurisdictions. Ms Miller stated that the LIV has identified these and other issues (and recommendations to address those issues) in its recent submission to the Royal Commission into Family Violence.[83]

79. Ms Miller explained that the Family Law Act does not require lawyers to disclose communications from their client, even when those communications include a threat to harm another person. Ms Miller stated that if a client is required by law to disclose a communication, client legal privilege or legal professional privilege protects that client from being forced to disclose that confidential communication, unless the communication is made for an illegal or improper purposes.[84]

80. Ms Miller further stated that:

> *[c]lient legal privilege is a substantive law right and common law immunity. It belongs to the client and is a fundamental keystone of the Australian legal system. The privilege ensures people can access legal advice without later being forced to disclose that advice or the communications required for the lawyer to provide such advice. It does not prevent the client from disclosing the information. If a client chose to disclose such information, they may lose the protection afforded by the privilege.*[85]

81. Regarding client confidentiality, Ms Miller stated that lawyers are required by strict ethical standards to maintain the confidence of their client's communications. An exception may arise if the disclosure of the confidential communication is required to avoid the probable commission or concealment of a serious criminal offence (i.e. harming a child or other person), but that a mere threat or concern is insufficient to engage this exception.[86] Where in family law matters a client discloses incidents of previous family violence or an intention to commit harm,

[81] Exhibit 10, letter from Ms Katie Miller dated 16 June 2015, coronial brief page 881.
[82] Ibid page 882.
[83] Ibid.
[84] Ibid.
[85] Ibid.
[86] Ibid.

Ms Miller stated that a lawyer faces a serious ethical dilemma. The LIV assists to provide free telephone services to lawyers to help with urgent dilemmas via its Ethics Inquiry Line, Mentoring Program and Lawyers' Health Line.[87]

82. In her letter referred to at paragraph 28, Ms Barnes suggested that a basic information pack would assist to educate parties in family law matters about family violence. Ms Miller stated that the LIV agrees with Ms Barnes' suggestion that such information would assist. Ms Miller stated that to assist practitioners, the LIV proposes to publish a Family Violence Information Pack on the LIV website which lawyers (and members of the public) will be able to access to ensure family law clients are informed about family violence, how it might impact on their family law matter and how the disclosure of family violence may be treated in Family Court proceedings. Ms Miller stated that the LIV Family Law Section will discuss with representatives of the Family Court the prospect of the Court making a Family Violence Information Pack available for family law litigants.[88]

83. I thank Ms Miller and the LIV for its assistance and contribution. I also thank Ms Barnes for her suggestions and am pleased that the LIV has decided to consider her suggestion for the introduction of a Family Violence Information Pack.

84. The President of the Victorian Bar Council, Mr James Peters QC, provided a comprehensive explanation outlining the obligations imposed on legal practitioners in the Family Court and Federal Circuit Court jurisdictions, including the relevant statutory and common law provisions. Mr Peters QC also provided detail of the interplay between those obligations and the constraints imposed by legal professional privilege relating to disclosure of family violence made to legal practitioners (as addressed by Ms Miller above).

85. The Victorian Bar submitted that there is already in Victoria a comprehensive legislative and regulatory regime for the reporting of family violence and child abuse, by reason of the provisions of the Family Law Act, *Family Law Rules 2004* (Cth) and the *Federal Circuit Court Rules 2001* (Cth). The Victorian Bar submitted that '*to require barristers, (or lawyers in general), to personally report violent behaviour or concerns in cases in which they become professionally involved on behalf of the accuser would duplicate existing obligations*'.[89]

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[87] Exhibit 10, letter from Ms Katie Miller dated 16 June 2015, coronial brief page 883.
[88] Ibid pages 884-5.
[89] Exhibit 10, submission of the Victorian Bar Council, coronial brief page 918.

86. The Victorian Bar further submitted that any change to the law and the ethical requirements of barristers so as to compel or entitle a barrister acting for a person accused of family violence or child abuse to disclose instructions '*would substantially affect the lawyer/client relationship, would limit the obtaining of proper instructions, the giving of appropriate legal advice and overturn centuries of jurisprudence*'.[90]

87. The Victorian Bar set out the ethical requirements for barristers. Broadly, they require a barrister not to disclose confidential information obtained as to a client's affairs save with the consent of the client, as the Rules specifically provide or as otherwise compelled by law. However, a number of other Rules pertain to the ethical obligations of barristers to the courts and others are relevant to the issue of confidentiality.[91]

88. The Victorian Bar concluded by submitting that '*within the [Family Law Act] there is a very extensive and multi-faceted legislative approach to the issue of family violence. Strong emphasis is placed upon prompt disclosure by relevant persons, primarily litigants, to the court of allegations involving abuse and family violence.*'[92] The Victorian Bar submitted that the Family Law Act and Family Violence Protection Act correctly place emphasis upon the obligations of the litigants themselves to report family violence or abuse allegations.[93]

89. I thank Mr Peters and the Victorian Bar for their contribution and assistance.

EMERGENCY SERVICES TELECOMMUNICATIONS AUTHORITY

90. Ms Barnes raised some concerns about both the police and 000 response on the day of Darcey's death and regarding her previous calls to emergency services. This matter fell outside the scope of the inquest, however, I requested that ESTA provide information to the Court to assist Ms Barnes.

