IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 0855

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of:	**LUKE GEOFFREY BATTY**
Delivered On:	28 September 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	20-24, 28-30 October, 1-5 December 2014 (13 days)
Findings of:	Judge Ian L. Gray, State Coroner
Representation:	Ms Rachel Doyle SC and Therese McCarthy, instructed by Ms Paula Shelton and Mr Charandev Singh, Shine Lawyers, on behalf of Ms Rosemary Batty. Dr Ian Freckelton QC with Mr Ben Ihle, instructed by Ms Rose Singleton, Victorian Government Solicitors' Office, on behalf of the Chief Commissioner of Police. Ms Erin Gardner and Ms Michelle Wilson, instructed by Ms Colleen Carey, the Department of Human Services[1].
Counsel Assisting the Coroner	Ms Rachel Ellyard, Counsel, instructed by Ms Jodie Burns, Senior Legal Counsel, Coroners Court of Victoria.

[1] At the time of the Inquest, the Department was known as the Department of Human Services. On 1 January 2015, the Department of Health and the Department of Human Services joined to form the Department of Health and Human Services. To avoid confusion I will refer to the Department of Human Services (and where relevant Child Protection) in the Finding and to the Department of Health and Human Services when making recommendations.

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of LUKE GEOFFREY BATTY

AND having held an inquest in relation to this death on 20-24, 28-30 October, 1-5 December 2014 (13 days) at Melbourne

find that the identity of the deceased was Luke Geoffrey Batty

born on 20 June 2002

and the death occurred 12 February 2014

at Bunguyan Reserve, 1475 Frankston-Flinders Road, Tyabb, Victoria, 3913

from:

1(a) CRANIOCERVICAL TRAUMA

INTRODUCTION

1. On 12 February 2014, Gregory Anderson (**Mr Anderson**) killed his son, Luke Geoffrey Batty (**Luke**), aged 11, in the cricket nets at the Bunguyan Reserve[2], at 1475 Frankston-Flinders Road, Tyabb, Victoria. Luke's death was a tragic loss of a young life full of promise.
2. The killing was a premeditated act of filicide.[3]
3. Mr Anderson deliberately and forcefully swung a cricket bat at Luke's head. Mr Anderson then produced a knife and inflicted deep wounds to Luke's neck. Both injuries were equally fatal.
4. Had Mr Anderson not engineered a confrontation with police officers in the immediate aftermath of Luke's death and been shot by a police officer, in self-defence, he would have been criminally charged with causing his son's death.
5. The physical absence of Luke's killer does not reduce the importance of placing responsibility for Luke's death where it properly lies. It lies solely on Mr Anderson.
6. Luke's death, from a practical point of view, was not preventable from the time he entered the cricket nets to practice with his father.
7. My investigation focused on the role of various elements within the family violence system and their interaction with Luke and his mother Ms Rosemary Batty (**Ms Batty**) in the 18 months leading up to Luke's death. At paragraph 96 of these findings I set out the full scope of the Inquest.
8. It is important to say something briefly at this point about Luke's mother, Ms Batty. I will say far more about her evidence later, but this should be said at the outset: Ms Batty was a compelling witness; she was, and of this there can be no doubt, a loving, caring, intelligent and thoughtful mother. Her decisions and actions were clearly motivated by her deep love for her son. She, with her lawyers, played a constructive role in the Inquest, and in submissions, proposed a number of recommendations.

[2] The Bunguyan Reserve is the home ground of the Tyabb Cricket and Football clubs.
[3] Filicide is the deliberate act of a parent killing their own child.

SUMMARY OF KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

9. I find the deceased's identity to be Luke Geoffrey Batty, born on 20 June 2002.
10. I find that the cause of Luke's death was craniocervical trauma.
11. I find that Luke's father, Gregory Anderson caused Luke's death.
12. I find that there is no validated risk assessment tool that can accurately predict whether a parent is likely to commit filicide.
13. I find that Luke's death was preceded by years of family violence perpetrated by Mr Anderson to him and his mother. Luke was exposed to emotional harm, conduct engendering fear and anxiety, and he witnessed physical harm inflicted by Mr Anderson on his mother, Ms Batty.
14. I am unable to make any findings in relation to the reasons for Mr Anderson's decision to kill his son. I note Ms Batty's plausible speculation that Luke was growing older and wished to withdraw from his father, and that Mr Anderson was aware of this and wished to assert his control over his son.
15. I accept the evidence of Emeritus Professor Paul Mullen, Centre for Forensic Behavioural Science (**Professor Mullen**) that Mr Anderson may have had a delusional disorder[4]. However, the absence of any full psychiatric assessment during Mr Anderson's life, means that no finding can be made with certainty about whether Mr Anderson suffered from any particular mental illness or how he might have been treated.
16. While it is tempting, with hindsight, to regard Luke's death as foreseeable because of the way Mr Anderson behaved towards Ms Batty and others, I conclude, based on the comprehensive evidence in this case, that Luke's death was not reasonably foreseeable by any entity or person, including Ms Batty. No one person or agency could have reasonably been expected to foresee that Mr Anderson would be that rare perpetrator, and Luke the rare victim, of a violent filicide.
17. My investigation identified a number of gaps or flaws in the family violence system operating in Victoria. While there were process and system gaps, and flaws in responses to Luke and Ms Batty's family violence experiences, I find that none of the actions of the organisations or persons whose conduct has been analysed, either singularly or in combination, caused or directly contributed to Luke's death.
18. While there was no causative link between the system gaps and flaws and Luke's death, I have made a number of comments and recommendations from a public health and safety, and the administration of justice, perspective.
19. The most important of these relate to the following topics:

A The failure to engage Mr Anderson in the family violence system and make him accountable for his actions

Perpetrator engagement in the family violence system will be strengthened by:

(a) *Reducing delays in serving family violence charges:* There were delays in charging Mr Anderson with family violence related criminal offences.

[4] Exhibit 104, expert report of Professor Mullen.

(b) *Reducing delays in executing warrants:* Warrants were not put onto LEAP in a timely manner, resulting in delays, and the failure, to execute warrants for Mr Anderson's arrest.

(c) *Reducing delays in serving family violence intervention orders (**FVIOs**):* Delays in serving FVIOs resulted in protective measures for Luke expiring.

(d) *Bail:* Bail for family violence perpetrators needs to be revised to ensure:

i. A warrant for arrest does not have the effect of cancelling bail.

ii. Bail should be refused where the accused can not demonstrate the failure to appear was not due to causes beyond his or her control.

iii. Protected persons named on a FVIO are updated as to the progress and outcome of all FVIOs, warrants, bail applications and criminal proceedings which relate to them and any other protected family members.

iv. Police prosecutors dealing with bail applications inform themselves of previous L17s.

(e) *Warning flags:* Victoria Police should introduce a warning flag in LEAP to identify 'high risk' family violence perpetrators.

(f) *Mental Health Assessments for perpetrators:* There should be a judicial power that can be activated where there are safety concerns, particularly in relation to children, to mandate that a perpetrator (respondent) be assessed by a forensic psychiatrist. Had such a power existed, the Court could have ordered Mr Anderson be psychiatrically assessed before his application for contact with Luke was considered.

B Risk assessments

The Common Risk Assessment Framework (**the CRAF**) is not validated. It should be validated to ensure it can robustly assess risks of family violence, particularly in relation to children.

Where a risk assessment in the system indicates a high risk of family violence to a person, including a child, Victoria Police and the DHHS should be notified as soon as practicable.

Risks assessments will be strengthened if they are:

(a) undertaken upon notification of risk to a child;

(b) in writing;

(c) refer to previous risk assessments;

(d) routinely shared with relevant agencies and persons, such as protected persons named in a FVIO;

(e) uniform in *approach* while acknowledging the different legislative mandates of agencies;

(f) co-ordinated with respect to risk management and safety planning, such as RAMPs;

(g) remove the practice of asking women at risk of family violence to enter into undertakings which require them to supervise or manage the behaviour of the perpetrator.

A family violence agency should not stop its risk assessment or close a file until a thorough attempt to engage with the perpetrator is undertaken.

All family violence agencies, and the Magistrates' Court of Victoria, need to provide comprehensive training on how to undertake a family violence risk assessment.

Where one parent is assessed as 'protective' but the other parent is not, the DHHS should support the protective parent to ensure safety to a child at risk of family violence.

C Family Violence Intervention Orders

Family violence intervention orders will be strengthened by:

(a) FVIO police informants being provided with important information arising out of all family violence related court proceedings in their absence;

(b) all FVIOs being served as a matter of priority;

(c) ensuring the format and language of FVIOs is reviewed to make them clearer and simpler and preferably written in plain English;

(d) clearly stating whether parenting orders under the *Family Law Act 1975* are affected/varied.

D Magistrates' Court - Family Violence Cases

This case has demonstrated that the response by the Magistrates' Court to family violence is optimal when there is an alignment between criminal cases and family violence cases affecting the same parties. The Family Violence Division of the Magistrates' Court of Victoria (currently operating at two locations) is a sound model. It ensures integration of relevant jurisdictions – IVOs, crime, interim family law, children protection and VOCAT. In addition the effectiveness of the Division would be significantly enhanced if at each location the Court Integrated Services Program (CISP) was co- located and able to provide services.[5]

Magistrates' Courts dealing with family violence cases should have the "fast track" system, and bench mark periods for listing family violence related matters.[6]

Magistrates should have the power to mandate a family violence perpetrator's attendance at relevant change behaviour programmes, where deemed appropriate. This should also include the power to request proof of attendance and completion.

[5] I note the Magistrates' Court of Victoria's submission to the Royal Commission into Family Violence on this point.

[6] I note the issue of Magistrates' Court of Victoria Practice Direction No. 8 of 2015. I was informed of this after the Inquest. I have dealt with this issue in greater detail at paragraph 577 in these findings.

E. Agencies Operating within the Integrated Family Violence System

The need for agencies operating within the integrated family violence system to be clearly identified and their respective roles and responsibilities for responding to family violence contained in legislation and/or documented in publically available policies.

20. The complete and detailed recommendations are set out at pages 103 – 110.

BACKGROUND

Luke's family structure

21. In 1992, Ms Batty commenced a relationship with Mr Anderson, which lasted intermittently for approximately two years.

22. Ms Batty and Mr Anderson recommenced their relationship in 2001 and Luke was born on 20 June 2002, in Clayton. At the time of Luke's birth, Ms Batty and Mr Anderson did not have any relationship, other than Mr Anderson being Luke's father. Ms Batty's evidence was that one of the reasons the relationship ended was because Mr Anderson was verbally abusive toward her. Ms Batty and Mr Anderson also had conflicting and incompatible views, including how to raise Luke.

23. Ms Batty was Luke's primary care giver and provider during the entirety of his life.

24. To manage Mr Anderson's contact with Luke, consent orders with the Family Court of Australia, allowed Mr Anderson to have weekly access to Luke. These orders remained in place from approximately 2006 to 24 April 2013. However, during this period, Mr Anderson's access to Luke became more and more restricted through the involvement of Victoria Police, the Department of Human Services (**the DHS**) and the Courts.

25. Ms Batty's family lived in the United Kingdom. Luke travelled with his mother to the United Kingdom on seven occasions to visit his maternal relatives. The first visit was when Luke was six months of age and the last time was on 10 December 2013. He returned five weeks later, in January 2014.

Luke's relationship with his parents

26. Luke was a loving and loveable child. Ms Batty adored Luke and their close and loving relationship was clear to all who knew them. Ms Batty's evidence was:

> *As soon as I had Luke, I felt I had joined a secret and special club where everyone knows your special joys and everyone wants to share it. I became a very proud and protective mum and Luke became my whole life. Luke filled a gap in me like nothing else had.*[7]

27. On his own account, Luke loved his father "*to bits*".[8] Mr Anderson was devoted to Luke, he took him to museums and art shows to broaden his education, taught him maths and purchased educational gifts to help him academically. Mr Anderson regularly took Luke to the beach and parks and taught him how to sail. Luke described his father to others as always having a smile on his face and as always being prepared to lend things to people.[9]

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[7] Coronial brief, p. 1483.
[8] Coronial brief, p. 629-630.
[9] Coronial brief, p. 639.

28. According to Ms Batty, Luke was never afraid of his father.[10] However, Ms Batty's Inquest evidence revealed that Luke had managed his relationship with his father carefully:

> *[Luke] would push my boundaries, back-chat me, do all the things that kids do when they know they're safe with their parent. He would never challenge Greg in that way, but it didn't mean to say that he, you know, didn't have a very - yeah, he just knew some of the things that his dad didn't like or approve, and he would never have challenged them in the same way as he would me, but frightened of him hurting him, no. I know absolutely he never believed his dad would ever hurt him by physically hurting him. I think that the only time Greg did something with him, he flicked him. Other than that, Greg would talk to Luke about his behaviour rather - and he never, ever used physical strength or abusive behaviour towards Luke at all.*[11]

29. As Luke grew older, he had an increasing appreciation that his father was different from other fathers, and that some of his father's behaviours were inappropriate and embarrassing.

30. Despite Ms Batty wishing she could take Mr Anderson out of Luke's life,[12] she supported Luke having a relationship with his father. For the best reasons, Ms Batty was determined that Luke should have a positive relationship with his father. Ms Batty's Inquest evidence was:

> *... well fostering a relationship, you know, for me it was really important that a child should know his father. There was never any doubt in my mind that Luke should know his father. Greg was a really loving and keen to - to be involved with Luke's life. So it was never a - any doubt in my mind that I should set aside, um, animosity and acrimony between Greg and I for what I believe was the best interests - for the best interests of Luke. I said to myself that this is a journey that um, I'll keep doing things that feel right until they don't feel right anymore. And so when people would say to me, you know, do you think it's a good idea for Luke to know his dad, I would be very clear and certain that he gained more from knowing his dad that (sic) from not knowing him and not spending time with him. He was always wanting to see his dad even though it was kind of confusing for him at times.*[13]

31. Ms Batty also put significant emphasis on developing and seeking positive male role models for Luke to have access to so he could see that not all men behaved like Mr Anderson.[14]

Luke's interests

32. Luke's favourite colour was yellow. He loved Lego® Star Wars™ and Lego® City, and with them created everything from police trucks, police stations, and boats to aeroplanes.

33. Luke also enjoyed football, cricket, the Scouts, playing games on his Sony Play Station PS3 and computer, especially Minecraft®, taking photographs and communicating on-line with other children all around the world.

Luke's education

34. From 8 years and up until his death, Luke attended the Flinders Christian College. Ms Batty's evidence was that Luke loved school and he was an intelligent, deep-thinking child. However, being an only child, Luke struggled to fit into the class and understand where he sat with his peers. Despite his struggles Ms Batty's evidence was:

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[10] Coronial brief, p. 1497.
[11] Transcript, p. 65-66.
[12] Transcript, p. 68.
[13] Transcript, pp. 32-33.
[14] Transcript, p. 231.

...Luke was an effervescent, funny little boy, and I would say that, for most of his life, he was happy. He didn't know his Dad to be any different, but in the last two years of – were really hard – the last 18 months. The pressure he was under, and the way that I was handling things, put a lot of pressure on Luke too, but generally speaking, he still handled himself pretty well.[15]

35. Although well liked by his peers and much loved by his family, Luke was also a troubled boy. In the years prior to his death, understandably Luke experienced problems at school.

Luke's exposure to family violence

36. In his very short life, and from a very young age, Luke was a victim of family violence in that he had witnessed his father's physical and psychological violence towards his mother on a number of occasions.

37. The Expert Panel[16] agreed there is persuasive evidence that exposure of children to family violence results in cumulative psychological and emotional harm.[17] The Expert Panel also agreed that the evidence confirmed Luke's behaviour at school, his art therapy sessions and his night terrors demonstrated he was sad and unable to articulate this. When he did express his feelings, he said he felt like he was walking on eggshells and felt his life was not worth living.[18]

38. Despite his father's eccentric and increasingly troubling behaviour, Luke was generally an outgoing and happy boy. Dr Robyn Miller (**Dr Miller**), Chief Practitioner with the DHS accurately commented on Luke's qualities of sensitivity and empathy:

> *Luke's communication skills were advanced for his age, as often boys in particular, struggle to express such painful emotions and to make meaning with the maturity Luke displayed. His compassion for his father's difficulties and the way he felt responsible for his father's happiness in life reflect the values and compassion that his mother obviously modelled and continues to model. Children of this age frequently see difficult and or violent parents as 'goodies' or baddies, whereas Luke was able to relate more of a coherent narrative about his father's complex difficulties.*[19]

39. As a result of Luke's exposure to family violence, he was provided assistance by creative art therapist counsellor, Ms Kate Perry (**Ms Perry**).[20] Ms Perry's evidence was that Luke told her that he was worried about his mum and his dad.

40. By the time of his death, Luke was not seeing his father very often and Ms Batty felt he was doing very well as a result of the less frequent contact. Dr Miller's opinion was that:

> *Luke had learnt to accommodate to his father's strange and scary behaviors. In my opinion, Luke would have been hyper-vigilant to his father's mood and would have 'managed' him by de-escalation strategies, which were very adaptive. In this respect, Luke could be described as "parentified" in relation to his father; that is, needing to be the adult who has to manage the out*

[15] Transcript, p. 68.
[16] The Family Violence Expert Panel members for the purposes of the Inquest were Ms Beth Allen, Ms Fiona McCormack, Professor James Ogloff, Dr Robyn Miller, Professor Paul Mullen, Detective Superintendent Rod Jouning, Dr Lesley Laing, Professor Cathy Humphreys, Ms Catherine Plunkett, Mr Rodney Vlais and Magistrate Anne Goldsbrough (The Expert Panel). The Expert Panel gave concurrent evidence on 5 December 2014.
[17] Expert Aide Memoire Exhibit 110, p. 61.
[18] Expert Aide Memoire Exhibit 110, p. 62.
[19] Exhibit 108, Expert Report of Dr Robyn Miller at [81].
[20] Ms Perry saw Luke for four of his five funded creative arts therapy sessions (approximately. one hour per session), funded by Windermere Victims of Crime Assistance.

of control and erratic adult father. This is not uncommon where a parent is violent or has unmanaged mental health issues. [21]

41. I agree and accept Dr Miller's assessment of Luke as a parentified child in relation to his father.

Luke's father, Gregory Anderson

42. Despite an extensive investigation, little is known about Mr Anderson (born 3 November 1959). His family requested not to participate in the coronial investigation and I respect their decision.

43. From time to time Mr Anderson held various jobs, but did not maintain stable employment. Ms Batty's evidence was that Mr Anderson was always well dressed and well presented, but did not follow instructions and was often sacked from each job.[22] Mr Anderson did not have stable accommodation and at times lived in his car.

44. In November 2010, Mr Anderson's wrist was badly broken, resulting in approximately two weeks hospitalisation. During hospitalisation, on 10 November 2010, Mr Anderson, unrelated to his wrist injury, was reviewed for mental health issues due to aggressive and hostile outbursts. A mental health assessment that appears to have taken approximately 34 minutes took place. It was noted that Mr Anderson was co-operative, that his mood was 'Ok' but his affect was mildly elevated and his thought stream 'pressured and voluminous'. However, Mr Anderson was not assessed as being delusional, with the assessor expressing the tentative view that Mr Anderson was "*sub-clinical bipolar illness exacerbated by cessation of cannabis with mild hyper-mania.*"[23] A further note from the Liaison Psychiatry Service dated 11 November 2010 stated that Mr Anderson "*did not display any psychotic thinking.*"[24] No formal mental illness was diagnosed and the hospital's treatment plan was to maintain a regular dose of diazepam.[25]

45. Mr Anderson had interest in numerous religions including the Hare Krishnas, the Mormons and the Russian Orthodox Church. Ms Batty's evidence was that Mr Anderson often talked about hearing voices, referred to rituals of cleansing and diet and had "*obsessive*"[26] views about some food groups and Western medicine, preferring Chinese herbal medicine.[27]

46. Mr Anderson had a long history of over-bearing and violent conduct towards Ms Batty. She believed he had mental health issues, including paranoia and religious fixations, something also observed by other persons including police officers who encountered him. However, there is no evidence of any formal diagnosis of a mental illness during Mr Anderson's life.

47. A psychiatric autopsy/desk top review[28] was performed by Professor Mullen and he expressed the opinion that Mr Anderson likely suffered from a delusional disorder,[29] a form of psychosis which is exhibited by individuals who are able to present as normal and 'pull themselves together'. Professor

[21] Exhibit 108 – Expert Report of Dr Robyn Miller at pp. 33-34.
[22] Coronial brief, p. 1480.
[23] Clinical notes from Frankston hospital dated 11 November 2010, coronial brief p. 2413.
[24] Clinical notes from Frankston hospital dated 11 November 2010, coronial brief p. 2416.
[25] Gregory Anderson coronial brief, p. 2410. Diazepam is an oral medication that is used to treat anxiety. It belongs to the benzodiazepine family of drugs.
[26] Coronial brief, p. 1483.
[27] Coronial brief, p. 1483 and Transcript, p. 225.
[28] Without any clinical interaction.
[29] Exhibit 104 – Professor Mullen Expert report, pp.54-57.

Mullen noted that recognition and diagnosis of such disorders is not easy, but they are treatable.[30] Ms Batty's evidence was that Mr Anderson was guarded, untrusting and would only share limited parts of his personal history with her.[31]

48. Professor Mullen reasoned that had Mr Anderson been diagnosed and treated with medication to control his delusions, his abnormal ideas and delusions might not have driven him to criminal and violent behaviour.[32] Professor James Ogloff (**Professor Ogloff**) expressed the view that even if a period of time in prison may have ameliorated the risk in relation to this condition, there is no guarantee that his condition would not recur later or, in fact, even have been exacerbated.[33]

49. The Expert Panel agreed that while a psychiatric assessment of Mr Anderson was desirable, "*there are very few points where a psychiatric assessment can be mandated.*"[34] Detective Superintendent Jouning confirmed that the powers of police officers under the *Mental Health Act*[35] are limited.[36]

50. Ms Batty's evidence was there were two sides to Mr Anderson. He could be warm, appropriate and sensitive and this, for the most part, was how he conducted himself with Luke and, at times, with Ms Batty. However, Mr Anderson's other side was controlling, threatening, very angry, impulsive and manipulative. Ms Batty's Inquest evidence was:

> *You know, he was not an abusive man every single day, every single moment. That would make me foolish. In between his violent episodes, he could be very amusing, he could be very kind, and he could be very helpful, he was very intelligent in many, many ways and interesting. So, you know, you've got a man that's got a lot of positive qualities but clearly some very concerning ones. He was a very loving father to Luke, he, you know, in my experience of my father - my father has never said he loved me, my father's never hugged me, my father's never done anything with me as a child that was full of attention and quality time. Greg did all of those things. Greg was - would do anything for Luke, would protect Luke against all odds, he was - I would have said - overly protective at times and very distrusting of anybody else.*[37]

51. When being interviewed by Ms Tracie Portelli (**Ms Portelli**) Advanced Child Protection Practitioner, Sexual Assault Investigation Team, the DHS, Luke also reported the complex and often contradictory experiences he had of his father:

> *Luke said there were two sides to Mr Anderson, one nice, and the other angry. He continued saying that Mr Anderson always had a smile on his face. He also said he was the only thing that was good for Mr Anderson... Luke described the bad things about Mr Anderson, that he gets angry, starts praying, and acts a bit different, and that he prays he is in his own head and is ok.*[38]

52. Mr Anderson appeared to be able to exercise a level of control over his own conduct and switch between irrational and rational behaviours and presentations. One of the most important issues to

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[30] Transcript, p 1717-1736.
[31] Coronial brief, p. 1479.
[32] Transcript, p. 1738.
[33] Transcript, p. 1790.
[34] Expert Aide Memoire Exhibit 110, p. 56.
[35] At the relevant time the *Mental Health Act 1986* applied. On 1 July 2015 the *Mental Health Act 2014* commenced.
[36] Section 10 of the *Mental Health Act 1986* provided a police officer a discretionary *'power'* to apprehend a person who appeared to be mentally ill and there were reasonable grounds for believing that the person had recently attempted suicide or attempted to cause serious bodily harm to herself or himself or to some other person; or the person was likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person.
[37] Transcript, p. 76-77.
[38] Coronial brief 639.9.

emerge here, and in other cases, is the inability or failure of the system to bring people like Mr Anderson inside the framework of the system and begin processes of change.

JURISDICTION

53. Luke's death was a reportable death pursuant to section 4 of the Coroners Act 2008 (**the Act**) because it occurred in Victoria and it was unexpected, unnatural and violent.

54. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by a family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

THE PURPOSE OF A CORONIAL INVESTIGATION

55. The Coroners Court of Victoria is an inquisitorial jurisdiction[39]. The purpose of a coronial investigation is to independently investigate a reportable death[40] to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[41] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances to the death, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[42]

56. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the investigation findings and the making of recommendations by coroners, generally referred to as the 'prevention' role. Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[43] These are effectively the vehicles by which the prevention role may be advanced.[44]

57. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[45] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

58. Detective Sergeant Allan Birch and Detective Senior Constable Paul Bubb from the Homicide Squad were the coroner's investigators and prepared the coronial brief. I thank them for their tireless work in

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[39] Section 89(4) *Coroners Act 2009.*

[40] Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear to have been unexpected, unnatural or violent.

[41] Section 67(1) of the Act.

[42] *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[43] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[44] See also sections 73(1) and 72{5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[45] *Keown v Kahn* (1999) 1 VR 69.

the investigation and for compiling a comprehensive coronial brief prepared in a professional and expeditious manner.

59. This finding draws on the totality of the material produced for the coronial investigation into Luke's death. That is, the investigation and coronial brief in this matter,[46] the coronial brief prepared in relation to Mr Anderson's death[47], the statements, reports and testimony of those witnesses who testified at the Inquest and any exhibits[48] tendered through them. All this material, together with the inquest transcript[49], will remain on the coronial file. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

STANDARD OF PROOF

60. All coronial findings must be made based on proof of relevant facts on the balance of probabilities and, in determining this; I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[50] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    (a) the nature and consequence of the facts to be proved;
    (b) the seriousness of an allegations made;
    (c) the inherent unlikelihood of the occurrence alleged;
    (d) the gravity of the consequences flowing from an adverse finding; and
    (e) if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the Court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

61. The effect of the authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

IDENTITY OF THE DECEASED

62. The Deceased's identity was not in dispute and required no further investigation.[51] Therefore, I formally find that the deceased was Luke Geoffrey Batty, born 20 June 2002.

MEDICAL CAUSE OF DEATH

63. On 13 February 2014, Dr Jacqueline Lee (**Dr Lee**), Forensic Pathologist, Victorian Institute of Forensic Medicine (**VIFM**) attended at the Bunguyan Reserve at 12.35am and certified Luke deceased.

64. At 10.00 am that day, Dr Lee performed an autopsy on Luke's body and provided me with a written autopsy report, dated 6 June 2014, giving the cause of Luke's death to be 1(a) Craniocervical Trauma.

[46] The coronial brief comprises approximately 3776 pages.
[47] The coronial brief comprises approximately 2625 pages.
[48] 110 exhibits were tendered at the Inquest.
[49] Inquest transcript comprises 1833 pages spanning 13 days of evidence.
[50] (1938) 60 CLR 336.
[51] On 14 February 2014, Ms Batty visually identified Luke Geoffrey Batty, born 20 June 2002.

65. Also on 13 February 2014, Dr Linda Elizabeth Iles (**Dr Iles**), Forensic Pathologist, VIFM performed macroscopic and microscopic neuropathology examinations on Luke's brain and provided a report dated 14 March 2014.

66. I also received a joint pathologist report of Dr Lee and Dr Iles dated 14 March 2014, stating that the injuries suffered by Luke could not have been survivable, even with immediate medical attention.

THE CIRCUMSTANCES OF LUKE'S DEATH

67. On 12 February 2014, Mr Anderson left the shared-accommodation house at 19 Culcairn Drive, Frankston South where he had been renting a room for the previous three weeks. Prior to leaving this address, Mr Anderson packed almost all of his belongings into a backpack. When Mr Anderson left, he was wearing the backpack and had taken a large knife from the kitchen of the house. Mr Anderson walked[52] to a bus stop in Wells Street, Frankston, boarded a bus and travelled to the Bunguyan Reserve.

68. On the same day, at about 4.37 pm, Ms Batty drove Luke to the Bunguyan Reserve for cricket training.[53] When they arrived, Mr Anderson was already present. Ms Batty asked Luke whether he was all right and whether he wanted her to stay, as she usually did not stay for practice. Luke said he would be all right. Ms Batty left Luke with the training staff, parents and other children from the cricket team and returned home. Ms Batty's Inquest evidence in relation to seeing Mr Anderson at the Bunguyan Reserve that night and why she did not ring the police to try and get him arrested on unexecuted warrants was:[54]

> *His dad stood up looking very happy to see Luke, very affable, he didn't look agitated or problematic, it was a really nice sunny night. We hadn't seen Greg at cricket practice all season. I - we didn't know he was going to be there, but we weren't surprised that he was there, in fact, I was quite - and Greg - Luke on the way to the um, practice had kind of, you know, probably was wishing he wasn't there and I said, "Are you going to be all right?" And he said, "Yeah, I'm all right, mum." I said, "Your dad will be happy to see you. You'll be all right, buddy." And seeing Greg there looking happy to see Luke, I'd had some really unpleasant situations trying to - involving the police at the oval. It was traumatic, stressful, unpredictable. I hadn't got - I didn't trust, I didn't trust the situation and I thought of Luke and thought, this will be the third time I've tried to get this man arrested in front of Luke and his friends at that bloody oval.*[55]

69. On this night there was an active FVIO, in place that named Mr Anderson as the Respondent and Luke as the Affected Family Member. While the FVIO, as amended on 9 September 2013, did not permit Mr Anderson to be at Luke's sporting events mid week, Ms Batty's evidence was that she was unaware of this and believed that Mr Anderson was permitted to be at Luke's cricket training on this night. Ms Batty's rationale of why she did not call the police to prevent Mr Anderson from remaining at training is understandable when seen in this context.

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[52] CCTV McDonalds Restaurant and Civic Video Store.
[53] Significant Witness Interview – Rosemary Batty.
[54] A Warrant to Arrest is an official Court document which provides a police officer with the power to arrest a person or place them in custody.
[55] Transcript, p. 62.

70. Shortly before 6.00 pm Ms Batty returned to collect Luke, as the cricket training was due to finish at 6.00 pm.[56] On the completion of the cricket training session, Mr Anderson was in the cricket practice nets with Luke, bowling balls to him. Luke was batting with his Gray Nichols cricket bat.[57] Children, parents and training staff were still packing up.

71. Luke approached Ms Batty and asked if he could continue practising with his father. Ms Batty agreed and Luke returned to the nets where he continued practising cricket with Mr Anderson.[58] At the inquest, Ms Batty spoke of her acceptance that allowing Luke to practice in the nets with his father was, a tragic misjudgement made in the moment:

> *Ms Ellyard:* *Ms Goldsbrough seems to have wanted there to always be other people close by when Greg and Luke spoke to each other and my question is - that's my reading of what she meant - is that your reading?*
>
> *Ms Batty:* *That's my reading - - -*
>
> *Ms Ellyard:* *Is that what you understood at the time?*
>
> *Ms Batty:* *That's my reading and that's pretty much what happened. I mean basically when you're at footy training or footy matches, there are opportunities for him to hug his son or have a quick chat, but the rest of the time, they're playing or they're being coached by the coach, there's parents there, there's the team's other parents there, they're on the pitch. He never got in a car, he never removed himself. He was on the pitch and if his dad went up and gave him a hug and had a quick chat with him, I saw there was nothing wrong with that because he was in my line of sight, in the public forum, on the oval, where everybody else was. On the night he died, lapse of judgment on my behalf because within five minutes, everyone had gone home and clearly that was a staged situation that I hadn't seen coming.*[59] (emphasis added).

72. While waiting for Luke, Ms Batty continued to talk with other parents and children. The under-12 team cricket coach[60] (**the Cricket Coach**), was in the car park organising his three sons into his car, preparing to leave. The Cricket Coach's 8-year-old son[61] (**the 8-year-old boy**), realised that his cricket bag had been left near the practice nets and ran back to collect it. As the 8-year-old boy was picking his bag up, he heard a noise from inside the practice nets and turned to see Mr Anderson gripping the handle of a cricket bat that was raised over his right shoulder.[62] Mr Anderson brought the cricket bat down in a strong chopping action. The 8-year-old boy, did not see the cricket bat connect but saw Luke laying on the ground inside the practice nets. The Cricket Coach observed his son return to the car visibly distressed. The 8-year-old boy described to his father that Mr Anderson had hit Luke with a cricket bat.[63] The Cricket Coach, relying on information given to him by his distressed son,

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[56] Significant Witness Interview – Rosemary Batty.
[57] Significant Witness Interviews of Rosemary Batty and The Cricket Coach.
[58] Significant Witness Interview – Rosemary Batty.
[59] Transcript, p. 110
[60] Name suppressed pursuant to the *Open Courts Act 2013*.
[61] Name suppressed pursuant to the *Open Courts Act 2013*.
[62] VARE Interview – The 8-year-old boy.
[63] VARE Interview - The 8-year-old boy.

believed that Luke had been accidentally injured while practising with his father in the cricket nets. No one else was present at the practice nets and no one witnessed exactly what had happened to Luke.

73. At the same time, just prior to 6.29 pm. Ms Batty heard a "*distressed sound*", a "*noise of anguish*"[64] emanating from the cricket practice nets. Ms Batty observed Luke lying on the ground in the cricket nets, with Mr Anderson kneeling over him.[65]

74. Ms Batty became hysterical, believing that Mr Anderson had accidentally, but seriously, injured Luke while playing cricket with him. Ms Batty could see blood on Luke's head and saw Mr Anderson kneeling over Luke. She ran toward the clubrooms and asked for the ambulance to be called. Ms Batty did not approach the cricket nets, terrified that if she did so she might witness a tragedy involving Luke.

75. The Cricket Coach approached Mr Anderson and Luke, getting within about four metres, and asked if Luke was alright. Mr Anderson charged at him and he retreated. After a few minutes, the Cricket Coach approached the nets again, although not as close as before, and asked Mr Anderson if Luke was alright and whether he was breathing. Mr Anderson responded:

> *Yeah, he's - he's OK. He's OK now, he's gone to heaven.*[66]

76. The Emergency Services Telecommunications Authority (**ESTA**) recorded a call at 6.29 pm from the Cricket Coach.[67] At about 6.33 pm, Hastings-based ambulance paramedics, Sheldon Carr and Camilla Glasby, were dispatched to the Bunguyan Reserve. The information provided to the paramedics, at this point in time, was:

> *A patient with a traumatic injury, serious haemorrhage in Tyabb. At the Tyabb Cricket Ground, an 11 year old there has been hit by a cricket ball.*[68]

77. A further update was then provided by ESTA:

> *Query arrest. Query stabbing.*[69]

78. Upon arrival, the paramedics observed a woman waving and yelling and screaming, telling them:

> *He's killed him!*[70]

79. The paramedics drove to behind the cricket rooms and parked the ambulance near the playground. They observed a male standing in the nets, about 50 metres away,[71] who said to them:

> *It's too late. Get the police. It's too late. He's gone. Don't come near me.*[72]

80. The male, later identified as Mr Anderson, was brandishing a knife and stated:

> *He's gone. There is nothing you can do for him. You better get the cops.*[73]

81. The ambulance officers believed Mr Anderson had blood on his clothing and hands. Paramedic Carr's evidence was that Mr Anderson had a knife, which he *"slightly lifted his arm away from his body to*

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[64] Recorded witness interview with Rosemary Batty, Batty Inquest Brief, at p. 115.
[65] Significant Witness Interview – Rosemary Batty.
[66] Significant Witness Interview with The Cricket Coach. Coronial brief p. 174 and 176.
[67] This call lasted 8 minutes and 20 seconds.
[68] Anderson coronial brief, p. 896.
[69] Statement of Sheldon Carr, Anderson Inquest Brief, at p. 474.
[70] Coronial brief, p. 475.
[71] Anderson coronial brief, p. 481.
[72] Anderson coronial brief, p. 481.
[73] Anderson coronial brief, p. 475.

make it visible. It felt like it was escalating as his voice began to get louder and he moved out of the nets more."[74] Due to the unacceptable risk posed by Mr Anderson, the ambulance was driven about 100 metres away from Luke and paramedic Carr communicated to ESTA that there may be a deceased, a male had a knife and that the police were needed as soon as possible.

82. The police mobile patrol supervision unit with the designated call sign 'Mornington 251'[75] requested ESTA to send the mobile patrol units Mornington 303[76] and 304 to respond. At 6.39 pm, Mornington 303, crewed by Constables Anthony Hester and Richard Postlewaite advised ESTA that they were en-route to the incident. At 6.42pm, Mornington 304[77] crewed by Senior Constables Benjamin Swift and Bradley Carroll, advised ESTA that they were available to assist and were told:

> *Mornington 304 to Tyabb please and for all units information, the further information from the ambulance was, it was a call saying that a serious haemorrhage, that's regarding the child. The child's not moving. When asked if the child was still conscious the father implied that the child had gone to heaven. Was fitting and serious haemorrhage. I don't have any further info regarding the knife and the stabbing but safety principles obviously apply.*[78]

83. At 6.46 pm, the Hastings paramedics advised ESTA that they were unable to get near the patient as the offender had a knife. At 6.50 pm, Mornington 303 advised ESTA:

> *Mornington 303 urgent. 303, we have a male with a knife. It would appear that he's stabbed his son. His son would appear to be deceased. He's agitated. He's got a knife in his hand.*[79]

84. On arrival at Bunguyan Reserve, Constables Hester and Postlewaite were directed towards the cricket practice nets. They moved on foot towards the practice cricket nets where[80] they observed what appeared to be a child laying on the ground in the practice nets, with Mr Anderson crouching or kneeling over him. Constables Hester and Postlewaite ran towards the practice nets and as they did, Mr Anderson walked out of the nets toward them. Mr Anderson was holding a knife and appeared to be covered in blood. Constables Hester and Postlewaite immediately stopped and began retreating from the advancing Mr Anderson. They continually yelled at Mr Anderson to '*stop, drop the knife and get on the ground*'[81]. Both police officers drew their police issued Smith and Wesson .40 calibre semi-automatic pistols.

85. At 6.50 pm, all police units were advised:

> *Mornington 304, Mornington 701 and all units that can head to Tyabb Football Club on Frankston Flinders Road at the back of the tennis courts. Male armed with a knife.*[82]

86. At 6.51 pm, Mornington 303 requested urgent backup, including the assistance of Victoria Police Critical Incident Response Team, a negotiator, Victoria Police canine unit, the divisional supervising Senior Sergeant and all Major Crime Units.

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[74] Anderson coronial brief, p. 476.
[75] 251 is Victoria Police code for a sergeant supervisor shift for a police service area.
[76] 303 is Victoria Police code for the afternoon divisional van shift that commenced duty at 3:00pm.
[77] 304 is Victoria Police code for the afternoon divisional van shift that commenced duty at 4:00pm.
[78] Anderson coronial brief, p. 915.
[79] Anderson coronial brief, p. 916.
[80] Statements of Constables Hester and Postlethwaite and SCs Swift and Carroll.
[81] Coronial brief, p. 343, 380, 487, 494, 503, 504, 525.
[82] Anderson, coronial brief, p. 916.

87. By 6.52 pm, both Senior Constables Swift and Carroll had arrived and took up positions to form a line of four police officers between Mr Anderson and the civilians and ambulance paramedics behind them. Mr Anderson's positioning and actions prevented the police officers and paramedics from accessing the practice nets to provide medical aid to Luke.

88. All four police officers were retreating from Mr Anderson, walking backwards and requesting him to stop, drop the knife and get down on the ground. Mr Anderson continued to advance on the police officers with the knife in his hand. Mr Anderson briefly stopped moving forward and Senior Constable Swift deployed Oleoresin Capsicum Spray (**OC Spray**).[83] It appeared to the police officers that the OC spray did not reach Mr Anderson due to the prevailing wind, subsequent investigation reveals that it did contact him on his face, upper body and surface of his prescription spectacles that he was wearing. At the same time OC foam was also deployed, Mr Anderson suddenly moved directly at Constable Hester who discharged one round from his police issue pistol. The bullet struck Mr Anderson in the upper chest and it did not exit his body. Mr Anderson immediately fell to the ground, with the knife still in his right hand.[84] Mr Anderson resisted paramedics' efforts to attend to the bullet injury. The police officers helped restrain Mr Anderson so that he could be treated. Mr Anderson repeatedly said "*let me die.*"[85]

89. Immediately after Mr Anderson was shot, at 6.55 pm, the attending paramedics pronounced Luke deceased. The medical evidence is that it was unlikely Luke was alive at the time the police officers attended the Bunguyan Reserve.

90. Mr Anderson was flown by Victoria Police Airwing air ambulance to the Alfred Hospital. Despite emergency surgery, Mr Anderson was pronounced to be deceased at 1.25 am on 13 February 2014.

91. The investigation has not identified why Mr Anderson chose to kill Luke on 12 February 2014 or why at the cricket training location.

THE INQUEST

92. Section 52(2) of the Act mandates that I must hold an inquest into a reportable death if the death or cause of death occurred in Victoria and the death is suspected to be a result of homicide,[86] or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

93. The uncontentious fact is that Mr Anderson killed his son Luke, and it was mandatory to hold an inquest into his death.

Witnesses called at the Inquest

94. On 20-24, 28-30 October, 1-5 December 2014 (13 days), I conducted an inquest into Luke's death. The following witnesses gave evidence:

    (a) Ms Rosemary Batty;

[83] Statements of SC Swift and Graeme Pollard.
[84] Statements of Graeme Pollard, Lisa Powell, Sheldon Carr, Camilla Glasby, Constables Hester and Postlethwaite and SCs Swift, Carroll and Pringle.
[85] Coronial brief, p.472, 489, 516.
[86] Homicide is defined as the killing of one person by another.

(b) Senior Constable Kate Anderson, Victoria Police;

(c) First Constable Paul Topham, Victoria Police;

(d) Constable Bradley Guenther, Victoria Police;

(e) Sergeant John Schroen, Victoria Police;

(f) Senior Sergeant Courtney, Victoria Police;

(g) Detective Acting Sergeant Andrew Cocking, Victoria Police;

(h) Senior Constable Darren Cathie, Victoria Police;

(i) Senior Constable Ross Treverton, Victoria Police;

(j) Senior Constable Dianne Davidson, Victoria Police;

(k) Senior Constable Scott Walters, Victoria Police;

(l) Detective Leading Senior Constable Deborah Charteris, Victoria Police;

(m) Detective Sergeant Peter Drake, Victoria Police;

(n) Ms Tracie Portelli, Advanced Child Protection Practitioner, the DHS;

(o) Dr Jan Heath, Forensic Psychologist;

(p) Leading Senior Constable Bronwyn Martin, Victoria Police;

(q) Sergeant Stephen Neville, Victoria Police;

(r) Dr Farlow; Eramosa Medical Clinic;

(s) Ms Kate Perry, Creative Art Therapist Counsellor;

(t) Ms Jade Blakkarly, Good Shepherd;

(u) Ms Karen Wilde, Windermere;

(v) Ms Christine Allen, Court Family Violence Support Worker;

(w) Ms Beth Allen, Assistant Director of Child Protection for the DHS;

(x) Assistant Commissioner Luke Cornelius APM, Victoria Police;

(y) Ms Fiona McCormack, Chief Executive Officer, Domestic Violence Victoria;

(z) Professor James Ogloff, AM FAPS, Centre for Forensic Behavioural Science, Swinburne University and Victorian Institute of Forensic Mental Health (Forensicare);

(aa) Dr Robyn Miller, Director of the Office of Professional Practice Chief Practitioner, Human Services, the DHS;

(bb) Emeritus Professor Paul Mullen, Centre for Forensic Behavioural Science;

(cc) Detective Superintendent Rod Jouning, Victoria Police;

(dd) Dr Lesley Laing, Senior Lecturer in Social Work and Policy Studies, University of Sydney;

(ee) Professor Cathy Humphreys, Professor of Social Work at University of Melbourne;

(ff) Ms Catherine Plunkett, Domestic Violence Resource Centre Victoria trainer and consultant;

(gg) Mr Rodney Vlais, Acting Chief Executive Officer, No To Violence Male Family Violence Prevention Association Inc. and the Men's Referral Service; and

(hh) Magistrate Anne Goldsbrough, Magistrates' Court of Victoria.