91. ESTA provided an extensive outline of their operations, including specific further considerations they now have for call takers in matters involving family violence. ESTA specifically investigated all calls made to it by Ms Barnes in the relevant period, and provided a critical analysis of the call taker's response. ESTA also provided the Court with copies of two externally commissioned reviews of the public perception of their service which were

[90] Exhibit 10, submission of the Victorian Bar Council, coronial brief page 918.
[91] Ibid page 919.
[92] Ibid page 924.
[93] Ibid.

undertaken in 2014 and 2015, and which ESTA has used to inform their recruiting and training practices.[94] I thank ESTA for its assistance and contribution.

WEST GATE BRIDGE BARRIERS

92. In March 2009, VicRoads commenced installation of a temporary safety barrier on the West Gate Bridge. This was completed in April 2009. Between May 2009 and May 2012, the temporary barrier was progressively replaced by a permanent barrier that is about 3 metres in height. The permanent barrier includes several features to prevent climbing attempts.

93. I asked the Coroners Prevention Unit (CPU)[95] to provide information on every jumping suicide at the West Gate Bridge from 2000 to 2014. The CPU data revealed a general trend upwards in annual frequency of jumping suicides from 2000 to 2008, then a reversal in the trend from 2009 to 2014, which coincided approximately in time with the installation of the temporary safety barrier at the West Gate Bridge. During the pre-barrier period (January 2000 to the completion of the temporary barrier installation in April 2009) there were 98 deaths or an average of 11.8 per year. During the temporary barrier period, there were six deaths or an average of 1.9 per year. There were no jumping suicides during the permanent barrier period.

94. The death of Darcey was a homicide and not a suicide, however from a prevention perspective it has meaningful similarities with the pre-barrier West Gate Bridge jumping suicides. In particular, the low railing did not act as an impediment to Mr Freeman accessing the edge of the bridge. I am of the view that the permanent barrier, which appears to be an effective impediment to jumping suicides, would similarly prevent any future homicides occurring in circumstances similar to Darcey's death.

CONCLUSION

95. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities (with the *Briginshaw*[96] gloss or explication). The effect of the authorities is that coroners should not make adverse findings against or comments about individuals, unless the

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[94] Exhibit 10, submission of the Emergency Services Telecommunications Authority, coronial brief pages 976-1137.
[95] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.
[96] *Briginshaw v Briginshaw (1938) 60 CLR 336 esp at 362-363.* 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences'.

evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

96. The circumstances surrounding Darcey's death had a profound impact on those who knew and loved her, as well as the community as a whole. It is therefore fitting that a comprehensive investigation and enquiry was made into the circumstances surrounding her death to determine whether there were any opportunities that might have prevented this death, or to reduce the number of future similar deaths. This was the key question for examination at the inquest. That said, the importance of conducting such an investigation does not reduce the importance of placing responsibility for Darcey's death where it properly lies – solely with Mr Freeman.

97. The evidence before me leads me to conclude that Mr Freeman's actions, and Darcey's death, were unable to have been predicted with any great certainty. As I recently found in my investigation into the death of Luke Batty (Batty), there is no validated risk assessment tool that can accurately predict whether a parent is likely to commit filicide.[97]

98. In relation to the further information I requested from various parties, I must emphasise that each that was asked conveyed it, appreciated being provided the opportunity to contribute, and did so both comprehensively and in the spirit of actively assisting in the coronial process. I thank them for their assistance.

99. I make no adverse finding against any of the treating GPs or other professionals in this matter, as the weight of the available evidence does not support a finding that they departed from the prevailing standards of their respective professions. I acknowledge that dealing with patients and clients who are experiencing or are at risk of family violence or child abuse is complex and that practitioners are eager to improve their own knowledge, skills and practice in order to be better equipped to assist their patients and clients.

100. Nevertheless, and while emphasising that my comment does not apply directly to the professionals involved in the circumstances surrounding Darcey's death, there is scope generally for improvements in training and education for GPs and for other professionals whose work brings them into contact with clients who are experiencing or are at risk of family violence or child abuse. Such training and education should involve both family violence and abuse generally, and mandatory reporting obligations and the functions of the Child Protection Service specifically, as well as ensuring that GPs understand that they are able to report family

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[97] COR 2014 000855 Finding into the death of Luke Geoffrey Batty dated 28 September 2015.

violence and child abuse that does not meet the mandatory reporting threshold to either Child FIRST or Child Protection. I acknowledge that the professional organisations that contributed to this investigation all indicated an acute awareness of the importance of this issue and a desire to improve their practice. I also encourage the various professions to continue working collaboratively, or to form working relationships with each other to share information.