The Expert Family Violence Panel

95. On 5 December 2014, Ms Beth Allen, Ms Fiona McCormack, Professor James Ogloff, Dr Robyn Miller, Professor Paul Mullen, Detective Superintendent Rod Jouning, Dr Lesley Laing, Professor Cathy Humphreys, Ms Catherine Plunkett, Mr Rodney Vlais and Magistrate Anne Goldsbrough gave concurrent evidence (**the Expert Panel**). The purpose of the Expert Panel was to receive expertly informed evidence about how the system is, and should be, responding to family violence in Victoria.

Scope of the Inquest

96. On 28 August 2014, at a directions hearing, I set the scope of the Inquest. Primarily, the scope of the Inquest was directed to matters relating to public health and safety and the administration of justice approximately 12-18 months prior to Luke's death, for the purposes of examining whether it could have been prevented, improving systems for responding to and preventing family violence, in particular family violence causing death or serious injury to children.

97. I directed the scope of the Inquest to be:

(a) What the DHS:

i. knew, or should have known, of Luke being at risk of violence by Mr Anderson;

ii. did, or should have done, in relation to the risks of violence by Mr Anderson to Luke;

iii. had in place, by way of systems, policies, protocols, procedures and training to inform and train its employees for dealing with threats of violence and family violence matters involving children;

iv. did in response to Luke's death (e.g. reviews) and

v. changed, if anything, to its systems, polices, protocols, procedures and training since the incident involving Luke.

(b) What the Chief Commissioner of Police:

i. knew, or should have known, of Luke being at risk of violence by Mr Anderson;

ii. did, or should have done, in relation to the risks of violence by Mr Anderson to Luke;

iii. had in place for systems, policies, protocols, procedures and training to inform and train police members for dealing with warrants, family violence matters and mental health issues presented by perpetrators;

iv. did in relation to reviews in response to the incident involving Luke; and

v. changed, if anything, to systems, policies, protocols, procedures and training since the incident involving Luke.

(c) What Ms Batty:

i. knew of her son Luke being at risk of violence by Mr Anderson; and

ii. did in relation to the risks of violence by Mr Anderson to Luke.

98. On 19 September 2014, the Court wrote to the interested parties in response to a request by the DHS for clarity on the time frame for the scope of the Inquest. To avoid doubt, the interested parties were

advised that this time-frame was intended to cover the knife incident alleged by Luke in relation to his father.

Issues within the scope of the Inquest

99. During the Inquest the following issues were also identified:

(a) the risk assessments made by police officers and Child Protection officers who encountered Luke and his mother;

(b) the process by which intervention orders were made and varied, and the extent to which Mr Anderson complied with them;

(c) the way that information given by Ms Batty to police officers was or was not shared with other relevant police officers;

(d) the extent to which information about Mr Anderson was or was not shared between police officers and with Ms Batty;

(e) the respective responsibilities of the DHS and Victoria Police with regard to investigating risks of harm to children; and

(f) the way police officers dealt with Mr Anderson, including their behavioural assessments of him and execution of warrants.

Suppression orders

100. On 20 October 2014, I made a Proceeding Suppression Order pursuant to section 18(2) of the *Open Courts Act 2013*, that any information that would identify or tend to identify:

(a) Ms Rosemary Batty's address, email address, telephone number, Luke's former address and any information that may lead to the identification of her residence or location;

(b) specific details about the manner of Luke's death and his fatal injuries; namely Dr Lee's autopsy report[87] (except for the cause of death)[88], Dr Iles neuropathology report[89] and the joint report of Dr Iles and Dr Lee;[90]

(c) information regarding the abuse and threats described in paragraphs 6, 7 and 8 of the Affidavit of Ms Shelton dated 27 August 2014 and Exhibits 1 and 2 thereto;

(d) the names of Luke's friends and team mates who attended the cricket practice where Luke was killed and who were witnesses to the immediate circumstances surrounding his death; and

(e) the confidential affidavit of Paula Shelton dated 27 August 2014 and exhibits 1 and 2 thereto and the supplementary affidavit in support of amended suppression order application of Paula Shelton dated 14 October 2014.

[87] Coronial brief p. 110-123.
[88] Coronial brief p. 122.
[89] Coronial brief p. 124-127.
[90] Coronial brief p. 127.1-127.2.

and not be published or broadcast in Victoria or elsewhere in Australia pursuant to section 18(2) of the *Open Courts Act 2013,* as I am satisfied, based upon sufficient credible information, that publication would be contrary to the public interest. This order will expire on 19 October 2019.

101. Also on 20 October 2014, I made a Proceeding Suppression Order pursuant to section 18(2) of the *Open Courts Act 2013*, suppressing any information that would identify or tend to identify Mr Anderson's parents address, email address or telephone number. This order will expire on 19 October 2019.

102. On 21 October 2014, I made a Proceeding Suppression Order pursuant to section 18(2) of the *Open Courts Act 2013* suppressing any information that would identify or tend to identify any residential address, email address or telephone number of Mr Anderson's previous landlord. This order will expire on 20 October 2019.

103. On 28 October 2014, I made a Proceeding Suppression Order pursuant to section 18(2) of the *Open Courts* Act 2013, suppressing any information that would identify or tend to identify the bench clerk referred to in the hearing before Magistrate Goldsbrough on 22 July 2013. This order will expire on 27 October 2019.

104. On 3 December 2014, I made a Proceeding Suppression Order pursuant to section 18(2) of the *Open Courts Act 2013*, suppressing the Commission for Children and Young People's Child Death Inquiry Report prepared in relation to Luke's death. This order will expire on 2 December 2019.

Non publication orders

105. During the course of my investigation, I made a number of conditions on release of documents pursuant to section 115 of the Act for the following documents:

    (a) Magistrate Anne Goldsbrough's notes; and

    (b) exhibit 26 annexed to Assistant Commissioner Luke Cornelius' **(AC Cornelius)** statement titled 'Victoria Police - Family Violence Risk Assessment and Referral Process Review Internal Audit Report' published in September 2014[91]; and

    (c) the Commission for Children and Young People's Child Death Inquiry report.[92]

EVIDENCE AT THE INQUEST - MATTERS CONNECTED TO THE DEATH.

106. The circumstances of Luke's death on 12 February 2014 are largely known and it is clear that Mr Anderson killed Luke. In determining the scope of my investigation and the Inquest, I included an examination of the 18 months leading up to Luke's death to determine whether it could have been prevented, specifically focusing on the numerous services, including the police and the DHS interventions.

107. A number of matters in the 18 months prior to Luke's death are related to his death. While not causative or contributory, they pointed to the likelihood that Luke would continue to be exposed to family violence from his father and that active risk management of Mr Anderson was necessary.

[91] Coronial brief, p. 3197-3228.
[92] Ruling pursuant to section 115 of the Act dated 3 December 2014.

Before June 2004

108. While I limited the scope of the Inquest to the 18 months prior to Luke's death, the family violence 'path' Luke and Ms Batty endured can be traced back to when Luke was a young baby and for Ms Batty before his birth.

109. Ms Batty's evidence was that before June 2004, there were numerous incidents of Mr Anderson behaving in a violent, intimidating and threatening manner toward her, none of which were reported to the police. Despite this, Ms Batty found it increasingly difficult to stand up to Mr Anderson when it came to the issue of his contact with Luke but felt that it was:

> *rewarding as Luke's mother to see the bond between Luke and Greg grow and how much Luke loved to see his dad.*[93]

110. During this time, Ms Batty sought legal advice from Victoria Legal Aid and emotional support from Relationships Australia. Ms Batty's support from Relationships Australia enabled her to understand the different forms of family violence, which was instrumental for her in changing her approach to Mr Anderson.[94]

3, 4 and 21 June 2004

111. On 3 June 2004, Mr Anderson collected Luke from crèche and took him home to Ms Batty's house. It was approximately 6.00 pm and Luke was not wearing a jacket. Ms Batty asked Mr Anderson where Luke's jacket was, to which he exploded in anger and became verbally abusive. Mr Anderson's behaviour became increasingly intimidating,[95] Ms Batty was scared and Luke cried in distress.

112. While Ms Batty comforted Luke, Mr Anderson, standing on the mezzanine level above them threw one of Luke's ride-on cars in their direction. Mr Anderson grabbed Ms Batty by the hair, pushed and pulled her head back and forward, and said angrily:

> *If you ever stop me from seeing Luke, I will kill you, I will kill your animals.*[96]

113. While this incident was not reported to the police, the next day, Ms Batty, unrepresented, attended the Dandenong Magistrates' Court and was successful in having Mr Anderson named as the respondent in an interim FVIO. Ms Batty was the only protected person named on the interim FVIO, which precluded Mr Anderson from engaging in any form of violence against her and prohibited him from being within 200 metres of Ms Batty's home except for the purposes of exercising child contact pursuant to the Family Court order. After this, Ms Batty engaged a lawyer as she felt she needed assistance to finalise the interim FVIO.

114. On 21 June 2004, the Dandenong Magistrates' Court made a final FVIO in the same terms as the interim FVIO, with an expiry date of 21 June 2005. Mr Anderson appeared at this hearing and gave evidence that Ms Batty was the one who was violent.

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[93] Coronial brief, p. 1485.
[94] Coronial brief, p. 1487.
[95] Coronial brief, p. 1488.
[96] Coronial brief page 1488 and Supplementary Statement of Rosemary Batty, Exhibit 4.

115. Subsequent to this hearing, on 25 June 2004, Mr Anderson applied to the Dandenong Magistrates' Court for a FVIO against Ms Batty, however, he later withdrew his complaint.

2005 and 2006

116. Ms Batty's evidence is that around February 2005, Mr Anderson advised her that he no longer wanted to be a father to Luke. Between March and November 2005, Mr Anderson spent significant periods of time at a Russian Orthodox Monastery and overseas. He had no contact with Ms Batty or Luke during this period.

117. Ms Batty's evidence was that, by November 2005, Mr Anderson had returned and escalated in his psychological and abusive behaviour to a degree that he had not done before.[97]

118. In early 2006, Ms Batty again sought legal advice in relation to managing Mr Anderson's access arrangements with Luke.

119. On 18 April 2006, Ms Batty attended the Family Court of Australia with her legal representative and made an application before the Registrar to clarify matters related to Mr Anderson's contact with Luke. Ms Batty's evidence was that Mr Anderson, unrepresented, was rude and intimidating toward her, her lawyer and the Registrar and was insistent on seeing Luke every weekend.[98] Mr Anderson was permitted weekly access to Luke (**Family Court consent order**).

10 June 2006

120. On 10 June 2006, by agreement, Mr Anderson cared for Luke at Ms Batty's home while she visited a friend in Bendigo. Upon Ms Batty's return, Mr Anderson believed she was having a relationship with her former partner and became aggressive. Mr Anderson ordered Luke pack his bags. Ms Batty's evidence was that she objected and Mr Anderson:

> *became abusive, intimidating and threatening. When I told him that his abuse was unacceptable and that I would call the police, he forcibly prevented me from using the landline or mobile. He threw me against a wall, held me there by the scruff of my neck. He then threw me to the ground and knelt over me and said in a threatening way that he would like to knock me into next week.*[99]

121. Luke, nearly 4 years old at the time, witnessed the incident. Ms Batty ran to a neighbour's home, where they called the police. The police attended and Mr Anderson acted as if nothing had happened. Neither criminal charges nor a FVIO resulted. It is outside the scope of the Inquest to examine the details of this, but at least on the face of it, and accepting Ms Batty's account, this was a missed opportunity for protective intervention for her and Luke and to potentially bring Mr Anderson within the framework of the criminal justice system.

16 May 2012

122. On 16 May 2012, by agreement, Mr Anderson was to pick Luke up from school and take him to football practice. Unforeseen, Mr Anderson's vehicle broke down. Ms Batty asked Mr Anderson if he wanted to stay for dinner and stay one night only so he could make appropriate arrangements. Ms

[97] Coronial brief, p. 1490.
[98] Coronial brief, p. 1492.
[99] Coronial brief, p. 1493.

Batty proposed that Luke would sleep with her in her bed and Mr Anderson sleep in Luke's bed. Ms Batty's evidence was:

> *Greg immediately reacted to this proposal and displayed utter disgust to the idea that Luke would sleep with me. He became angry and abusive and I demanded that he leave. However, I did not lock the door and after he left and soon after he returned... Greg was highly aggressive towards Luke and demanding that Luke should tell him for how long he had been sleeping in my bed.*[100]

123. Mr Anderson became aggressive with Ms Batty and took a heavy vase, threatened her with it, threw her to the floor and kicked her. While Mr Anderson did not physically assault Ms Batty with the vase he left, taking it with him. Luke witnessed the incident, during which he found his mother's mobile phone and gave it to her so she could call the police.

124. On the same day, Senior Constable Kate Anderson (**SC Anderson**) arrested Mr Anderson in relation to the assault and conveyed him to the Hastings Police Station. Charges of unlawful assault, assault by kicking and assault with an instrument were authorised on 1 August 2012.[101] SC Anderson's Inquest evidence was that the delay getting the charges issued was due to workload issues related to preparing the brief and the time taken to have it authorised.[102] SC Anderson's evidence was that, due to problems with serving Mr Anderson, the charges had to be re-issued on 8 January 2013. I accept SC Anderson's explanation for these delays. However delays such as these, particularly when combined with other delays within the system, can lead to an increasing risk of escalating problematic behaviours on the part of the perpetrator. At the time of Luke's death, these charges still had not been heard by a Court.

125. On this night SC Anderson issued Mr Anderson with a Family Violence Safety Notice (**FVSN**)[103] naming Luke and Ms Batty as the protected persons. The FVSN, stated that the reason for its issue was to '*ensure the safety of the affected family member*' and to '*protect a child who has been subjected to family violence carried out by the respondent*'.[104] The FVSN conditions included a prohibition on Mr Anderson from being within five metres of Ms Batty or Luke or 200 metres of Ms Batty's home.[105] SC Anderson also exercised her protective intervener powers and reported the incident to the DHS with respect to Luke witnessing the incident.[106]

126. SC Anderson also formed the belief that Mr Anderson had a mental illness, was a danger to others[107] and apprehended him under the, then, section 10 of the *Mental Health Act 1986* (**Mental Health Act**) for a psychiatric assessment. SC Anderson's reasons were based on Mr Anderson's abusive behaviour towards the police, his uncontrollable ranting and raving and constant talking about God.[108] Mr Anderson also accused the police officers of injuring his wrist when they handcuffed him. Mr

[100] Coronial brief, pp 1495-1496.
[101] Anderson coronial brief p. 1898, 1900-1902.
[102] Transcript, p. 291.
[103] Exhibit 18 and coronial brief pp. 1525 – 1527. The FVSN has the effect of providing immediate protection for the protected persons but does not have the effect of suspending the Family Court consent orders that allowed Mr Anderson to have contact with Luke.
[104] Exhibit 4, Supplementary Statement of Ms Batty -IB 1525 (Family Violence Safety Notice).
[105] Exhibit 4, Supplementary Witness Statement Ms Batty, CB 1526.
[106] It was determined to be in the interests of justice to ask SC Anderson whether she was the notifier. See transcript, p. 318-319.
[107] Transcript, p. 265.
[108] Transcript, p. 252-253.

Anderson was taken to the Frankston Hospital for psychiatric assessment. Examinations and x-rays conducted did not bear out Mr Anderson's allegations that the police officers injured him when they handcuffed him. At the hospital, Mr Anderson's behaviour changed, and hospital records recorded him to be *"rational, discursive, articulate, completely normal, essentially in behaviour and presentation."*[109] Under mental state examination Mr Anderson was assessed to be *"discursive, neat, rational articulate"* and that, he had full insight, that his cognition was intact and he denied suicidal ideation.[110]

127. Mr Anderson was found to have no psychiatric symptoms and discharged by the hospital without any recommendation for follow-up or referral to a mental health specialist for further assessment.

128. On the face of it, this non referral for any follow-up revealed a surprisingly superficial approach in my view.

129. This may have been the second missed opportunity to potentially engage with Mr Anderson through the mental health system.

130. In addition to the FVSN, SC Anderson also completed an L17[112] in relation to this incident. In doing so SC Anderson relied upon her discussion with Ms Batty earlier in the evening when she attended at Ms Batty's home and took a brief history (20-30 minutes). SC Anderson also looked on Victoria Police's Law Enforcement Assistance Program (**LEAP**)[113] for previous family violent incidences and intervention orders that had been in place.[114] I accept SC Anderson's evidence that, in relation to the L17, her risk assessment begins as soon as she hears a 'job' come over radio and, from that point onwards she continually builds upon that risk assessment, gathering information along the way from the victim, witnesses and other relevant sources. Such risk assessments build to a point whereby she is able to make her decision in how to best manage that particular case. SC Anderson said there was no particular document she used: *That's how I've always done it. And I did on that particular night, and I do it all the time.*[115]

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[109] Coronial brief, p. 2254.
[110] Coronial brief, p. 2256. Anderson coronial brief p. 2242-2521.
[112] L17 is Victoria Police document that captures the risk assessment conducted for family violence and risk management and is the integral document, which informs Victoria Police's decisions on how best to assist affected family members. L17s are required to be completed for every family violence incident and intrafamilial related sexual offence and child abuse reported to police. Assistant Commissioner Luke Cornelius' inquest evidence in relation to the L17 was *"development and introduction of the L17 form, which if you like was developed as an aide-memoire, particularly to our frontline responders, to ensure that at the point of first response they turn their mind to capturing information which might then usefully inform a considered assessment of the risks that those who are facing the threat of family violence from a perpetrator put us in a position to consider those issues and ensure that we can put in place arrangements not only from a policing perspective but with our partners, put in place arrangements that might render those victims safe"* Transcript, p. 1524. LEDR MKII is an electronic version of the L17.
[113] On 1 March 1993, Victoria Police implemented the Law Enforcement Assistance Program (LEAP) state-wide. The LEAP database is relational and stores particulars of all crimes bought to the notice of police as well as family incidents and missing persons. The database is accessible by Police online and updated constantly, 24 hours a day.
[114] Transcript, p. 278.
[115] Transcript, p. 263.

131. Upon completion of the L17, SC Anderson faxed the L17 and other relevant paperwork to the Central Data Entry Bureau (**CDEB**).[116] The original L17 was placed in the Sergeant's tray for filing. Her Inquest evidence was:

> *I would have faxed it, both for women's and men's formal referrals for both parties involved and also for Luke as he was present. He was a child present at the time of the assault.*[117]

132. The L17 requires the person filling out the form to assess the future risk of harm to be 'likely' or 'unlikely'. The original L17 filled out by SC Anderson indicated that future risk to harm was 'likely' and that the victims' level of fear (both Ms Batty and Luke) was 'fearful'[118]. However, for unknown reasons CDEB upon entering the L17 details into LEAP did not enter the details for the level of risk and the victim's level of fear.[119] Inaccurately entering the original L17 into LEAP meant relevant information was not available for other police officers. In my view this constitutes a clear process flaw in documenting critical information relating to family violence incidents. SC Anderson had done all she reasonably could.

17 May 2012

133. On 17 May 2012, at the Frankston Magistrates' Court, a 12 month FVIO was made against Mr Anderson naming Ms Batty and Luke as affected family members. Importantly, this was the first time Luke was named on a FVIO as an affected family member. Ms Batty and Mr Anderson were both present at the hearing, neither were legally represented.[120] SC Anderson did not attend the hearing believing that her attendance was not mandatory. SC Anderson's evidence reasoned if police were required to attend all intervention hearings they '*wouldn't be operational*',[121] given the extensive numbers of intervention orders taken out by police.[122] SC Anderson also believed that a family violence liaison officer would be available at the Court if assistance was required. On this occasion, Ms Batty did not receive any such support. I accept SC Anderson's explanation as to her non-attendance at Court on this day. The gap in the system on this day was that there was no family violence liaison officer at the Court to assist Ms Batty. However, there was a need for someone to fill that role, or for Ms Batty to be otherwise supported at Court.

134. The final FVIO was made with Mr Anderson's consent, without any admission of the allegations and with an expiry date of 17 May 2013. The final FVIO prohibited Mr Anderson from:

    (a) committing family violence against Luke and Ms Batty;

    (b) intentionally damaging property of Luke and Ms Batty or threatening to do so; and

    (c) getting another person to commit the above two matters on his behalf.

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[116] The Central Data Entry Bureau is responsible for the bulk of data capture within Victoria Police. The area operates 24 hours a day, 7 days a week with trained operators adding in excess of 430,000 crime reports and non-crime events onto LEAP per year. The MAS Unit is responsible for the processing of Member Activity Sheets (MAS) which are scanned using Optical Character Recognition (OCR) software to capture data. The Central Data Entry Bureau plays an important role in ensuring the integrity of information recorded on LEAP and LEDR. Staff at the Central Data Entry Bureau provide advice and assist operational members in filling out and submitting LEAP Forms.

[117] Transcript, p. 279.

[118] Inquest Exhibit 73 and 111. Coronial brief pp. 3622-3625.

[119] Transcript, p. 283-284.

[120] Supplementary Statement of Rosemary Batty, Exhibit 4, Batty Inquest Brief, at p1497.

[121] Transcript, p 294

[122] Transcript, p 294.

135. The final FVIO did not replicate the FVSN restraints on Mr Anderson from being anywhere within five metres of Ms Batty or Luke or 200 metres of Ms Batty's home.[123]

136. The FVIO also stipulated, subject to Mr Anderson's agreement, that he contact the Men's Referral Service to obtain confidential advice and information about services that may assist him.[124] This was the most the Magistrate's Court of Victoria could do at that court location. It could not mandate participation in men's behaviour change programs.

137. SC Anderson's Inquest evidence, which I accept, was that because she was the applicant for the FVIO she made the ultimate decision about the terms of the order presented to the Magistrate. In relation to considering the views of Ms Batty and Luke, SC Anderson's evidence was, when an application is made on behalf of the victim, a police officer's assessment is important and they determine the conditions considered necessary for the individual case.[125]

138. SC Anderson's handling of this matter was thorough. The fact that she issued the FVSN was evidence that she conducted a risk assessment, despite Ms Batty's evidence that she was unaware or had no recollection of any police officers conducting a risk assessment on this occasion.[126] I accept SC Anderson's evidence on these matters. She was a credible and impressive witness.

139. Following this incident, the DHS and Good Shepherd Youth and Family Services (**Good Shepherd**)[127] contacted Ms Batty.[128] The Good Shepherd is a voluntary service reliant on the referred protected person to 'opt in' to the service.[129] As a result of this incident, the Good Shepherd referred Ms Batty to South Eastern Centre Against Sexual Assault (**SECASA**)[130] for counselling, and encouraged Ms Batty to seek counselling for Luke. Good Shepherd also provided information about supervised contact centres to facilitate access visits between Mr Anderson and Luke. Ms Batty's evidence was that she did not consider a supervised contact centre was appropriate and did not follow up this option.[131]

140. Ms Batty's evidence in relation to the proactive contact by the DHS and Good Shepherd was:

> *I don't know that it was that night ...it was certainly the next day, I got one of two phone calls from different organisations and I was really - I felt that was great because many years ago when I'd had to involve the police or anything, there was no response. But this time it was like services were linked in and - which was really good because, you know, you didn't have to go looking for them, they came to you..... principal called me as well.*[132]

141. The proactive contacts to Ms Batty, flowing from the referrals triggered by SC Anderson's L17, are good examples of the family violence system working in an integrated way.

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[123] Coronial brief p. 526.
[124] Coronial brief, p. 1529.
[125] Transcript, p. 262.
[126] Transcript, p. 53-54.
[127] Good Sheppard is a predominantly funded service by the DHS which operates within the Mornington Peninsula shire to provide specialist family violence support to women and children providing case management support, intake and assessment, group work programs and a high security refuge which accommodates women and children from other parts of Victoria who have fled family violence.
[128] Ms Batty had contact with Good Shepherd on eight occasions (seven by phone and one face to face).
[129] Transcript, p. 1276.
[130] SECASA provides counselling and other services to victims of sexual assault and family violence.
[131] Transcript, p. 38.
[132] Transcript, p. 244-245.

142. Ms Jade Blakkarly (**Ms Blakkarly**) of Good Shepherd, said that her organisation's involvement was a result of receiving an L1 'Incident Field Report' (1 page)[133] and not the L17. Her evidence was that this was common at the time.[134] However, documentary evidence supports SC Anderson's evidence was that nine pages, including the L17 was sent.[135] Whether there was a communication error in transmitting the L17 is not known, however, there was sufficient information for Good Shepherd to contact Ms Batty. Ms Blakkarly's evidence was that the L17 in most cases is the starting point for most specialist services, such as Good Shepherd. Upon receipt of an L17 it is entered into the Good Shepherd database and checked to determine if there are multiple L17s in relation to the protected person. Ms Bakkarly's evidence was that immediately upon receipt of the referral a risk assessment, based on the Common Risk Assessment Framework (**the CRAF**), is commenced and a case worker allocated. The case worker calls the protected person to determine if she is currently safe, if the response from the police was appropriate and whether there are supports that the woman may need. The protected person is advised at this initial stage of what will happen with any action that the police have taken.

143. Ms Blakkarly's evidence was that while the Good Shepherd conducted immediate and ongoing risk assessments when they engaged with Ms Batty, they did not complete the CRAF risk assessment form.[136] Had a formal CRAF risk assessment been conducted it would sit on the client's file and be used to lead discussion with the client and also for staff in planning required actions, depending on what risks were identified.

28 May 2012

144. On 28 May 2012, Dr Farlow, a general practitioner, consulted with Luke and prepared a Mental Health Care Plan arising from him witnessing the family violence incident on 16 May 2012. Ms Batty was rightly concerned about Luke modelling violent behaviour and acting out at school. Consequently, Luke received counselling from Mr Michael Warner, psychologist. Luke responded well to the counselling.

17 November 2012

145. On 17 November 2012, Mr Anderson was observed viewing child pornography[137] on a public computer at the Emerald Hill Library in South Melbourne. On 22 January 2013, Detective Senior Constable Cocking (**DSC Cocking**) was assigned the investigation and later compiled a brief of evidence that resulted in child pornography charges. Efforts to locate Mr Anderson to serve the charges proved difficult due to his itinerate lifestyle, living in his vehicle and having no known telephone contact.

146. On 28 January 2013 DSC Cocking arranged for Mr Anderson to be arrested in relation to the child pornography charges while reporting on bail on SC Anderson's charges, at the Malvern Police Station.

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[133] Coronial brief, p. 3774.
[134] Transcript, p. 1265.
[135] Transcript, p. 3774.
[136] Transcript, p. 1279.
[137] Category 1 images.

DSC Cocking interviewed Mr Anderson and he was bailed to appear at Melbourne Magistrates' Court on 2 April 2013. Mr Anderson's bail included a condition that he report once a week to the Malvern Police Station.

147. The charges were considered to be at the lower end of child pornography seriousness, and unsurprisingly conditional bail was granted.

148. Evidence revealed that Mr Anderson did not miss a bail sign-on from this date until his bail conditions became void on 24 April 2013, when Magistrate Goldsbrough issued warrants for his arrest.[138]

3 January 2013

149. On 3 January 2013, Mr Anderson attended at Ms Batty's property to collect Luke for an access visit. While collecting Luke, Mr Anderson warned Ms Batty to watch herself and made negative comments about a friend she had staying at her house.

150. Later that day, Mr Anderson returned Luke to Ms Batty for her to give him something to eat. Mr Anderson then returned in the afternoon to collect Luke. Ms Batty spoke with Mr Anderson at the front gate, he was agitated and threatened:

> *Right now I would really like to kill you. You think you're going to outlive me in this lifetime, but I can make you suffer. I will cut off your foot. ... I hope you have made a will."*[139]

151. Luke was not present when Mr Anderson made the threats. Ms Batty allowed Luke to go with Mr Anderson, fearing that if she refused he would react with violence. As soon as Mr Anderson returned Luke that day, she attended the Hastings Police Station to report the threats. Police officers arranged to be at Ms Batty's house the next day as Mr Anderson was expected to return to collect Luke.

152. Constable Abernethy completed, amongst other documents, an L1 and L17 in relation to this incident. The L17 recorded the assessment of future risk to be 'likely' and Ms Batty's level of fear as:

> *The victim (Ms Batty) expressed a high level of fear but believes the offender will only direct his anger toward her and not the child.*[140]

153. While Constable Abernethy was not called to give evidence, Constable Guenther's Inquest evidence was that he had been trained in how to fill out an L17 but not how to conduct the risk assessment.[141] Constable Guether's evidence highlighted the inadequate training in relation to the L17:

> *In terms of the L17s, we get trained in how to fill them out, but not in terms of conducting the risk assessment, it's just the form that needs to be filled out that we do.*[142]

154. Similarly, First Constable Paul Topham's (**FC Topham**) evidence was he was not aware of specific training in relation to weighting the risk factors on the L17 and believed it was left to the individual discretion of the police officer. [143]

155. The L17 is the family violence risk assessment tool used by Victoria Police. As to her awareness of Victoria Police's risk assessment, Ms Batty's evidence was:

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[138] Transcript of hearing on 24 April 2013, Exhibit 6, Batty Inquest Brief, at p1430.
[139] Coronial brief, p.1498.
[140] Exhibit 111 – Remainder of Brief LEAP Family Violence Report CB 3626 – 3629.
[141] Transcript, p. 408.
[142] Transcript p. 408.
[143] Transcript, p. 396.

...I remember them talking to me, I don't recall, again, questions of history of violence or um - you know, there's a lot of chat to them about Greg and you know, your fears and - but I don't remember an official risk assessment being discussed with me. The policeman did indicate and told me what to do and said the next day when you see, you know, he comes to collect Luke, call 000.[144]

4 January 2013

156. The next day, 4 January 2013, Mr Anderson was arrested and interviewed by FC Topham and Constable Guenther. While Mr Anderson was aggressive and abusive toward the police officers, they did not believe they should exercise their section 10 of the *Mental Health Act 1986* powers.[145]

157. FC Topham charged Mr Anderson with the indictable offences of making a threat to kill, making a threat to commit serious injury and for breaching the FVIO of 17 May 2012. Police bail was refused, as FC Topham formed the belief Mr Anderson was '*in a show cause*'[146] situation and was also '*an unacceptable risk to society*' within the meaning of sections 4(4) and 4(2)(d) of the *Bail Act 1977* (**Bail Act**). FC Topham also executed a warrant for Mr Anderson's arrest issued in relation to Mr Anderson failing to appear to answer the charges issued by SC Anderson.[147]

158. FC Topham gave evidence at the Frankston Magistrates' Court in support of remanding Mr Anderson (i.e. opposing bail).[148] FC Topham's evidence was that if Mr Anderson was not remanded in custody, he wanted to obtain stricter bail conditions than those possible on a variation of Ms Batty's FVIO conditions. FC Topham reasoned that strict bail conditions could provide Ms Batty and Luke greater safety pending the variation of the FVIO.[149] FC Topham also reasoned that a breach of bail conditions gave a police officer the power to bring Mr Anderson back before a magistrate, whereas a breach of a FVIO triggered an interview with police and a possible summary offence charge. FC Topham's evidence was that if Mr Anderson breached bail and was brought before a magistrate on every occasion, this was a better tool than the accumulation of summary charges for breach of the FVIO. FC Topham's evidence of his logic was compelling:

the more times his true colours and spots would shine through and people would become aware that this guy is dangerous. [150]

159. I fully agree with his proposition. Holding family violence offenders to account in court after breaches of bail is a far better way to promote the safety of the victim than is serving summons for breaches over time.

160. FC Topham's assessment of Mr Anderson was accurate and prescient.

161. Mr Anderson was bailed by the Court on the following conditions:

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[144] Transcript, p. 55.
[145] Section 10 of the Mental Health Act 1986 (now in principle replaced by section 351 of the Mental Health Act 2014) provided a police officer with the discretionary power to apprehend a person who appeared to be mentally ill and they had reasonable grounds for believing that—(a) the person has recently attempted suicide or attempted to cause serious bodily harm to herself or himself or to some other person; or (b) the person is likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person.
[146] The court shall refuse bail unless the accused shows cause why his detention in custody is not justified.
[147] See email from FC Topham to SC Anderson dated Saturday, 5 January 2013 3:12pm (See also transcript p. 3671.)
[148] Transcript, p. 369.
[149] Transcript, p. 352 - 353.
[150] Transcript, p. 378 - 379.

(a) he was to reside at the Evancourt Motel;

(b) he was to notify FC Topham of any change of address within the time he was on bail; and

(c) he was banned from the suburb of Tyabb.

162. This highlights the need to ensure that intervention order conditions are aligned with bail conditions to the greatest possible extent. In my view, prosecutors should always promote this outcome. This should apply whether it is the bail order, or the intervention order which is being varied. At the point of variation of one or the other, prosecutors should apply to magistrates for mutually consistent variations – to ensure an outcome of parallel bail order and intervention order conditions.

163. At approximately 4.15 pm, the same day FC Topham telephoned Ms Batty and advised her that a magistrate had granted Mr Anderson bail. This was entirely appropriate information sharing. Constable Guenther's evidence was that the decision to contact Ms Batty was because of the:

> *need to notify the victim of the bail so she knows what to expect and she knows what he can and can't do, so she can notify us if she knows that he's breaching his bail conditions.*[151]

164. The police officers also promptly contacted the CDEB and requested Mr Anderson's bail details be added to the LEAP as soon as possible. Constable Guenther's evidence was that having bail details added to LEAP so quickly after the hearing was not the usual course, but he, FC Topham and their Acting Sergeant decided it was necessary because of:

> *the way in which Anderson reacted towards us and the fear that Rosemary - Ms Batty had for him...it was advised to - to get those added on to the system as soon as possible. So they were there with all future encounters with him.*[152]

165. The police officers' actions were completely appropriate. The approach they took should, in my view, be routine for all bail matters related to family violence.

166. FC Topham's charges had not been heard by a Court at the time of Luke's death. This was a very significant delay. It represented a lost opportunity to bring Mr Anderson account, sentence him in respect of his offences, (if they were proven), potentially place him on correctional orders and potentially engage him with mental health treatment services.

11 January 2013

167. On 11 January 2013, Ms Batty attended at the Frankston Magistrates' Court to apply for a variation to the FVIO made on 17 May 2012. The matter could not be dealt with because Mr Anderson had not been served with notice of the application and was not present.

11 February 2013

168. On 11 February 2013, a magistrate issued an interim FVIO including Ms Batty and Luke as protected persons and precluding Mr Anderson from coming within ten metres of Ms Batty and 200 metres of her residence or workplace. The interim FVIO did not alter the original FVIO order conditions as they related to Luke.

[151] Transcript, p 411 412.
[152] Transcript, p 407.

169. FC Topham's evidence was that he advised Ms Batty to have the FVIO 'strengthened' for the following reasons:

> *....because of the fact that I dealt with Anderson I knew immediately that we weren't going to let him off on summons, we were going to go for a remand application. I then knew that by the remand application we would then - if he was granted bail or if he was held in prison, if he was granted bail the conditions I would get for him I would anticipate to be stronger than what I could get the conditions on an IVO application - for an application for variance. So yes, I went back and I had a conversation with Ms Batty and told her what we were going to do is this: I would be attempting to remand him in custody if he is granted bail, the conditions I would get on the bail will hopefully be that strict that it will cover you in the meantime for safety. Failing that, you should also attend at the court tomorrow and you should also apply for an intervention order variance, ban him from the address and get it sorted.*[153]

170. FC Topham's advice to Ms Batty was sound and demonstrated a commitment to reducing the risk of further family violence.

171. Ms Batty was unrepresented at the hearing. While at the Court, Ms Batty had a discussion with the Court family violence support worker, Ms Christine Allen (**Christine Allen**).[154] Christine Allen spent approximately 65 minutes with Ms Batty, providing Ms Batty emotional support and information on the Court's processes, safety measures and reporting breaches, amongst other things.[155]

172. Importantly, Christine Allen completed an Intake and Risk Assessment Form[156], based upon the CRAF. Although not recorded on the form itself, Christine Allen assessed Ms Batty's risk of further family violence to be at an 'elevated' level.[157] This was the first of three support sessions Ms Batty had with Christine Allen in 2013. Ms Batty's evidence was that she found Christine Allen very empathetic and respectful.[158]

173. Christine Allen did not share her risk assessment with the police or any other persons. It is not a criticism of Ms Allen, but in my view, the protocols/practices/procedures within a properly integrated system should have required her to do so. The routine sharing of risk assessment information is a fundamentally important issue. It has arisen in this case and in others. The absence of it reflects a flaw in the system.

The knife incident

174. Ms Batty's evidence is that one afternoon in April 2013, when she was driving Luke home from school, Luke told her that Mr Anderson had driven him to a Mornington foreshore car park (in Mr Anderson's car), that Mr Anderson began praying in the car and Luke was playing on his iPad. Ms Batty's evidence was that Luke told her that Mr Anderson held a knife and said:

> *It could all end with this*[159]

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[153] Transcript, p 352.
[154] Ms Allen's role was to provide support at Court and was not to provide ongoing case management.
[155] Statement of Christine Allen, Exhibit 96, at p. 3662.
[156] Coronial brief, pp 1558-1565.
[157] Transcript, 1338.
[158] Transcript, p. 159.
[159] Transcript, p 33 and 620.

175. The evidence reveals variations on this utterance. Ms Batty evidence was that Luke also said Mr Anderson told him "*this could be the one to end it all*"[160] or "*It could all end with this. Cain has spoken.*"[161] Immediately after Luke's disclosure of the knife incident Ms Batty tried to extract more information but Luke "*clammed up*"[162] and made it clear that he was not going to say anything further.[163] It was for this reason that Ms Batty "*did not sit down and grill him about it.*"[164]

176. Ms Batty's Inquest evidence was that it was difficult for her to know exactly when the knife incident occurred because Luke had no concept of time and had not come home from any particular outing with Mr Anderson showing signs of distress.[165] While Luke told the DHS workers that the incident happened the previous year (i.e. 2012), Ms Batty was not convinced this was the case based on what she knew of Luke.[166]

177. Information Luke provided during an interview with Detective Leading Senior Constable Deborah Charteris (**DLSC Charteris**) and Ms Portelli on 5 September 2013 suggests that the knife incident may have occurred in November 2012. Ms Batty's evidence to Magistrate Goldsbrough on 24 April 2013 was that Luke told her of the knife incident in the Easter holidays of 2013.[167] Ms Batty in her Inquest evidence stated that she believed Luke told her in April 2013.[168]

178. While Ms Batty did not understand the context of Mr Anderson's comments or what they meant, she was so alarmed that she knew she could no longer support Mr Anderson's relationship with Luke. Ms Batty's Inquest evidence demonstrated a responsible and measured response to this situation:

> *I didn't know where to go with that information and I don't believe if I had gone to the police it would have gone anywhere because what's that, a child said something. I've got no proof and I've got no idea what to say. He didn't want to get his dad into trouble, so all I knew was I wasn't going to let Greg have him again until I could work out what to do about this information.*[174]

179. Ms Batty, while believing that Mr Anderson would never harm Luke, was concerned there was a risk to Luke but it was not clear in her mind what that risk was:

> *I didn't know whether Greg was referring to his own suicidal tendencies, or that Luke - he would like to have a joint suicide attempt - um, ending. But I guess my image of this ah suicide, if there was - that was he was referring to, would be that if he took Luke somewhere in his car like he used to, where I wasn't there an nobody else was there and he could take him away somewhere private, then I was fearful of what he could do. But I thought that while I was able to keep him safe, while I was able to be around people and he was around people, that image of a suicide*

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[160] Coronial brief, p. 620.
[161] Inquest exhibit, p. 10.
[162] Transcript, p. 34.
[163] Transcript, p. 33-34.
[164] Transcript, p. 79.
[165] Transcript, p. 78.
[166] Transcript, p. 78-79.
[167] Exhibit 6.
[168] Transcript, p. 34.
[174] Transcript, p. 80.

pact couldn't happen. It couldn't happen in a public bloody place in the Tyabb oval, it couldn't happen and it did. I thought I was keeping him safe because he was around people.[175]

180. After Luke's disclosure of the 'knife incident' Ms Batty told her doctor at the Eramosa Medical Clinic, Prosecutor Senior Constable Darren Cathie (**Prosecutor Cathie**), Magistrate Goldsbrough, the school in a parent teacher interview, DLSC Charteris and Ms Portelli.[176] On 15 April 2013, Ms Batty's doctor advised her to speak to the police.[177].

22 and 23 April 2013

181. On 22 and 23 April 2013, Mr Anderson failed to attend Frankston Magistrates' Court to answer the charges laid by SC Anderson and FC Topham. The matters listed as contested hearings were adjourned to the next day, 24 April 2013.

182. Prosecutor Cathie was assigned to prosecute the matters.

24 April 2013

183. On 24 April 2013, at the Frankston Magistrate' Court, Magistrate Goldsbrough[178] heard Ms Batty's application to vary the conditions of the FVIO issued on 17 May 2012. Ms Batty was unrepresented as she did not understand that the police prosecutor did not represent her.[179] Mr Anderson did not attend the hearing.

184. Prosecutor Cathie represented the police applicant, SC Anderson, who did not attend. Prosecutor Cathie also provided Ms Batty assistance during the hearing. Magistrate Goldsbrough adjourned the matter to 10 May 2013 and issued two warrants for Mr Anderson's arrest in relation to his failure to answer the criminal charges issued by SC Anderson and FC Topham.

185. Prosecutor Cathie's evidence was that prior to the hearing he spent time discussing the FVIO variation application with Ms Batty, during which she disclosed the 'knife incident'.

186. Ms Batty's evidence to Magistrate Goldsbrough detailed Mr Anderson's controlling behaviour in relation to his contact arrangements with Luke. Ms Batty's evidence to Magistrate Goldsbrough was that:

(a) Mr Anderson loved Luke dearly;

(b) Mr Anderson was transient and unable to hold down employment; and

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[175] Transcript, p. 91-92.
[176] Transcript, p. 34-35.
[177] Transcript, p. 1224.
[178] Magistrate Goldsbrough was appointed a Victorian Magistrate on 22 October 1996 and was the Supervising Magistrate for Family Violence and Family Law for the years 2002-2007. Her Honour developed and oversaw the implementation of the Court's specialist Family Violence Court Division, the Specialist Family Violence Services Courts and is gazetted as a specialist family violence Magistrate appointed by the Chief Magistrate pursuant to section 4H(2) of the Magistrates' Court Act. Magistrate Goldsbrough was also the Magistrates' Court of Victoria's representative on the State-wide Steering Committee to Reduce Family Violence 2002-7 and part of the Advisory Committee for the Victorian Law Reform Commissions '*Review of Family Violence laws*" 2006; contributed to consultations engaged in to develop the Family Violence Protection Act 2008. An Australian Law Reform Commissioner in 2009-10 for the inquiry into Family Violence and Family Law resulting in a report "*Family Violence – a National Legal Response*" in 2010. At the request of the Australian Human Rights Commission, Magistrate Goldsbrough continued to be involved in local and international programs including developing improved family violence justice system responses in China. She is one of five magistrates allocated to the Melbourne Magistrates' Courts Assessment and Referral Court (ARC List) or specialist mental health and disability list.
[179] Transcript, p. 41.

(c) she believed Mr Anderson was mentally ill, however, she was not privy to whether he had any formal diagnoses.