101. I acknowledge correspondence received by Mr Freeman's father, Mr Peter Freeman, who expressed that he did not witness any evidence in their involvement with Mr Freeman or the children to indicate that there was a basis for fear for the children's safety. Mr Peter Freeman stated that the children loved their paternal relatives and involvement in family life, and that they loved and were much loved by their paternal grandparents. I accept this submission and note that this is evident in Dr Neoh's report. I acknowledge the sadness and loss felt by Mr Peter and Ms Norma Freeman, who were evidently doting grandparents who were doing all they could to support and assist their son and grandchildren.

102. I extend my sincere thanks to Ms Barnes and her extended family for their contribution to the coronial investigation and inquest. It is clear that Ms Barnes was a loving, intelligent, and protective mother to Darcey who had worked tirelessly to provide a safe environment for her and her brothers. I also acknowledge Ms Barnes' very important role in the coronial investigation and inquest; it was constructive, gracious and measured. I convey my sincere condolences to Darcey's family and friends.

COMMENTS

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

103. Filicide, the deliberate act of a parent killing their own child, is a statistically rare form of homicide that is, even to the trained eye, unable to be predicted with certainty. There is no validated actuarial tool available to predict filicide. I refer to the expert evidence of Professor Ogloff in Batty.[98] The evidence was that while there is no validated risk assessment tool capable of reliably identifying whether a parent will commit filicide, there are validated tools that can predict with reasonable certainty the families in which there is likely to be a recurrence of family violence. I agreed with the expert evidence in Batty that strengthening family

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[98] COR 2014 000855 Finding into the death of Luke Geoffrey Batty dated 28 September 2015, page 79.

violence responses generally may lead to a reduction in the number of children killed by their parents. I commented that filicide should be considered as part of the broader phenomenon of family violence, rather than existing in a separate category.[99] I also commented that the lack of certainty about filicide does not mean that we must give up or stop assessing risk.[100]

104. Specifically in relation to Prof Hegarty's recommendation for compulsory family violence training for GPs, I note the position of the RACGP that mandated or compulsory training in any field is not desirable, and that the reason for this position is that it would then be arguable that training in almost every field of medicine should be mandated for GPs. I understand the position of the RACGP in this regard.

RECOMMENDATIONS

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

1. General Practitioners (GPs) are at the front line and have a role in identification, responding to and follow-up support of patients and their children experiencing family violence. They can contribute to prevention. I therefore recommend that the Royal Australian College of General Practitioners (RACGP) consider the introduction of compulsory family violence training for GPs.

I direct that a copy of this finding be provided to the following for their information only:

Ms Peta Barnes, Senior Next of Kin

Ms Kym Peake, Acting Secretary, Department of Health and Human Services

The Honourable Diana Bryant AO, Chief Justice, Family Court of Australia

Mr James Peters QC, President, Victorian Bar Council

Ms Katie Miller, President, Law Institute of Victoria

Ms Kirsty McIntyre, Department of Health and Human Services

Emergency Services Telecommunications Authority c/o Mr Fatmir Badali, Gadens Lawyers

Ms Karen McDonald, Manager Legal Services, VicRoads

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[99] COR 2014 000855 Finding into the death of Luke Geoffrey Batty dated 28 September 2015, page 80.
[100] Ibid.

Ms Belinda Bales, Civil Litigation Division, Victoria Police

Principal Commissioner Bernie Geary OAM, Commission for Children and Young People

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

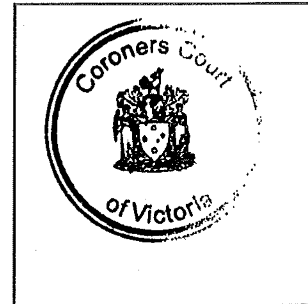
Senior Sergeant Damian Jackson, Coroner's Investigator, Victoria Police

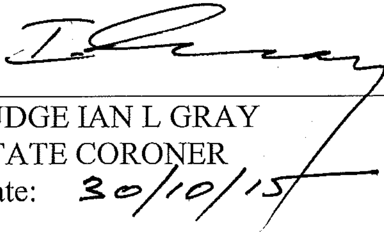
Sergeant Sharon Wade, Police Coronial Support Unit.

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

Associate Professor Morton Rawlin, Royal Australian College of General Practitioners

Signature:





JUDGE IAN L GRAY
STATE CORONER
Date: 30/10/15