187. Magistrate Goldsbrough stated:

> *To use a child like that to punish you though, is what we would call a red flag in risk assessment, because this isn't about love or the child, this is about doing something to upset you.*[180]

188. The transcript of this hearing records the following exchange:

> *Ms Batty:* *In the holidays when Luke was with him all day, he came home asking me about marijuana and it was evident that Greg was smoking marijuana in front of him. And I think my son is old enough now to start to recognise that his behaviour changes after he's smoked marijuana. But what was more concerning to me was that he held up a knife and I assume it to be a sharp knife, as his father could use to cut fruit or whatever. And he held it up and said, "It could all end with this. Cain has spoken"*
> *Her Honour:* *He said that to you or he said it to Luke?*
> *Ms Batty:* *He said it to Luke.*
> *Her Honour:* *And Luke has told you?*
> *Ms Batty:* *Luke has told me. He has also said - this is only just very recently*
> *Her Honour:* *How recently?*
> *Ms Batty:* *It would have been Easter holidays, so that's within the last two weeks I think. He's also has spoken to Luke about what, being out of this world and that something around that he would really like to die with Luke. But I had always believed that his religious beliefs prevent him from committing suicide, so I never ever felt that he was that type. But I do believe with this recent (indistinct) and this situation I can't see changing. So now I have grave concerns for Luke and his father, or I have now no confidence, what little confidence I have, I now question. I also didn't want to breach his confidence because he will be disappointed with his father and he has told me that then his father would know.*[181]

189. During this hearing, Magistrate Goldsbrough suspended the existing Family Court consent orders that allowed Mr Anderson weekly access to Luke. Despite Magistrate Goldsbrough suspending the Family Court consent orders, Ms Batty's Inquest evidence was that she was confused, even after independent legal advice, how this operated.[182]

190. Magistrate Goldsbrough made a 'no contact' order for both Luke and Ms Batty. Magistrate Goldsbrough's judgment included the following analysis of the risks to both Ms Batty and Luke:

> *Her Honour:* *I am satisfied there is a considerable risk to you and to Luke of continued contact. The Act tells me I must consider prohibiting child contact in these circumstances. I am alarmed at the threats and assault to you, the use of knives and comments in relation to the 11 year old. I accept that you have endeavoured, despite all odds, to maintain a relationship beyond what others would expect to do, all motivated to maintain a relationship between the young person and his father, and it is against the odds. I am of the view that it is not in Luke's interests to have contact with Gregory Anderson and I am concerned for his safety. I can't say it more clearly than that. It is not from lack of love by Mr Anderson in my speculation, but a determination that has been not only in his behaviour, but outlined by him specifically to hurt you and sadly children become collateral damage. And I trust and hope that he receives mental health support. In my experience it would appear*

[180] Inquest exhibit 6.
[181] Inquest exhibit 6.
[182] Transcript, p. 195-197.

that that is exactly what is urgently required, but many people who are paranoid, his cannabis use, a range of drugs and have this florid presentation, are in most denial.[183]

191. Magistrate Goldsbrough asked Ms Batty to consider whether she would be comfortable with Mr Anderson attending Luke's football and the transcript recorded the following exchange:

Her Honour: *Ms Batty, have you given any consideration to how you want to deal with the things like Luke's football that you gave evidence about? I am making it an absolutely clear no contact order. I have already given very brief reasons, which I can expand on, of my great concern of the risks to Luke and you. I feel gravely concerned about what might occur. We know family violence is predictable, all of the risk indicators are here and it makes it not a challenging decision. If he does attend football and all of those things that he has always done, this order would not stop him attending the football. It will stop him having any contact with Luke and it will stop him having any contact with you. Any contact would be a breach at the football and that should be reported. I wonder if you have thought about any of those things and you wanted to say anything else to me, or have me consider anything else at all.*

Ms Batty: *I respect your judgment and I'm really not clear how to navigate this situation either. He would be welcome to come to the football, observe, and I guess it would difficult for him to do that without having interaction or speaking to his son. But in a public forum I feel there's less reason for concern. So a public forum like where there are, you know, lots of other parents and child are around and it's really active I feel that there is a degree of safety. So I feel that that is something that would be positive and to consider. But I find ---*

Her Honour: *You may want to think about some of those things when you talk to others about it---*

Ms Batty: *Yes.*

Her Honour: *If there is a decision there is a risk it becomes very complicated as to how to manage that and very confusing.*

Ms Batty: *I agree, and that's probably some of the things I've done in the past.*

Her Honour: *Well intentioned, that is right. To the point where you own safety and sanity has clearly been put in issue. And you now have significant threats, concerning threats made.*[184]

192. Ms Batty's evidence, at the Inquest, was that she could not recall exactly what she wanted to achieve as a result of her FVIO variation application, but that she felt 'greatly relieved' when Magistrate Goldsbrough ordered no contact between Mr Anderson and Luke.[185] Ms Batty wanted someone else to tell Mr Anderson that he could no longer see Luke because she could not stand up to him, she was fearful of him and could not do it herself stating:

I wanted someone that could step in and stand up to him and say - where he could take out his blame and his hatred on somebody else and not just me all the time.[186]

193. Ms Batty, while understanding what Magistrate Goldsbrough meant by ordering that Mr Anderson have no contact with Luke, did not appreciate the gravity of the risk she had assessed. When Magistrate Goldsbrough used the expression that Luke could be "*collateral damage*", Ms Batty's

[183] Inquest exhibit 6.
[184] Inquest exhibit 6.
[185] Transcript, p. 89.
[186] Transcript, p. 93.

Inquest evidence was that she thought that Magistrate Goldsbrough believed Mr Anderson could be abusive towards Luke:

> *I certainly didn't interpret that as what ended up happening to Luke... I didn't even know what filicide was until this happened. I knew about Darcey Freeman, I knew about the Farquharson boys, but I never knew their fathers. I didn't know Greg was capable of killing. I didn't know that what their fathers were like with their sons, all I had known is he loved his son, he'd never laid a hand on him, he was never verbally abusive to him, he loved him...I perceived "collateral damage" or people's warnings to be that they - he could be abusive to Luke. Um, and I felt that he was never likely to be physically hurtful to Luke, he never ever had been.*[187]

194. Ms Batty's Inquest evidence[188] was that even if Magistrate Goldsbrough had been more explicit and stated it was her assessment was that Luke was at risk of physical harm from Mr Anderson, this would have been something that she would have found hard to match with her experience of Mr Anderson and his interactions with Luke. Ms Batty explained her reasons for holding this belief:

> *... you're on a long journey with somebody and you think you know the extent of what they're capable of, but things were clearly escalating outside of my knowledge. I didn't know what to do, I didn't know what to expect. It clearly was unperceivable - I don't think - I know nobody ever expected Greg to kill Luke. No matter what warnings I got, no one actually said, in my memory, "We believe he will kill Luke."*[189]

195. Ms Batty's Inquest evidence explained what was going on in her mind when Magistrate Goldsbrough invited her to think about how situations such as Luke's football would be managed. Ms Ellyard referred Ms Batty to the transcript from the Frankston Magistrates' Court and suggested to her that she appeared to be thinking through the issues. The Inquest transcript recorded the following:

> *Ms Ellyard:* *So after that was done and after she [Magistrate Goldsbrough] told you that she was going to make a "no contact" order, we hear in the transcript that there's then a discussion about how to manage things like the football situation. And it appears that you were thinking aloud, as you thought through these issues, that perhaps Luke might be safe to have contact with his dad in public and Ms Goldsbrough was inviting you to think about that a bit more?*
>
> *Ms Batty:* *Yeah.*
>
> *Ms Ellyard:* *Is that how you remember that happening?*
>
> *Ms Batty:* *Yeah. I think that um, you know, all the way along, I was trying to come up with a compromise that ---*
>
> *Ms Ellyard:* *Ms Goldsbrough had named it as "no contact"?*
>
> *Ms Batty:* *M'mm.*
>
> *Ms Ellyard:* *Can you explain why you still felt that you should try and compromise back from – it's like you were bidding against yourself?*
>
> *Ms Batty:* *Oh, you know, it's – it's – it's a wearing and wearing battle, trying to work out what's the best for everybody. What's the best for everybody. All the time, what's the best for Luke, what's the best for Greg, what's the best. There were no clear answers, no one has any clear answers about anyone - anything in life, it's a juggling act. My position was a juggling act, an extreme juggling act for a very long time.*
>
> *Ms Ellyard:* *But does that mean that although Ms Goldsbrough gave you the order that there be no contact, and in effect an affirmation that you were right to have had the concerns that you had?*

[187] Transcript, p. 89-90.
[188] Transcript, p. 90.
[189] Transcript, p. 90-91.

Ms Batty: *Yeah.*
Ms Ellyard: *You left court still feeling that there might be a need to - - -?*
Ms Batty: *Yeah.*
Ms Ellyard: *--- negotiate with Greg about him seeing Luke in the future?*
Ms Batty: *---I um - I was very happy to abide by the court's decision. I was still trying to work out a way that - I suppose, that um you know, how can Greg have some role with Luke?*
Ms Ellyard: *Why was that still on your mind? You may feel that you've already answered this question, but given what you've identified and given that you wanted it to stop?*
Ms Batty: *---I guess there's a number of reasons that seemed logical, but one was I - I felt really sorry for Greg. He loved him so much. And yeah, he'd got this bloody - he was just - his mental illness, his behaviour, it was all sabotaging everything in his life, everything in his life he'd lost. Me, everything. For me to stand in between him and his son, from an emotional point of view, I felt very, very torn about being that person. I also felt that um - I always believed, from a legal point of view as well, there is a - a child is not a possession, it's entitled to both parents. It's important for his development.*[190]

196. Ms Batty's written submissions were that despite her misgivings and shock about the child pornography charges, she compromised, believing that Luke was safe because Mr Anderson could not *"take him away privately or having him in his car or show him things, that it would be safe.*[191]

197. During this hearing, Magistrate Goldsbrough stated that it was her expectation that when Mr Anderson reported on bail to the Malvern Police Station, on Monday 29 April 2013, he would be served with the FVIO she had made that day and arrested in relation to the two warrants she had issued. Magistrate Goldsbrough said that Mr Anderson must be taken before a Court in order to determine bail, because she did not consider appropriate that it be a matter for police to determine.

198. Mr Anderson did not report for bail and the warrants were not executed.

199. Later that day, after the Court hearing, Mr Anderson attended Luke's football training, in Tyabb. Ms Batty believing that Mr Anderson was in breach of his bail conditions prohibiting him from attending Tyabb rang the police to advise them of the breach. Ms Batty was told that the effect of Magistrate Goldsbrough issuing the warrants for Mr Anderson's arrest resulted in the bail conditions, including the condition that he not attend Tyabb, were no longer operative and cancelled.[192] It is obviously an unintended consequence of the issue of warrants following a non-appearance on bail. It can be exploited, and was by Mr Anderson. In that regard the *Bail Act* needs amendment and I will recommend accordingly.

200. The evidence also strongly suggests that it was on this same evening Mr Anderson threatened Luke's football coach that he had a knife with his name on it. However, surprisingly, the football coach did not report this threat to police or take any further action in relation to it.

201. The initiating police officer for the FVIO, SC Anderson, was not aware of the evidence Ms Batty gave at the hearing on 24 April 2013.[193] In my view SC Anderson should have been informed as soon as

[190] Transcript, p. 94-95.
[191] Transcript, p. 44.
[192] Transcript, p. 234.
[193] Transcript, p. 269.

possible about the evidence Ms Batty gave, in particular the evidence about the knife incident. This was the very incident that gave Magistrate Goldsbrough such deep concern.

202. The bench warrant issued by Magistrate Goldsbrough in relation to SC Anderson's charges was sent to her on the understanding that she had two weeks to locate him.[194] SC Anderson was unable to locate Mr Anderson and the warrant was filed with 'criminal records' a Victoria Police department that amongst other matters, manages unexecuted warrants.

203. After the hearing, Prosecutor Cathie sent an email to a number of relevant police officers noting that Mr Anderson had unexecuted warrants and alerted them to the fact that Magistrate Goldsbrough had expressly stated the urgency in having them executed.[195] Prosecutor Cathie's actions were pro-active, and good examples of what should be routine information sharing within Victoria Police.

26 April 2013

204. On 26 April 2013, Mr Anderson failed to attend at the Melbourne Magistrates' Court for a contested mention hearing on the child pornography charges laid by DSC Cocking. The Court issued a bench warrant for Mr Anderson's arrest. DSC Cocking attached a remand application to the warrant.

205. The warrant was later executed by police officers from the Hastings Police Station on 29 May 2013.

27 April 2013

206. On 27 April 2013, Senior Constable Anthony Coates (**SC Coates**) stopped Mr Anderson while he was driving his motor vehicle. During this interception, SC Coates raised with Mr Anderson his bail status. Mr Anderson became aggressive and maintained that the charges against him arose from an ASIO conspiracy.[196]

207. Critically, SC Coates was unaware of the unexecuted warrants in relation to Mr Anderson because they were not on LEAP. This was another lost opportunity to bring Mr Anderson to account.

May 2013

208. In May 2013, Ms Batty was referred to Windermere's Victims Assistance and Counselling Program (**Windermere**). Windermere referred Ms Batty and Luke to forensic psychologist, Dr Jan Heath (**Dr Heath**), for two counselling sessions to provide information about the legal system and to assist with the completion of a Victims of Crime Assistance Tribunal (**VOCAT**) application. Due to Luke's age, Dr Heath arranged for Luke to see Ms Perry.

209. Also in May 2013, after a series of communications including emails, Ms Batty was advised by both DSC Cocking and FC Topham to ring 000 if she saw Mr Anderson, so he could be arrested in relation to unexecuted warrants. Ms Batty's Inquest evidence was that she developed a rapport with both officers and found them to be supportive,[197] in particular that FC Topham extended himself and was someone she valued and trusted.[198]

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[194] Transcript, p. 270.
[195] Coronial brief, p. 3703.
[196] Anderson coronial brief, p. 717-721.
[197] Transcript, p. 134.
[198] Transcript, p. 175-176.

7 May 2013

210. On 7 May 2013, FC Topham sent an email[199] to numerous relevant police officers marked 'High' importance, which:

    (a) alerted them to the unexecuted warrants in relation to Mr Anderson;

    (b) requested the officers assist him to arrest Mr Anderson, who was believed to attend at Luke's football practice on 8 May 2013 at 4.30 pm;

    (c) advised the officers that he had instructed Ms Batty to ring 000 if she saw Mr Anderson;

    (d) stated *"If apprehended please strongly consider REMAND. 'Going Postal' would definitely apply to this bloke"*[200]; and

    (e) included a photograph of Mr Anderson.

211. This was another good example of appropriate information sharing within Victoria Police.

8 May 2013

212. At the request of DSC Cocking and FC Topham, on 8 May 2013, Ms Batty rang 000 when she saw Mr Anderson at Luke's football. After 45 minutes, she called 000 again to ascertain where the police were. Unknown to Ms Batty an undercover police car had been at the football oval the whole time. Ms Batty was advised that the warrants to arrest Mr Anderson were not available and they were unable to arrest him. At this stage, Ms Batty did not know one of the unexecuted warrants was for child pornography charges.[201]

9 May 2013

213. On 9 May 2013, Mr Anderson attended at Luke's school and was refused access to him on the basis that to do so would be a breach of the FVIO. The school's actions were appropriate and reflect the important role schools can play in the family violence system.

214. Also on this day Ms Batty telephoned Sergeant John Schroen (**Sgt Schroen**), during which she became emotional and hung up.

10 May 2013

215. On 10 May 2013 Ms Batty attended the Frankston Magistrates' Court in relation to the variation for the FVIO, adjourned from 24 April 2013 by Magistrate Goldsbrough. Prosecutor Cathie spoke with a distressed Ms Batty and it became clear that she did not know she was not required to appear at Court that day because Mr Anderson had not been served with the variation for the FVIO.

28 May 2013

216. On 28 May 2013, Ms Batty reported to First Constable Clinton Taylor (**FC Taylor**) that Mr Anderson had breached the FVIO, by telephoning her and speaking to her. The legal effect of the failure to serve Mr Anderson with the FVIO made by Magistrate Goldsbrough on 24 April 2013 (ultimately served on 30 May 2013) was that it was ineffective during that month.[202] Therefore, the breach as reported to FC

[199] Coronial brief, p. 3712.
[200] Coronial brief, p. 3712.
[201] Transcript, p. 98-100.
[202] Transcript, p. 236.

Taylor could not be prosecuted despite Ms Batty's reasonable understanding that she was reporting a breach of the FVIO.[203]

217. SC Anderson did not inform Ms Batty (after she received an email from the Malvern Police Station in early May 2013) that Mr Anderson had not been served with the variation of the FVIO made by Magistrate Goldsbrough on 24 April 2013 and that he had ceased reporting on bail at Malvern Police Station.[204] In my view, Ms Batty should have been informed.

218. The bench warrant issued by Magistrate Goldsbrough on 24 April 2013 had the effect of cancelling Mr Anderson's bail conditions, resulting in him ceasing to report to the Malvern Police Station. It also removed the best means police had of locating him to serve the FVIO and to execute extant warrants.[205]

219. Despite this, FC Taylor appropriately completed a LEDR Mk 2 (an electronic version of the L17) recording his assessment of future risk as "*likely*"[206] and that Ms Batty's level of fear as '*fearful*'.[207]

29 May 2013

220. On 29 May 2013, Ms Batty reported to police Mr Anderson's presence at the Bunguyan Reserve.

221. Acting on Ms Batty's information, Sgt Schroen arrested Mr Anderson in relation to unexecuted warrants. Mr Anderson was unable to be interviewed by police due to his demeanour and was remanded in custody.

222. Sgt Schroen's Inquest evidence was that the arrest was without incident and Mr Anderson did not display any aggression or violent behaviour.

30 May 2013

223. On 30 May 2013 Mr Anderson was served with a copy of the FVIO in the cells. As previously stated the delay in serving the FVIO allowed Mr Anderson the defence that he was unaware of the 'no contact' order in relation to Luke.

224. The failure to serve the FVIO on Mr Anderson in a timely manner also resulted in Magistrate Goldsbrough's suspension of the Family Court consent order ceasing to have effect from mid May 2013. This was clearly contrary to Magistrate Goldsbrough's intention.

225. Though not appreciated at the time, legally it was open for Mr Anderson, from mid May 2013 onwards, to argue he was entitled to rely on the Family Court consent orders to have weekly access to Luke.

226. No further section 68R order was made and the matter did not return to the Family Court. This case highlights an apparent anomaly within system – i.e. the interaction between *Victorian Family Violence Protection Act 2008* and the *Commonwealth Family Law Act 1975*. In my view the situation requires clarification and/or correction and I will recommend accordingly.

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[203] Transcript, p. 237.
[204] Transcript, p. 302.
[205] Transcript, p. 234.
[206] Coronial brief, p. 3630-3635.
[207] Coronial brief, p. 3630-3635.

227. On the afternoon of 30 May 2013, Mr Anderson appeared, unrepresented, at a remand hearing before Magistrate Holzer at the Frankston Magistrates' Court. FC Taylor attended the remand hearing, but was not required to give evidence before the Magistrate. The police relied on two remand applications during the hearing; one prepared by DSC Cocking and the other by FC Taylor. DSC Cocking's remand application detailed the history of the charges he had laid against Mr Anderson and also the charges issued by FC Topham and SC Anderson. In the weeks leading up to the remand hearing, DSC Cocking had been liaising with the Hastings Police Station in an attempt to arrange Mr Anderson's arrest on the outstanding charges. In anticipation of Mr Anderson's eventual arrest, DSC Cocking commendably prepared and circulated the remand application to assist the Hastings police officers.[208] DSC Cocking also communicated with Ms Batty in the weeks prior to the bail hearing regarding the police's attempts to have Mr Anderson arrested.[209]

228. FC Taylor's remand application detailed the 28 May 2013 incident, Mr Anderson's arrest on 29 May 2013, Ms Batty's concerns for her and Luke's safety, and Ms Batty's opposition to bail being granted to Mr Anderson.[210] FC Taylor's recollection was that one of the main reasons Mr Anderson was refused bail appeared to be because of his lack of address/residence.[211]

229. Mr Anderson was refused bail and remanded in custody.

6 June 2013

230. On 6 June 2013, Prosecutor Cathie, at the Frankston Magistrates' Court heard a mention being called over the loud speaker for a matter in relation to Mr Anderson. While not involved in the matter Prosecutor Cathie spoke with Mr Anderson's lawyer and ascertained that it was in relation to an application for bail. He also ascertained that SC Anderson's charges had not been re-listed, as the warrant for arrest had not been executed.

231. Mr Anderson was not bailed on this day. As a result of this information, on the same day at 1.22 pm, Prosecutor Cathie sent an email to SC Anderson, FC Topham and DSC Cocking updating them in relation to the matter.[212]

232. Again, Prosecutor Cathie's actions are evidence of good policing and communication with a focus on information sharing.

11 June 2013

233. On 11 June 2013, Mr Anderson made a further bail application before Magistrate Bolster in the Frankston Magistrates' Court. Leading Senior Constable Bronwyn Martin (**Prosecutor Martin**) prosecuted the bail application on behalf of the police applicants and Mr Anderson was legally represented.

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[208] See emails from Andrew Cocking to Paul Topham and police officer others dated 7 May 2013, 22 May and 29 May 2013, Exhibit 24, Batty coronial Brief, at pp 3707, 3716. 3727, 3728.
[209] See emails between Andrew Cocking and Rosemary Batty. Exhibit 31 and coronial brief, at pp 2519-2579.
[210] Remand Application (VP Form 286) prepared by Constable Taylor, Exhibit 88, Anderson coronial brief, at p. 2031.
[211] Statement of Clinton Taylor, Exhibit 57, coronial brief, at p693.
[212] Transcript, p. 705.

234. FC Taylor attended Court. FC Topham was on leave and SC Anderson unavailable to attend the hearing. However, SC Anderson's view was that bail should be opposed because:

> *he was continually not turning up and I believed the matters needed to be heard, you know, as soon as possible.*[213]

235. SC Anderson also believed Mr Anderson was in a 'show cause' situation pursuant to the *Bail Act.*[214] FC Topham's Inquest evidence was that he did not believe he discussed the merits of the application with any prosecutor, but did not dispute attempts were made to ascertain his views.[215] Sgt Schroen's evidence was that he discussed the matter with FC Taylor and advised him that bail should be opposed,[216] however it appears vital information that was contained in the emails was not made available to FC Taylor, because there was no formal way to disseminate this information.[217]

236. DSC Cocking offered to attend the hearing but understood he was not required.[218] No criticism is made of DSC Cocking for not attending this hearing. FC Topham's Inquest evidence was that had he been available for the matter, he would have opposed bail because he believed Mr Anderson was in a 'show cause' situation:

> *I've surmised up until this point, that he was an unacceptable risk to society; to Ms Batty. He was – he had no fixed place of abode. He was transient. He was a dangerous man.*[219]

237. FC Topham's assessment was accurate.

238. Prior to the hearing, the Frankston Magistrates' Court mention co-ordinator and the Sergeant on duty, Sergeant Stephen Neville (**Sgt Neville**), reviewed the remand brief against Mr Anderson. Sgt Neville's evidence, based on his handwritten notes, was that he read FC Taylor's and DSC Cocking's remand applications in opposition of bail[220] and also discussed the application with FC Taylor and Mr Anderson's legal representative.

239. By this time, Mr Anderson had secured a residential address.[221] FC Taylor's inquiries determined that the identified person and address were suitable for the purposes of bail.[222] Notably, this was the same address Mr Anderson was served with an intervention order by the Chelsea Police on 27 January 2014. The evidence also suggests that Mr Anderson lived at this address between 11 June 2013 and 27 January 2014.

240. Sgt Neville, while unable to recall specific reasons, formed the view that there were no legitimate grounds to oppose the bail application. Sgt Neville's evidence was that based on his usual practice and having regard to the relevant material, he would have considered the following factors supported Mr Anderson's bail application:

    (a) he had no prior convictions;

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[213] Transcript, p. 272.
[214] Transcript, p. 273.
[215] Transcript, p. 368.
[216] Transcript, p. 426.
[217] Transcript, p. 432-433.
[218] Transcript, p 494.
[219] Transcript, p. 365.
[220] Transcript, p 1191.
[221] address suppressed pursuant to the *Open Courts Act 2013*. Herein after referred to XYZ's house.
[222] Brief Cover Sheet in relation to Gregory Anderson with handwritten notes of Stephen Neville, Exhibit 81, Anderson Inquest Brief, at p. 1967.

(b) he had already spent 12 days in custody and was facing charges which, if proved, would be unlikely to result in a custodial sentence;

(c) he had obtained a suitable address since the bail hearing on 30 May 2013;

(d) the strength of evidence in respect of the two family violence charges against him was low as both were one on one contested matters with no independent witnesses;

(e) he had previously been bailed in respect of the child pornography charges which indicated that the charges did not require immediate detention; and

(f) he had a history of reporting on bail.

241. Sgt Neville's Inquest evidence was that Mr Anderson was nominally required to 'show cause'[223] within the meaning of the *Bail Act.* He reasoned that even though telephoning Ms Batty was a breach of the FVIO, there was no evidence that it had been served on Mr Anderson and therefore technically no breach could be proved.

242. Sgt Neville negotiated bail conditions with Mr Anderson's legal representative. Prosecutor Martin was given the remand brief containing a notation from Sgt Neville that bail was not opposed. Prosecutor Martin's Inquest evidence was that it was her understanding that bail was by consent between the parties but included conditions that Mr Anderson:

(a) reside at the nominated address (XYZ's[224] house);

(b) report to the Officer in Charge of Chelsea Police Station each Monday, Wednesday and Friday between 6.00 am and 9.00 pm; and

(c) not to contact any prosecution witness other than the informant unless allowed by a Family Court Order.

243. In a short hearing, Magistrate Bolster granted Mr Anderson bail with the conditions outlined above.

244. After Mr Anderson was released from custody he commenced living with XYZ. XYZ observed Mr Anderson to be reclusive and chronically angry, except towards Luke.[225]

245. Significantly, Ms Batty was not told of Mr Anderson's release and new bail conditions.[226] She should have been.

246. While not directly contributing to Luke's ultimate death, the police handling of this bail hearing underestimated Mr Anderson's risks. Given his knowledge of the case, FC Topham's risk assessment and views should have been before the Court. In my view, a prosecutor should consider himself/herself duty bound to inform a Court of an assessment of risk made by an officer with significant knowledge of a case and of the risks attributed to a particular person (Mr Anderson). Further, in my view, it is not appropriate to predict that bail is likely and therefore not oppose it when there is a risk assessment as cogent as that made by FC Topham, based as it was upon his interactions with the parties. Equally, in my view, prosecutors should not decline to oppose bail (where there are

[223] Transcript, p. 1176.
[224] Name suppressed pursuant to the *Open Courts Act 2013.*
[225] Exhibit 83 - Statement of XYZ. Coronial Brief, at pp 639-641.
[226] Transcript, p. 238.

proper grounds for opposition) simply because it is anticipated that a particular judicial officer will grant that bail.

25 June 2013

247. On 25 June 2013,[227] during Ms Batty's first session with Dr Heath, she provided a detailed history of the family violence and legal proceedings (including FVIOs and breaches) related to Mr Anderson. Dr Heath raised her concerns with Ms Batty in relation to the seriousness of the specificity of the threat and explained to Ms Batty that in her view this revealed a different style of thinking and intent.[228]

248. Ms Batty also told Dr Heath about the alleged threat Mr Anderson made to Luke's football coach. However, she did not mention the knife incident involving Luke.

249. Dr Heath formed the opinion that the situation that Ms Batty was then experiencing and coping with was extremely high risk and she needed more than two sessions to support and assist her. Ms Batty detailed to Dr Heath Mr Anderson's threat to kill her if she prevented him from having contact with Luke. Dr Heath's opinion of Ms Batty was that she was terrified of Mr Anderson.

250. A theme throughout their discussions was that Ms Batty maintained she wanted Luke to continue to see Mr Anderson. Dr Heath questioned Ms Batty in relation to Luke's safety. Dr Heath's Inquest evidence was that Ms Batty was adamant on each occasion that Mr Anderson would not hurt Luke because he loved him.

251. Ms Batty advised Dr Heath that while she had always had to juggle Mr Anderson's behaviour she had chosen to support him as Luke's father because in some ways he was a good dad.[229]

252. It was Dr Heath's evidence that Ms Batty firmly stated that she believed that Mr Anderson would only hurt her and not Luke. Dr Heath's evidence was that Ms Batty also told her that contact between Luke and Mr Anderson occurred in a public place and Ms Batty believed this added a layer of safety.

253. During her sessions with Ms Batty, Dr Heath continued to raise the issue of Luke's safety and suggested to her that it was possible that as Luke got older he may want to say 'no' to his father and he was highly likely, with time, to also be the subject of Mr Anderson's anger and rage. Dr Heath's Inquest evidence was that her purpose in raising this was to get across to Ms Batty that Luke was not necessarily safe. Dr Heath's Inquest evidence on this issue was that Ms Batty nodded and acknowledged her comments and said she understood.[230]

254. Dr Heath's approach was in my opinion, entirely appropriate.

255. Dr Heath's evidence was that, from the information she was provided by Ms Batty, she believed Mr Anderson was showing narcissistic and anti-social personality disorder traits. Dr Heath qualified her evidence with the caveat that she had never seen Mr Anderson.[231]

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[227] Ms Batty had a total of nine sessions in 2013: 25 June 2013, 3 July 2013, 10 July 2013, 18 July 2013, 25 July 2013, 8 August 2013, 15 August 2013, 30 August 2013, 17 September 2013.
[228] Transcript, p. 1011.
[229] Transcript, p. 1010.
[230] Transcript, p. 1005.
[231] Transcript, p. 1004.

I felt that he certainly was showing characteristics or traits of personality disorders. I - I can't diagnose from a distance.[232]

256. As part of her sessions with Ms Batty, Dr Heath discussed personality disorders and cautioned Ms Batty about a person's propensity to fall into relationships where the other person had personality disorders.

257. Dr Heath formed that opinion that Ms Batty believed that Mr Anderson could be somewhat placated by being allowed access to Luke. To this end, Ms Batty wanted to support their father/son relationship but at the same time wanted the Court to cease Mr Anderson's contact with Luke. Dr Heath's Inquest evidence was:

And I saw that as an - um anomaly, insomuch as um she did want the courts to say that he couldn't, because she didn't feel strong enough to say no to him, um however, ah, it - she also wanted him to have access. So that was always at odds, as far as I was concerned, in terms of you know, um wanting to support the father/son relationship, and - and I sort of always suspected that had something to do with Rosie's background, with regards to having lost her mother at - at an early age, um and so by virtue of that, she wanted to ensure that Luke would have a relationship with his father, um however, um given the circumstances, it was all at a bit of odds there.[233]

258. Dr Heath's Inquest evidence was that during the course of her sessions with Ms Batty:

within the dialogue there would be red flags or what I would call a red flag, something that would make me prick my ears up and think, oh gee, that concerns me and - and I would ask a question or I would seek further clarification about it and Rosie was always absolutely sure that Luke was not at risk. Quite adamant actually and I had no reason to - to disbelieve her, from the information that I was being given.[234]

259. Dr Heath's Inquest evidence was that, while not informed of the knife incident, it crossed her mind as to whether she should notify the DHS regarding the concerns she held about Mr Anderson's possible risk to Luke. Dr Heath's considered reason for not notifying the DHS was that Ms Batty was, and would be considered to be by the DHS, a protective mother.[235]

260. Dr Heath was a good witness and in my view, it would not be fair to criticise her actions, given what Ms Batty told her.

3 July 2013

261. On 3 July 2013, Mr Anderson made a variation application in respect of the FVIO made on 24 April 2013, to either remove Luke's name from the order or allow him contact with Luke.[236] Magistrate Holzer granted Mr Anderson leave to apply for this variation.[237] The new facts and circumstances upon which Mr Anderson relied upon for this application are unknown.[238]

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[232] Transcript, p. 1011-1012.
[233] Transcript, p. 1002-1003.
[234] Transcript, p. 1001.
[235] Transcript, p. 1015.
[236] Application for Variation made by Gregory Anderson dated 3 July 2013, Exhibit 37.
[237] See Transcript, p 633, lines 16-17 and page 643, line 14 (Treverton).
[238] *Family Violence Protection Act* 2008, s 109 (1) and (2) requires that such applications may only be made when there has been a "change in circumstances" since the FVIO was made and the change may justify a variation or revocation of the order.

22 July 2013

262. On 22 July 2013, Leading Senior Constable Ross Treverton (**Prosecutor Treverton)** appeared before Magistrate Goldsbrough on behalf the FVIO police applicant, SC Anderson, in relation to Mr Anderson's application to vary the FVIO. This hearing was also the return date for previous applications before Magistrate Goldsbrough. Mr Anderson was legally represented, Ms Batty was unrepresented.

263. While SC Anderson did not attend the hearing, Prosecutor Treverton noted her memorandum opposing Mr Anderson's variation application and Prosecutor Cathie's 24 April 2013 hearing notes.[239] Although he did not specifically recall, Prosecutor Treverton's Inquest evidence was that, per his usual practice, he requested the Court Registrar to conduct an 'all courts' search to establish whether Mr Anderson had any pending criminal matters.[240] The Registrar advised Prosecutor Treverton that charges were pending against Mr Anderson in relation to a threat to kill and an assault. After reviewing the file, Prosecutor Treverton spoke with Ms Batty in the Court foyer about the FVIO variation application, his role and what Ms Batty hoped to achieve from the hearing. This was one of three discussions Prosecutor Treverton had with Ms Batty over the course of the day. Prosecutor Treverton's Inquest evidence was that Ms Batty was visibly upset during their initial conversation. As such, he directed her to the family violence support worker, Christine Allen who spent approximately 45 minutes with Ms Batty whereby she added to her CRAF risk assessment and provided her support in the Court.[241] Christine Allen did not share her risk assessment with any other persons.

264. Prosecutor Treverton also introduced Ms Batty to a solicitor at the Court so that she could seek independent legal advice. Ms Batty's Inquest evidence was that she did not seek any legal advice on this day, but subsequently made contact with the lawyer and received advice:

> *My initial response was negative, I resented the fact that it would cost me money to - that I didn't have to be able to get help. So I initially was quite dismissive but I did take the card and they were really kind to me and I subsequently made contact.*[242]

265. Prosecutor Treverton advised Ms Batty that he intended to oppose Mr Anderson's variation application seeking to remove Luke from the FVIO. Ms Batty told Prosecutor Treverton that, while she wanted Luke to remain on the FVIO, she also wanted Luke to have a relationship with Mr Anderson and did not oppose "*safe and sustainable*" contact.[243] Prosecutor Treverton's Inquest evidence was that although his initial view was to oppose Mr Anderson's variation application, this changed following his discussion with Ms Batty about what she sought to achieve.[244] In their discussion about "*safe and sustainable*" contact, Ms Batty indicated that she would be comfortable with Mr Anderson having contact with Luke at sporting competitions where there were plenty of people present.[245] Ms Batty's

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[239] Supplementary Statement of Leading Senior Constable Ross Treverton, Exhibit 36, Batty Inquest Brief, at p706.5A; Transcript, p 631.
[240] Transcript, p 657.
[241] Coronial brief, p. 1566.
[242] Transcript, p 41.
[243] Statement of Leading Senior Constable Ross Treverton, Exhibit 35, Batty Inquest Brief, at p706.2.
[244] Transcript, p 662, lines 5-11 (Treverton).
[245] Statement of Leading Senior Constable Ross. Treverton, Exhibit 35, Batty Inquest Brief, at p706.2.

Inquest evidence explained in full her reasons for this. In essence, she wanted Mr Anderson to enjoy a father/son relationship at cricket and football training, along the lines that other parents did. She felt that it was safe if it was in an open and public setting. She believed it was a reasonable compromise. Ms Batty's Inquest evidence was:

> *...we were trying to work out a way that perhaps Luke could access - Greg could have access to Luke in a safe way and ... Greg always went with Luke to cricket and football ... So I thought that that was more of a natural environment for Greg and Luke...I guess there was other parents there ... that it was open, public, it was during the day. I guess it's just because of its - it being a public place, that was where it was deemed that it would be a safe idea....* [246]
> *...It seemed like a reasonable compromise. You know, I really struggled with having to maintain that boundary with Greg, that he wasn't allowed to see his son. I was terrified about saying no to him. It was really hard to say no to him. Nobody understood that.*[247]

266. Prior to the Court being advised of Mr Anderson's child pornography charges, Prosecutor Treverton advised Magistrate Goldsbrough that Ms Batty did not oppose "*safe and sustainable*" contact in a public setting for sport events and unlimited telephone contact. Magistrate Goldsborough acknowledged that Ms Batty was looking for a controlled arrangement with Mr Anderson that would permit father/son contact at sporting events and explained the relationship between family violence legislation and family law legislation. The transcript from the hearing recorded the following exchange:

Police Prosecutor:	*Thank you, Your Honour. I spoke to Ms Batty over lunch and she has also had the opportunity to talk to [a lawyer whose name has been redacted] briefly. She's not opposed to contact per se. However, understandably, she wants it to be in a safe and sustainable manner. She has some concerns about Mr Anderson's behaviour over the past 12 months. There are outstanding criminal matters which have yet to be finalised. I think the return date on those is early August. Her proposal at this stage is for – or her preference is for the Family Court to finalise, formalise the access matters, essentially because they have the opportunity to take the welfare reports and the child psychology reports. So that's uppermost in her mind and she understands that that may be two or three weeks away from occurring, even on an urgent application. In the interim she understands that Mr Anderson has a real interest in Luke's sporting involvements and she was hopeful that contact could be made during the weekends while those sporting involvements took place. As I understand it, Luke plays football. He has cricket and he has Little Athletics every weekend, depending on whether it's a Saturday or Sunday and occasionally it's both. So her resolution would be that he, the 25-metre distance prohibition would be dropped during that time, that Mr Anderson could have that time with Luke because of his interest and involvement, and that during the week there would be unlimited telephone contact, as it were.*
	.....
Her Honour:	*Thank you. Both of you know the difference between family violence legislation and family law legislation, but for the parties family violence legislation is an assessment of risk and decisions are made by magistrates along the way to ensure that there could be no family*

[246] Transcript, p. 39.
[247] Transcript, p. 40 (Note revised transcript having listened to the audio).

violence that could occur again in the future either to or in front of Luke to Ms Batty, or to Ms Batty not in Luke's presence or hearing. As it happened, I was the person who dealt with the matter and heard all of the evidence in relation to the variation over some considerable period of time. And it was based on all of that evidence, some of which I anticipate may be part of criminal matters, that the decision had been made. Though I haven't now read back through all those notes today but glanced through them, it was certainly my decision to – and Mr Anderson should know that, that I'm the person that decided, based on the evidence, that I needed to ensure that nothing could happen until the matter returned to court. And that's what a magistrate is obliged to do by the act. It makes it quite clear that if I am concerned I must stop contact until the matter can be properly looked at. In relation to family law, the Family Law Act is a federal act that provides for operational decisions about children but takes into account matters of best interests, including family violence. So there's a different angle on the legislation. These proceedings are not intended to provide opportunities for assessment of child contact but they can practically in many ways. So today, based on what I had heard and what I see here and taking into account the distinction in the legislation – I had heard all about the sporting events and the involvement with Mr Anderson with them and his interest in following through with them. And it may be that contact with Luke in that environment with an order not to discuss any legal proceedings with him, if it's not already there, and simply to enjoy contact at these events and surrounding them is what I'm hearing Ms Batty is prepared for today, and telephone contact which would also be required not to have any discussion or communication about legal proceedings during that contact. I would be certainly moved to make those variations today.

Mr Anderson's Lawyer: *As the court pleases.*

Police Prosecutor: *If Your Honour pleases.*

Her Honour: *Ms Batty, that's what you're prepared for today?*

Ms Batty: *Yes.*

Her Honour: *Okay, that's good. It's important that you've had that opportunity to think about it over lunch as well, because there is no obligation that you deal with that today and it's important that you feel comfortable, because you're not legally represented as well. I appreciate police are assisting you in the application as they were the original applicant.*[248]

267. Ms Batty described Magistrate Goldsbrough's comments as follows:

> *I was really relieved when the Magistrate addressed Greg in open court and said to him: 'Rosie has been really supportive of your relationship with Luke'. She then made it really clear to him that it was she who had made the decision about no contact. Again, this made me feel relieved: it made it clear that an independent person had made the decision about what contact Greg would be permitted to have with Luke...*[249]

268. The hearing resumed after lunch, during which Mr Anderson's lawyer revealed to the Court that Mr Anderson had pending child pornography charges. Until that time Ms Batty, Prosecutor Treverton and Magistrate Goldsbrough were unaware of these charges. Magistrate Goldsbrough commented:

> *I must say, puts a different complexion on the issue of risk, as to whether this should be varied at all until after the first... It's a surprise to me. It makes me feel differently about varying this*

[248] Inquest exhibit 7.
[249] Transcript, p. 44.

order....My view is that I'm not prepared to vary this order until there's some certainty about that charge and an assessment of risk or, I must say, I'd be failing in my duty.... I haven't heard what the others say, unless they want to talk me into it, but I intend to tell you that's my preliminary view.[250]

269. At this time, the hearing was adjourned to allow Prosecutor Treverton to have a third discussion with Ms Batty. During this discussion, they agreed to oppose any FVIO variation that allowed Mr Anderson personal contact with Luke. After being advised of Mr Anderson's child pornography charges, Prosecutor Treverton advised that Ms Batty opposed any variation to the current access arrangements. Ms Batty was prepared to countenance telephone contact but Magistrate Goldsbrough refused to allow it in the light of the revelation about child pornography. Ms Goldsbrough accepted that Ms Batty wanted Mr Anderson to be in a position to attend sports training, because it has been important to him.

270. Magistrate Goldsborough stated that she would only be prepared to consider allowing Mr Anderson to attend sporting events if Ms Batty was comfortable with it. Ms Batty agreed, stating that Mr Anderson was already doing so and respecting the restrictions in place. Ms Batty also commented that Luke played and trained harder to *"please his dad ... since Luke's birth Greg has seen Luke on a weekly basis and I understand that that's an important thing for him, and it's an important thing for my son. I just want my son to be safe and to be happy."*[251]

271. The transcript recorded the following exchange:

Police Prosecutor:	*Thank you, Your Honour. Certainly in light of what has come up, Ms Batty is reluctant to give approval to a variation, particularly in a situation where the Family Court may well require some sort of supervision if those matters were to be dealt with there. So the application would be opposed in terms of any variation being granted now with access. She's certainly of a mind that telephone contact can be made up until any time when the matters are heard and determined.*
Her Honour:	*I have a different view about telephone contact and I wouldn't be allowing it.*
Police Prosecutor:	*Very well, Your Honour.*
Her Honour:	*It's, in fact, I would have been more interested in allowing him to watch some of the football, cricket, so that Luke knows his dad is there and he can see it and still enjoy that, because it has been so important to him. I've had an opportunity to reread through my notes and the concerns outlined that I had, based on the evidence I heard – and again, it was clear to me that Ms Batty appreciated that Mr Anderson was very connected with his son about those matters. But the level of threat and allegation was significant, some of which only would be part of these criminal matters that have been outlined.*
	....
Her Honour:	*The only question, I think, remaining for Ms Batty and the prosecutor, is there a practical way that Mr Anderson – and people would be comfortable that Mr Anderson attended these events and watched the football. I presume, by the sound of things, Luke is a competent athlete, by all the things he does, and that Mr Anderson could happily attend there, be bound by an order not to discuss any other matter with Luke about proceedings or documents or so on but that could be in contact as a parent would at some of those events. So that's the context that I would be prepared to consider*

[250] Inquest exhibit 7.
[251] Inquest exhibit 7.

something today if you are. And if not then we're going to leave it till the 9th.

Mr Anderson's Lawyer: I'm getting some nods, Your Honour.

Her Honour: *Thank you. Do you feel comfortable with that?*

Ms Batty: *Yes, thank you, Your Honour.*

Her Honour: *How do you think that that would operate? You know, attend, even speak?*

Ms Batty: *Mr Anderson has already been attending the football and respecting the restrictions in place.*

Her Honour: *Great. Good news.*

Ms Batty: *I know my son is pleased to see him there and also seeks to play harder and try harder because he wants to ---*

Her Honour: *To please his dad.*

Ms Batty: *To please his dad. It is confusing for him and he feels torn.*

Her Honour: *Yes. Sadly, that's normal.*

Ms Batty: *But I do understand that since Luke's birth Greg has seen Luke on a weekly basis and I understand that that's an important thing for him, and it's an important thing for my son. I just want my son to be safe and to be happy.*[252]

272. In her Inquest evidence, Ms Batty explained her reasons, after learning of the child pornography charges, for not opposing the variation of the no contact FVIO to allow Mr Anderson to have contact with Luke as follows:

> *Well - and so I felt that with the pornography, if he was in a public place like football and cricket, he couldn't be subjected to grooming and other behaviours that may be inappropriate. Although I'm not an expert in paedophilia or any of those things, I felt that if Luke, if he wasn't able to see Luke and take him away privately, have him in his car or show him things, that it would be safe.*[253]

273. Her Honour amended the FVIO on an interim basis to allow Mr Anderson to have contact with Luke at sporting events. This represented a loosening of the previous order she had made on 24 April 2013.

274. There was some confusion regarding the FVIO's operation, particularly whether it applied only to contact on weekends or also weekdays. Order 15 of the FVIO accorded with what Magistrate Goldsbrough said during the hearing, that it only applied to weekends. However, Order 16 for unknown reason referred to weeks, not weekends.[255] Ms Batty's Inquest evidence was that she believed Mr Anderson was able to attend sporting events on weekends and practice sessions during the week.[256] Ms Batty also understood the type of contact Mr Anderson could have with Luke included:

> *...when you're at footy training or footy matches, there are opportunities for him to hug his son or have a quick chat, but the rest of the time, they're playing or they're being coached by the coach, there's parents there, there's the team's other parents there, they're on the pitch. He never got in a car, he never removed himself. He was on the pitch and if his dad went up and gave him a hug and had a quick chat with him, I saw there was nothing wrong with that because he was in my line of sight, in the public forum, on the oval, where everybody else was.*[257]

275. Magistrate Goldsbrough ascertained from Mr Anderson that he had not contacted the Men's Referral Service and strongly urged he make contact. In answer to Magistrate Goldsbrough's questions, Mr

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[252] Inquest exhibit 7.
[253] Transcript, p. 44.
[255] Transcript, p. 106.
[256] Transcript, p. 108.
[257] Transcript, p. 110.

Anderson said that he had no formal counselling support and was not subject to a mental health care plan.

276. At that court location, Magistrate Goldsbrough had no power to mandate Mr Anderson attend counselling or a men's behaviour change program at this point in time. The availability to magistrates of a power to mandate men to attend counselling or men's behavioural change programs was historically limited to a number of courts. However, I note that there is now a broadening of that service.[258] Magistrate Goldsbrough's Inquest evidence was that it was her intention, in issuing the warrants directed to Mr Anderson, to have him brought before the Court. In her view, Mr Anderson could then have been referred to the psychiatric nurse at the Frankston Magistrate Court (although this was something she could only encourage, not require). Magistrate Goldsbrough was asked:

> *Are there other things that can be done to make perpetrators more accountable either using the armoury we already have, the bail system, the remand system, or is there an innovation that you've become aware of that would also assist?*[259]

Her evidence was:-

> *Ms Goldsborough: As far as the court's concerned having respondents or accused's before the court, in my view, is the key element. There needs to be judicial oversight and support. Um my purpose in uh issuing warrants for Gregory Anderson to only be bailed by a court was to have him back before the court. Um in my observation and my assessment he needed an urgent uh medical mental health assessment. I intended our forensic uh psychiatry nurse at Frankston undertake that task when he was brought to the court. In - - -*
>
> *Ms Doyle: Can I just pause and ask you is that something you could've mandated or only requested?*
>
> *Ms Goldsborough: Um I could've encouraged by saying that these - I want you, as I do now regularly. 'I'd like our nurse to see you or assist,' and then I'll have that report and I can make some uh decisions. The (indistinct) - the nurses are very experienced at dealing with um those in custody and I can require her to go and see them and we'll see if a report can be obtained. So there's an element of coercion about it, to use a - a particular word. Um in those circumstances there, after an assessment may have been obtained, um then there are factors - sorry services of the court, including what's called credit bail or court integrated services programs which are bail programs where there is regular contact with the particular judicial officer, with a support worker, a court clinician who can refer to and require, via that report, attendances uh for GP's, mental health care plans, um to live at a certain address, to have drug treatment, for example...that's a bail program, and of course it's a supported bail program. If there are breaches of that program and uh failure to attend then often bail is considered to be revoked, depending on what else has occurred. Um in my view men's behaviour change programs um are critical. I find in dealing with offenders in family violence related matters who are often um agitated, wild at court, really need to be engaged and treated with fairness and equity to understand they're part of the system. I want the respondents at court where I can send them to a response worker, make sure they've got legal advice and ensure they're part of the system. That way I can also give further information to*

[258] Frankston and Moorabbin Magistrates' Court were gazetted on 20 October 2013 as court locations at which magistrates could mandate participation in these programs. I was informed of this after the Inquest.
[259] Transcript, p. 1723

> *make an assessment of what's required to manage risk and manage risk of further family violence or death. Um there are many processes at court that can assist, uh we have a mental health (indistinct) as well that I've said in some circumstances, I'm one of the magistrates who sit in it, who could manage in a more particular way, those severely (indistinct).*[260]

277. I fully agree with Magistrate Goldsbrough's emphasis on the importance of engaging men such as Mr Anderson in the system. She spoke of a number of ways that can be done. The evidence is that not all courts are provided with the resources to direct men to programs or connect them with services. Historically there has been a highly differential availability of services depending on court locations. This is unsatisfactory, it limits the availability of tools to magistrates and it inhibits them in engaging perpetrators with the system in the ways discussed by Magistrate Goldsbrough. Expansion of services inevitably requires resources, but it is a topic on which I will make a specific recommendation for change. There is a need to ensure that magistrates across the State, in dealing with family violence cases, have available to them an appropriate suite of options ('the armoury' as Magistrate Goldsbrough put it), to deal effectively with the cases before them in a way that maximises the prospects of protecting those on intervention orders.

278. I agree with Magistrate Goldsbrough's evidence that:

> *opportunity for engagement, insight, and hopefully even a moderate change and approach to that sense of privilege and coercive control that others have talked about here and that's particularly relevant in relation to whether they're likely to obey an intervention order, if they're likely to turn up to court again, or obey the bail terms that I'm ordering.*[261]

279. Magistrate Goldsbrough's comments, in my view, are accurate, insightful and useful. She was the one who first identified the red flag of danger in reflecting on Ms Batty's evidence of the knife incident. She was prescient in her assessment of the case. She was highly attuned to the emerging risks. Magistrate Goldsbrough raises an important question, 'How does society engage men who are actually or potentially dangerous, and possibly escalating to a high level of risk of family violence?'. On the evidence in this case, and other cases, it is clear that every opportunity for engagement needs to be taken – any chance to counsel, treat (for example in a mental health context), modify or change behaviour should be taken. It is a central lesson from this case.

280. Magistrate Goldsbrough also ordered that the matter be listed for a contested hearing on 9 September 2013.

281. Ms Batty later obtained legal advice[262] in relation to this hearing. Part of that advice was that she notify the DHS to allow them to consider whether to make an application to the Children's Court for a protection order.[263] The legal advice also suggested that the DHS might be able to provide Ms Batty

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[260] Transcript, p. 1724-1725
[261] Transcript, pp. 1803 – 1804.
[262] It is understood that Ms Batty waived her right to legal professional privilege in giving evidence about these matters at the Inquest and was legally represented when she did so.
[263] Transcript, p. 42.

with more information about Mr Anderson's child pornography charges. Ms Batty did not retain her lawyer due to insufficient funds.

282. After this hearing, Ms Batty sought to obtain information from Victoria Police about the child pornography charges and was advised they could not release any details to her. Ms Batty's evidence on this issue was:

> *I couldn't understand that when I wanted to protect Luke fully that I was not allowed to have access to information that enabled me to understand the risks.*[264]

283. I note the evidence in relation to the reasons why Ms Batty was not told about the child pornography charges by Victoria Police. I do not intend to comment on the respective police officer's reasons for not telling Ms Batty, save to say that clearer guidance should be given to police officers by Victoria Police in relation to such matters. In my view, such information should be shared. In any event, by 22 July 2013, Ms Batty knew of the child pornography charges and she acted on that information appropriately by contacting the DHS.

25 July 2013

284. On 25 July 2013 Luke attended his first of four sessions with Ms Perry. At no time was Ms Perry advised of the alleged knife incident.

285. During this initial session Ms Perry explained to Luke that she was dedicated to him, as his counsellor, that he was her priority as opposed to his mother or father or any other person. Luke cried quietly as Ms Perry explained client confidentiality and that she would not be discussing the sessions with anyone unless she was concerned for his or someone else's safety, and that any disclosure would be with his knowledge.

286. During this session, Luke drew scribbles and spoke about his worries for his mother's wellbeing and her stress levels. Luke also spoke about his own shame and worries regarding his father's mental health issues and homeless situation, that he was not able to share these worries with his friends.

287. Consistent with Dr Miller's comments that Luke was a parentified child with respect to his father, Luke told Ms Perry that he felt responsible for his father's wellbeing, telling her:

> *I think I am the only thing he is living for*[265]

288. Ms Perry noted that Luke was afraid that his father might have to go to jail[266] and that his mother might die. Luke did not indicate that he feared for his own safety, in relation to his father and referred Mr Anderson attending his sporting events and practice.[267]

July 2013

289. During a medical consultation at the Eramosa Medical Clinic, possibly in July 2013, Ms Batty again mentioned the knife incident. This time to general practitioner, Dr Farlow. While Dr Farlow had not received any formal training in family violence she told Ms Batty that sometimes disgruntled ex-

[264] Coronial brief, p. 1506.
[265] Exhibit 67 – Witness Statement of Ms Kate Perry (undated) and Coronial brief p. 2500.2).
[266] Exhibit 67 – Witness Statement of Ms Kate Perry (undated) and Coronial brief p. 2500.2).
[267] Coronial Brief, p. 2500.2.

partners feel that the best way they can hurt their ex-wives is to hurt her child such as situations involving Darcey Freeman and the Farquharson boys. Dr Farlow's Inquest evidence was that this discussion was not a specific warning made with any knowledge of a recent escalation of behaviour by Mr Anderson, rather that she was acting as a devil's advocate and bringing the possibility of harm to Luke to Ms Batty's attention.

290. Dr Farlow recalled that Ms Batty's response was that Mr Anderson would never hurt Luke because he loved him.[268] Dr Farlow did not form the impression, at the time of this discussion that the knife incident had resolved.

291. Dr Farlow did not conduct a formal risk assessment for Luke or Ms Batty with respect to harm from Mr Anderson. However, in response to questions asked by Ms Doyle SC, Dr Farlow stated it would be beneficial and feasible, depending on time constraints, for medical practitioners to be part of a multi disciplinary team or panel convened, with the patients consent, to assess a particular family's risks arising from family violence.[269] I agree.

7, 8, 12 and 13 August 2013

292. On 7 August 2013, as a result of learning about the child pornography charges, Ms Batty made a telephone report to Child Protection (part of the DHS) pursuant to section 183 of the *Children, Youth and Families Act 2005* (**CYFA**).

293. Ms Batty's Inquest evidence was that she was confused and did not understand how all of the orders worked and her legal advisers had expressed similar confusion. At the time she made her notification and involved Child Protection she thought they would protect Luke and that she did not know who else to go to for help.

> *I was hoping someone, someone was going to step in and help me protect Luke and take some weight off my shoulders about me having to constantly be the one to say to Greg, no. I had hoped, based on her suggestion that maybe they would take out a protective order for me because I couldn't afford to go through the legal process from the family law - through the family law court.*[270]
>
> *I didn't want all the onus and responsibility to be on me. I wanted support. I wanted other people to step in and make some decisions, so it wasn't all me, facing Greg. Having to deal with the wrath of him. I wanted other people to be making decisions to help me understand what was the best for Luke. I no longer knew, I was stressed out of my brain by this point. I've been in to court, I don't know how many times, I've lost count. I dealt with more police than you'll ever know. I'd been counselling, so I'm sick of counselling. The only thing that people can suggest is you have counselling. The only thing that Child Protection insisted on was I had counselling and Luke had counselling. No one spoke to Greg. If he stopped being violent I wouldn't need the bloody counselling. There's no - there was never - the only suggestion they can have is have counselling. It's the only solution. And then they make sure that you do it. It is a help, but it's not the solution. All it is, is a bloody help. It stops being helpful because the violence doesn't stop and yet you're supposed to have more counselling and then you're expected to keep controlled. You're not supposed to show emotion in court, you're not supposed to get upset, you've got to keep it together all of the time because if you show your true emotion the police lose interest, they're dealing with an irrational woman. If you deal like this in court people*

[268] Coronial brief, p. 3776. Transcript, p. 1224.
[269] Transcript, p. 1234.
[270] Transcript, p. 111.

can't handle it, but it's normal, it's normal for someone to get to the point where they can't handle it anymore. To get to this point, because you have no solution, there is nowhere else to go, there is no one else to help, and you've got a piece of paper that doesn't do anything and that is limiting what you can do.[271]

294. This was Ms Batty's moment of raw emotion in the Inquest. Her anguish and frustration were palpable. I do not and would not criticise her for the emotion she showed in Court. She had after all endured an extraordinarily harrowing experience. In this jurisdiction, persons in her situation can be expected to display emotion in hearings and the Court is expected to sensitively accommodate the next of kin who are giving evidence. It needs to be remembered that the Inquest was only eight months after Luke's death.

295. The DHS intake report, contained in the DHS' electronic Client Relationship Information System (**CRIS**), recorded that Ms Batty was concerned about Luke having access with his father who was facing criminal charges for assaulting and threatening to kill Ms Batty and child pornography charges. A Child Protection Intake worker contacted DSC Cocking because Ms Batty advised that he was the police officer dealing with the child pornography charges. That same day DSC Cocking, by email, confirmed that he had charged Mr Anderson, and the images were mostly of pre-teenage girls in suggestive poses.

296. On 8 August 2013, the Child Protection Intake worker consulted with the Team Manager and it was determined that the concerns raised by Ms Batty needed further investigation. Luke's case was transferred to an Investigation Team and a Victoria Police criminal records check revealed that Mr Anderson had charges pending, but no convictions.

297. On 12 August 2013, Luke's case was allocated to Ms Portelli. Ms Portelli, consistent with the Best Interests Case Practice Model **(the BICPM),** and her standard practice, conducted a preliminary risk assessment pertaining to Luke based on the information that had previously been uploaded onto CRIS. Ms Portelli's Inquest evidence was that this was the first of a number of risk assessments she completed concerning Luke. Ms Portelli's Inquest evidence was that when formulating a preliminary risk assessment she looks at any previous involvement with Child Protection to see what has occurred, what strategies were used and whether they were successful. She stated that it was also her habit to familiarise herself with any new information received at the time of a report. From her reading of CRIS, Ms Portelli could see that Luke was not residing with Mr Anderson and was having limited contact with him because of the FVIO. Her preliminary risk assessment concluded that Luke's risk of sexual assault by his father was low, however she considered that she required further information before any final assessment could be completed.

298. Ms Portelli's Inquest evidence was that she had not received training in how to undertake a risk assessment since she had undertaken her degree in social work; had never been trained in the CRAF; and had never been trained in the content of the *Child Protection and Family Violence Guide* 2005

[271] Transcript, p. 117-118.

although she conceded that it was a resource available to her.[272] Nonetheless, Ms Portelli's stated, and I accept, that as part of her role she conducts risk assessments on a daily basis. Her evidence, which I also accept, was that Child Protection risk assessments are holistic and take into account both static and dynamic risk factors. She stated that risk assessments conducted by Child Protection are guided by the BICPM, which provides a framework for determining risk to children. She also said that the Child Protection practice reflects that risk assessments must be ongoing and child centred.

299. In planning the first home visit, Ms Portelli considered all known risk factors, identified those that may increase risk and those that may decrease it, both present and in the past, including any protective factors.

300. Ms Portelli's evidence was that Child Protection practitioners frequently work out of the office and do a lot of analysis and planning through discussion, therefore not all risk assessments are recorded in writing or documented in the CRIS file.[273]

301. The first record Ms Portelli made about Luke's case on CRIS was on 13 August 2013 after she telephoned DSC Cocking. Ms Portelli wanted to obtain further information about the child pornography charges because, at that stage, they were the primary reason for her investigation as she had not been advised of the alleged knife incident. DSC Cocking confirmed that the Category 1 images were of females aged between 10 and 12 years, unknown to Mr Anderson. This information contributed to Ms Portelli's ongoing risk assessment as it meant that Luke did not appear to fall within Mr Anderson's target group for sexual interest given his gender. After speaking to DSC Cocking, Ms Portelli completed the 'Case Information and Response Plan' document in CRIS allowing her to add to her risk assessment. Ms Portelli determined that the next part of her investigation was to arrange a home visit with Ms Batty. The interaction between DSC Cocking and Ms Portelli demonstrates appropriate information sharing between the agencies within the system.

14 August 2013

302. On 14 August 2013, FC Topham and Leading Senior Constable Scott Chalmers intercepted Mr Anderson and issued him with a penalty notice for driving an unregistered vehicle. Mr Anderson was abusive, aggressive and intimidating toward the police officers, in particular toward FC Topham.

303. The police officers conducted a LEAP check on Mr Anderson and were not alerted to any unexecuted warrants. The fact that the warrants were not on LEAP resulted in a missed opportunity for the police officers to execute them and to take steps to bring Mr Anderson to account.

17, 22 and 24 August 2013

304. On 17 August 2013 Luke attended his second session with Ms Perry. Luke was happy, calm, talkative, and immediately wanted to engage in creative activities. Luke discussed topics such as his extra-curricular activities.

[272] Transcript, p 1048.
[273] Coronial brief, p. 639.2.

305. On 22 August 2013 Ms Portelli had her first conversation with Ms Batty by telephone. Ms Portelli's notes record that the focus of Ms Batty's concerns related to Luke's contact with Mr Anderson, that she had a FVIO in place (which Mr Anderson was contesting) and that Mr Anderson had attended Luke's scout group, which Ms Batty believed was against the FVIO. Ms Batty also stated that there was a history of family violence with Mr Anderson and that she was fearful for her own safety.

306. On 24 August 2013 Luke attended his third session with Ms Perry. Luke was unsettled on arrival. Luke advised Ms Perry that he had been using his journal but he did not want to show it to her. Luke was reluctant to talk and answered prompting questions with "*I don't know.*"[274] During this session Luke spoke about how he disliked having to take the responsibility to telephone his father to arrange visits because it made him feel different from his friends.[275]

28 August 2013

307. On 28 August 2013 Ms Portelli attended Ms Batty's home with her colleague Ms Annie Wheeler (**Ms Wheeler**) for the first home visit, which lasted approximately 70 minutes.

308. Only Ms Batty was present, Luke was at school. Ms Portelli explained the role and mandate of Child Protection and that she and Ms Wheeler were from a specialist team within Child Protection.

309. Ms Portelli's evidence was that she felt that she was able to build rapport with Ms Batty throughout the home visit. Her general impression of Ms Batty was that she was intelligent, open and honest. Further, Ms Portelli felt that Ms Batty was able to articulate and verbalise how she was feeling and she did not have the impression that Ms Batty was telling her what she thought she wanted to hear.

310. Ms Portelli's evidence was that she did not feel constrained in sharing the information about the pornography charges with Ms Batty as the CYFA permits protective interveners to share such information. Ms Portelli wanted to ensure that Ms Batty was fully aware of the child pornography charges. She also wanted to ascertain if there were sufficient supports and protection in place for Luke and Ms Batty. This was the first time Ms Batty learned the precise nature of the child pornography charges. Ms Portelli also discussed with Ms Batty the criminal charges and the possible outcomes if Mr Anderson was convicted. On each of these matters, Ms Portelli's approach was in my view, sound and appropriate.

311. Ms Batty spoke about previous family violence and indicated that she was now strong enough to report these matters to the police. Relevantly, Ms Portelli noted that Mr Anderson had never physically harmed Luke. The history Ms Portelli gained from Ms Batty indicated that Mr Anderson had assaulted Ms Batty in front of Luke, but not in front of others and the violence was in the home and never in public. Ms Portelli considered this to be important and it formed part of her risk assessment of whether Luke should be allowed to have contact with Mr Anderson in public.

312. When discussing family violence during the home visit, Ms Batty did not raise concerns for Luke's safety. Ms Portelli's evidence was that Ms Batty stated that she believed that she was the one who was

[274] Transcript, p. 1245.
[275] Coronial brief, p. 2500.3 - 2500.4.

at risk. Ms Portelli, cognisant of the need to scrutinise Ms Batty's protective capacities had regard to her willingness, intention and capacity to protect Luke. Ms Portelli was reassured by the fact that Ms Batty had reported Mr Anderson to police and he had been charged. By notifying the police of breaches on two separate occasions, Ms Portelli's evidence was that she perceived that Ms Batty had demonstrated her ability to promote the safety of herself and Luke. Ms Portelli also considered the fact that Ms Batty had telephoned the DHS and reached out for assistance as relevant to her assessment of Ms Batty's protective capacity.

313. Ms Portelli's evidence was that she wanted to ensure that Ms Batty understood the protective concerns about Luke and discussed at length the reasons for having a safety plan. Ms Portelli explained to Ms Batty the purpose of an 'undertaking', although not a legally binding document, was an agreement between Ms Batty and Child Protection to address issues relating to Luke's contact with Mr Anderson. Ms Portelli's evidence was that she perceived the undertaking to be an added layer of protection for Luke. Ms Portelli explained that undertakings are used to emphasise the protective concerns that Child Protection may have about another parent or person of interest. She said that an undertaking ensures that a parent is aware of the protective issues, and that Child Protection has documented its expectations of the parent. Ms Portelli's evidence was that an undertaking also enables a parent's willingness to adopt a course of action aimed at enhancing a child's safety to be assessed.

314. It was Ms Portelli's assessment that Ms Batty was an appropriate person to implement the safety plan (undertaking) and to make sure that it was followed. Ms Portelli's evidence was that if Ms Batty had indicated that she did not want to implement the undertaking, she could have discussed alternatives, such as nominating another suitable supervisor for contact between Luke and Mr Anderson, which Ms Batty expressly stated was not appropriate.

315. Ms Portelli formed the view that Ms Batty understood why Child Protection was requesting that there be a safety plan and was willing to sign the undertaking, without any pressure to do so.

316. Ms Batty's perception was that the undertaking was not significant, but *'pretty much'* what she was already doing. Ms Batty signed an undertaking at the request of Child Protection that she would keep Luke in her line of sight at all times when he was in the company of Mr Anderson. The relevant terms were:

    (a) I understand the protective concerns in relation to Gregory Anderson;

    (b) I am aware of the charges that Gregory is currently facing in relation to child abuse images;

    (c) I will not allow Luke to have any unsupervised access with Luke [should be Gregory] at any time;

    (d) I understand that supervision means that Luke will be in my line of sight at any time;

    (e) I will not allow Gregory to take photographs of Luke; and

(f) If I become aware of Gregory taking photographs of any child I will notify Child Protection and/or Police.[276]

317. I accept that safety plans have some potential to be protective. However, these undertakings can shift too much responsibility onto parents notwithstanding that they are considered to be protective parents. The undertakings are legally unenforceable. In my view this undertaking required far too much of Ms Batty.

318. While discussing the safety plan Ms Batty told Ms Portelli that she welcomed supervision for Luke because he had told her that during a contact visit Mr Anderson had smoked cannabis and had held a sharp knife saying '*it could all end with this.*'[277] Ms Batty informed Ms Portelli that Mr Anderson had also spoken about wanting himself and Luke to '*go to another world together.*'[278] Ms Portelli's Inquest evidence was that she was unaware that suicidal ideation can be a risk factor for future family violence.[279]

319. Ms Batty also mentioned the threat Mr Anderson made to Luke's football coach, where he threatened '*I've got a knife in my car with your name on it.*'[280] Ms Batty provided Ms Portelli the football coach's mobile telephone number stating he was extremely supportive of her and Luke.

320. This was the first time that Child Protection was told of the knife incident. Ms Portelli's evidence was that she was shocked at hearing this information and from a risk assessment perspective she was concerned for Luke's safety if he was alone with his father in the future. Ms Portelli noted that there had been no other information provided which suggested that Mr Anderson had made threats towards Luke.

321. In relation to the supervision of Luke's access with Mr Anderson, Ms Portelli was aware that the FVIO allowed Mr Anderson to attend Luke's sporting activities and that these events were held in public places. Ms Portelli stated that the undertaking was put in place on the understanding that Ms Batty would be at the sporting events with Luke and that she would therefore be in a position to supervise given that she had indicated that she herself was well supported when she attended.

322. While Ms Batty had presented as a person who was affected by her own history of trauma and difficult experiences, Ms Portelli's evidence was that she also presented as strong and intelligent – as she clearly is. Ms Portelli acknowledged Ms Batty became teary when speaking about Mr Anderson and his threats towards her, however, she was reassured by the fact that there was a current FVIO in place, and that Ms Batty had demonstrated she was protective by alerting the police when Mr Anderson had breached the FVIO.

323. Ms Portelli took additional reassurance from the fact that there was a safety plan, which provided that Luke not be left alone with Mr Anderson.

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[276] Coronial brief, p. 627.
[277] Transcript, p 33 and 620.
[278] Coronial brief, p. 268 and 625.
[279] Transcript, p. 1048.
[280] Coronial brief, p. 56.

324. At the conclusion of the home visit Ms Portelli considered, in line with her preliminary risk assessment, that Luke was at low risk of being sexually abused by Mr Anderson. While Ms Portelli's concerns regarding the child pornography charges were assuaged she remained concerned about the knife incident and appropriately formed the view that this information broadened her investigation. Ms Portelli's Inquest evidence was that she was worried for Luke's physical safety and the impact of being exposed to that type of behaviour by Mr Anderson.

325. Ms Portelli's preliminary risk assessment in relation to the knife incident took into account that Luke was having supervised contact with Mr Anderson. Ms Portelli also attached weight to the fact that Ms Batty had agreed to the undertaking and there was an active FVIO in place reinforcing that Luke was not to be alone with Mr Anderson.

326. While the information concerning the knife incident was historical, Ms Portelli considered that it was necessary to speak to Luke before concluding any definitive risk assessment.

327. When Ms Portelli returned to the Child Protection office she immediately spoke to her team manager advising that the home visit went well in relation to the child pornography issues, but that she was concerned about the alleged knife incident because it could have been a threat to kill. The team manager advised that while the knife incident appeared to be historic, Ms Portelli needed to follow the usual protocol and notify the police because it was a potential threat to the physical safety of a child.

30 August 2013

328. On 30 August 2013 Luke attended his last session with Ms Perry before his death. [281] Luke was relaxed during the session, casually chatted about home and school, with very little reference to his father. Early in the session, Luke stated that his mum was:

> *nicer to me than most people's mums, most of the time*[282]

329. Ms Perry assessed Luke to be unusually articulate for his age. Ms Perry was never advised of the knife incident and it was her evidence that at no time during Luke's sessions did he mention the knife incident. There was no communication to her from any of the family violence agencies involved with Luke in relation to the risks related to Luke. Ms Perry's evidence was that this information would have been beneficial in her sessions with Luke.

330. Also, on 30 August 2013 Ms Portelli telephoned the Frankston Sexual Offence Child Abuse Investigation Team **(SOCIT)**[283] and spoke to DLSC Charteris. Ms Portelli knew DLSC Charteris to be a very experienced police officer, having worked in the area since the 1980s. Ms Portelli advised DLSC Charteris about Ms Batty's disclosures concerning the alleged knife incident involving Luke and the threat to the football coach involving a knife. Ms Portelli also told DLSC Charteris about Mr Anderson's threat towards Ms Batty that he would cut off her foot. DLSC Charteris advised Ms Portelli that as the disclosure made by Luke seemed somewhat vague and ambiguous, there did not appear to be a role for SOCIT at that time.

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[281] At the time of Luke's death he had funding for another session and an application for further sessions pending.
[282] Coronial brief, p. 2500.5.
[283] SOCIT is co-located with Child Protection as part of the Multidisciplinary Centre.

331. DLSC Charteris' Inquest evidence was that during the course of the day she reflected on the information related to the alleged knife incident and reconsidered her position. DLSC Charteris contacted Ms Portelli requesting they speak with Ms Batty and Luke because she wanted to assess Luke's circumstances and safety. Later that day DLSC Charteris rang Ms Portelli and provided her with a verbal history of police involvement with Mr Anderson, including incidents of family violence directed towards Ms Batty. DLSC Charteris confirmed that there was a current FVIO in place. DLSC Charteris agreed with Ms Portelli's assessment that the information received was concerning and that they should do a joint home visit in order to speak with Luke.

332. Also, on 30 August 2013 Ms Portelli spoke to the Principal of Luke's school who advised that the school had been monitoring Luke for some time, and was aware of previous Child Protection involvement. The Principal confirmed the school had a good relationship with Ms Batty and undertook to facilitate Luke's teacher contacting Ms Portelli. Ms Portelli's evidence was that she was reassured that Luke's school was aware of Child Protection's involvement, and that Ms Batty had a good relationship with the school. Ms Portelli considered these to be protective factors for Luke.

333. Ms Portelli left a voice message for Luke's football coach to call her, leaving her name and advising she was calling from Child Protection. She also telephoned Karen Wilde (**Ms Wilde**) from Windermere to ascertain her involvement with Ms Batty and Luke. Ms Portelli left a voice message advising that Ms Batty had signed a Release of Information document that allowed Child Protection to obtain information from Windermere and requested a return call.

4 September 2013

334. On 4 September 2013 Ms Portelli left another voice message for Luke's football coach stating she was calling about an alleged threat made to him by Mr Anderson. Also on this day, Ms Portelli spoke to Ms Batty and arranged a home visit to discuss the knife incident with Luke.

5 September 2013

335. On 5 September 2013 DLSC Charteris and Ms Portelli interviewed Luke at his home.[284] Each had a wealth of experience in relation to interviewing children.

336. In the car on the way to the home visit it was agreed that DLSC Charteris would conduct the interview and Ms Portelli would take notes. The pair also agreed on a series of questions.

337. During the interview Luke said that he felt he was the only thing that was good for Mr Anderson. DLSC Charteris asked Luke how he felt about Mr Anderson and he replied that he "*loved him to bits.*"[285]

338. Luke talked about what he considered to be 'two sides' to Mr Anderson, one nice and the other angry, describing the 'bad' things about Mr Anderson was that he got angry, started praying (Luke had learned to stay quiet when Mr Anderson was praying[286]) and acted a bit different. Luke added that he got a bit embarrassed around Mr Anderson. Luke qualified these statements by stating that Mr

[284] The interview lasted approximately 60 minutes.
[285] Coronial brief, p 629-630.
[286] Coronial brief p.100. Inquest exhibit 3.

Anderson always has a smile on his face and was peaceful when he (Mr Anderson) was younger. Luke became upset at this stage and said that Mr Anderson had tests in life that were hard, such as going to Court.

339. DLSC Charteris expressly asked Luke whether he was worried about Mr Anderson, to which Luke replied, 'no' in an open, assertive and clear way. She also expressly asked him whether he was frightened with Mr Anderson, and again he said 'no'. DLSC Charteris enquired whether Luke was ever uncomfortable with Mr Anderson, and Luke told her that Mr Anderson had:

> *picked up a knife and said this could be the one to settle it all.*[287]

340. Upon questioning by DLSC Charteris, Luke said the knife incident occurred the year before. In her evidence, DLSC Charteris had a clear recollection that Luke described the knife incident as having occurred in November 2012. DLSC Charteris asked Luke what he did when Mr Anderson started talking about the knife and he said that he went quiet and looked into the iPad, then Mr Anderson got out of the car, walked around and then got back in, and it was fine.

341. Luke described the knife as a carpenter's knife, which Mr Anderson had all the time because he used to be a carpenter. Luke said that Mr Anderson would use the knife to cut up fruit and open packets of Lego® for him.

342. Around this time Ms Batty came back to the table and said that Luke had told her that Mr Anderson had also talked about '*going to another world together.*'[288] Luke became upset and tearful and said words to the effect of:

> *that didn't happen - you keep saying that's what I said but that didn't happen. He didn't say that.*[289]

343. Ms Batty described Luke as an assertive boy who knew how to stand up for himself, he wasn't a compliant, quiet boy. Ms Batty thought she was helpfully offering a bit more information but was:

> *surprised at how very clearly he shot me down.*[290]

344. Ms Portelli's Inquest evidence was that Ms Batty apologised to Luke and did not press the issue further. Ms Batty's evidence was that after Luke's retort she absented herself so as not to interfere with the interview. Ms Batty's Inquest evidence was that she was surprised by Luke's reaction and did not know how to handle it without having an argument with him.[291] Ms Batty stated:

> *Luke didn't lie. There's no question he didn't lie, but he's not going to get his dad into trouble. He was already scared that his dad would go to prison for what he'd been doing to me. The reason he - he wouldn't want to disclose to two strangers to get his dad into trouble. But there is no doubt that it happened. But I became confused too and never truly knew what was the context of Greg with this knife.*[292]*... The thought that this paedophilia thing - you know to me it was a huge change about whether Luke was ever going to - was safe with his dad or not, that was a huge - huge concern. You know everything was pointed to the fact that, you know, he -*

[287] Exhibit 48, second statement of Ms Portelli. Coronial brief p. 639.10. Exhibit 47, Ms Portelli's notes of the SOCIT/Child Protection interview 629-635.
[288] Coronial brief, p. 619.
[289] Exhibit 48, second statement of Ms Portelli. Coronial brief 639.10.
[290] Transcript, p. 169.
[291] Transcript, p. 169-170.
[292] Transcript, p. 49.

Greg would never have time alone with Luke again. Never. You know, did Greg mean he was going to take his own life, did he mean it was going to be joint suicide. What did it mean? I never really knew the extent, I just was so fearful of it could mean any of those but it just wasn't going to - Luke was never going to get in the car with him again.[293]

345. I accept Ms Batty's evidence that Mr Anderson did speak to Luke about '*going to another world*' despite Luke disavowing it.

346. Luke did tell DLSC Charteris that he was scared after the knife incident and that he thought his father was going to kill him, but immediately said that he thought that because of the horror movies he had watched. Ms Portelli and DLSC Charteris regarded the explanation of fear being due to horror movies as plausible. Ms Portelli's evidence was that she understood Luke to mean that because he had seen people kill each other in horror movies, he thought his father was going to kill him because of what he had seen, not because he thought Mr Anderson would actually commit such an act.

347. Ms Portelli assessed Luke to be an insightful, polite and honest boy and did not form the impression that he was trying to protect Mr Anderson when talking about the knife incident. She assessed that Luke was genuine in his presentation when discussing the incident with the knife, that he genuinely did not believe that he was in any danger and that he articulated this clearly.

348. Ms Batty's evidence was that she did not perceive that Luke was frightened of his father hurting him, stating:

I know absolutely he never believed his Dad would ever hurt him, by physically hurting him.[294]

349. Ms Batty's evidence was that when Luke told DLSC Charteris and Ms Portelli that he loved his Dad and was not scared of him, she believed he was being truthful.

350. During the interview Luke was asked what he would do if he was with Mr Anderson and he did not feel safe, he responded:

Stay quiet for the rest of the time with him, then would tell Mum about what happened when home.[295]

351. Luke was then asked what he would do in the situation where he had a couple more hours left with Mr Anderson and he became upset stating:

I can't tell Dad that.. .You can call police or Mum. You can tell them, 'Worried about Dad, worried about me, I couldn't do that to Dad. He would get angry with me.[296]

352. Luke was also asked about his current feelings for Mr Anderson and he said it was 'okay' and that the Court had told Mr Anderson that he has to change if he wanted to see him. Luke said that Mr Anderson was '*happy now*'[297], and that he thinks he has changed a lot, and that it is better.

353. Luke was clear that he was happy to see Mr Anderson, and that it was fun to see him. DLSC Charteris continued talking to Luke about other issues such as who he would talk to if he felt like he was in danger. At the end of the interview Luke appeared enthusiastic about going to school.

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[293] Transcript, p. 50.
[294] Transcript, p. 66.
[295] Inquest Exhibit 47.
[296] Transcript, p. 727. Inquest Exhibits 47 and 48.
[297] Coronial brief, p. 639.

354. When Luke spoke about Mr Anderson, Ms Portelli judged that he did so in a matter of fact way, however it appeared to her that he was conflicted about his relationship with Mr Anderson. Ms Portelli noted that Ms Batty advised her that Luke had reached a point in his life where he was not feeling as bad for not seeing his father as he had in the past.

355. Throughout the meeting, Ms Portelli did not get the impression that Luke was protective of his father, or that he was conflicted when speaking about him in a negative manner. She felt that there was an open dialogue with Luke during the interview and that he was being completely honest about how he felt. DLSC Charteris described Luke as a quiet, articulate and intelligent boy.

356. Ms Portelli characterised DLSC Charteris' conduct of the interview with Luke as '*exceptional.*'[298] She considered DLSC Charteris to be extremely experienced and having a soft nature when speaking enabling her to elicit information that others may not be able to get. Corroborative of this was Ms Batty's evidence that she was '*blown away*'[299] by the fact that Luke made disclosures during the interview that he had never made to her before. Ms Batty thought DLSC Charteris and Ms Portelli had developed a rapport with Luke and got him talking. Ms Batty also agreed that during the interview Luke was relaxed and showed his normal demeanour. Ms Batty agreed with DLSC Charteris' assessment that Luke was bright, open and honest during the conversation.

357. Ms Batty's evidence was that this interview was confronting for her because this was the first time Luke spoke in detail about some of Mr Anderson's behaviour, including that Mr Anderson could get angry with him. Generally, Luke did not come home from access visits and detail what had happened.[300]

358. Professor Ogloff's evidence was that the methodology, style and content of the discussion with Luke followed the normal routine for forensic interviews with children.

359. Professor Mullen's opinion was that the interview with Luke was a well-conducted child-focussed process worthy of praise.

360. Dr Miller described the interview as a skilled interview whereby DLSC Charteris and Ms Portelli demonstrated a valuable and meaningful process of attention and deep listening to Luke's voice.[301] She said:

> *The rapport building and effective engagement of Luke to enable him to disclose such sensitive and painful material during a first interview is commendable and no doubt was enhanced by their effective and established partnership, as well as their individual skills.*[302]

361. I note Dr Miller's attribution of Luke's capacity and manner to engage during the interview as a reflection on the quality of Ms Batty's parenting. Dr Miller commented:

> *Luke's capacity to engage, relate respectfully to the interviewers, intelligently respond and express complex emotional states is a credit to his mother and evidence of the strength of her modelling and good parenting. Luke's communication skills were advanced for his age, as often*

[298] Transcript, p. 1074.
[299] Transcript, p. 166.
[300] Transcript, p. 243.
[301] Exhibit 108, report of Dr Miller p. 31.
[302] Exhibit 108, report of Dr Miller p. 31.

boys, in particular, struggle to express such painful emotions and to make meaning with the maturity that Luke displayed. His compassion for his father's difficulties and the way in which he felt responsible for his father's happiness in life reflect the values and compassion that his mother obviously modelled and continues to model. Children of this age frequently see difficult and or violent parents as 'goodies' or 'baddies', whereas Luke was able to relate more of a coherent narrative about his father's complex difficulties. In my experience, this is evidence that he was able to express and discuss 'the good, bad and ugly' about his father with his mother, which is an enormous parenting strength and one which enables children to recover and find a place to make meaning of overwhelming events.[303]

362. I accept Dr Miller's evidence on these matters.

363. At the conclusion of the interview Ms Batty, DLSC Charteris and Ms Portelli had an opportunity to speak in Luke's absence. DLSC Charteris said that, to her, it did not appear that an offence had taken place. Ms Portelli spoke about Child Protection remaining involved, at that stage, and that the SOCIT and Child Protection were available to contact if Ms Batty had any further concerns.

364. Ms Portelli also spoke to Ms Batty about Luke's progress and behaviour at school. Ms Batty advised her that there had been behavioural issues, but that Luke had been linked in with supports. Ms Batty did not talk about Luke being depressed or having any other emotional issues.

365. Ms Portelli's assessment was that she again engaged well with Ms Batty during the second home visit. Ms Portelli's evidence was that she left the home visit thinking that there was nothing to suggest that Luke was at risk in Ms Batty's care and there was nothing to suggest that the information provided by Ms Batty should have been questioned. Ms Portelli had no reason to question Ms Batty as a parent, or her capacity to ensure Luke's safety.

366. Ms Portelli's risk assessment considered the FVIO, Ms Batty's demonstrated ability to report a breach of the order if required, and the written undertaking, were sufficient to ensure Luke's physical safety at that time. However, Ms Portelli's evidence was that she was aware that the existence of a protective mother and separation from a family violence perpetrator does not necessarily ensure safety and that Child Protection must be alert to history and any escalation and dynamic risk factors.

367. Ms Portelli said she was reassured after questioning Luke about seeking support if he felt fearful when in Mr Anderson's care that he would to speak with Ms Batty, as he had done in relation to the knife incident. Ms Portelli's evidence was to the effect that she did not need to reconcile the disparity between Luke and his mother's account of his report of the knife incident to her, in relation to whether the words '*go to another world together*'[304] were used by Mr Anderson. She considered that it was her role to form a view as to whether Luke was at risk as a consequence of any information she had, rather than assessing if the event occurred. Ms Portelli said she did not proceed on the basis that one person was right and one person was wrong. She did not form a view about the words used by Mr Anderson in the car but felt it was likely that the events occurred as Luke described.

[303] Expert report of Dr Miller, p. 32 (para. 81).
[304] Coronial brief, p. 625.

368. Ms Portelli said that she did not believe or prefer one account over the other, but gathered all the information as part of her assessment. Her ultimate position was that she did not feel that Mr Anderson was threatening himself or Luke.

369. DLSC Charteris' evidence was that she aware of the potential that Luke might be seeking to be protective of his father, but assessed that he did not display that tendency as he had been willing to speak of his father's negative points as well as his good points. While Luke became upset at times during the interview, DLSC Charteris viewed that to be indicative of distress, not fear of his father. She said she had every reason to believe that the account Luke gave was a clear, open, honest and an accurate one. DLSC Charteris felt that based on her conversation with Luke, her observations of him and his mother's affirmation that she did not believe Mr Anderson would harm Luke and that no offence had occurred. DLSC Charteris' assessment was that Mr Anderson did not present as a danger to Luke.[305] DLSC Charteris' evidence as to the basis of her assessment was:

    (a) Luke's self assessment that Mr Anderson would not harm him;
    (b) Ms Batty was very convincing that Luke's father would never hurt him and she did not think there was any reason to believe that Mr Anderson presented as a danger to Luke;
    (c) the knife incident was not recent, there had never been any direct violence towards Luke;
    (d) the last occasion Luke witnessed family violence between his parents was in January 2013;
    (e) there was an active FVIO in place that prevented Mr Anderson from having access to Luke other than at sporting events;
    (f) Ms Batty was going to Court, on 9 September 2013, in relation to the ambiguity in the FVIO with respect to the type of events Mr Anderson could attend, such as scouts and this demonstrated her protective capability.

370. DLSC Charteris completed a LEDR Mk 2 (L17) relying on Luke's self assessment of his risk at the hands of his father and assessed him as '*not fearful*',[306] noting that there was no evidence of threat to kill or threat to harm and assessed the risk of future violence as '*unlikely.*'[307] In my view, this assessment should not have been made so conclusively at that point.

371. While I commend the methodology of the interview, the fact is the risk assessment was based on the version of an 11 year old boy, with extremely conflicted feelings about his father.

372. Ms Batty was very concerned about the risks to Luke and had taken the step of making a notification to the DHS, yet the fact that this did not feature in any assessment of the risk posed at that time to Luke raises concerning questions. Equally concerning was that DLSC Charteris did not clarify with Ms Batty whether Luke's so-called 'retraction' in relation to the knife incident altered Ms Batty's concerns in relation to the knife allegation. It is easy to say with hindsight, but in this case it must be said, that this risk assessment following on from the disclosure of the knife incident (and allowing for various interpretations of that incident), was a serious misjudgement. In making this comment, I do not intend

[305] Exhibit 40, Statement of DLSC Charteris. Coronial brief 684. Transcript, p. 739.
[306] Exhibit 42, LEDR Mk 2 Summary report. Coronial brief, p. 649.8 -649.10.
[307] Exhibit 42, LEDR Mk 2 Summary report. Coronial brief, p. 649.8 -649.10.

to detract from the high standard of work performed by DLSC Charteris who was, as observed elsewhere, a conscientious officer.

373. When Ms Portelli returned to the Child Protection office from the home visit, she discussed the information obtained from the home visit with her Team Manager, advising her that it appeared that the allegation about the knife was historic and that Luke was no longer having one to one contact alone with Mr Anderson. They also discussed Luke's presentation when speaking about Mr Anderson. Ms Portelli advised her Team Manager that before closing the file she wanted to seek to talk to Mr Anderson directly in order to discuss all the information that she had received. This was a sound decision, however, unfortunately contact was never made with Mr Anderson.

374. Ms Portelli's evidence was that the DHS was satisfied, in closing Luke's file, that there was a sufficient safety plan in place for Luke by reason of the following matters:

    (a) the existence of a FVIO;

    (b) Ms Batty's own protectiveness toward Luke;

    (c) Ms Batty's use of support services; and

    (d) the existence of the undertaking.

375. In my view, none of these factors alone or in combination, should have been viewed as convincingly protective.

376. The DHS in closing Luke's file sent a letter dated 13 November 2013 to Mr Anderson advising him that it was closing its file. The letter also noted that as they had been unable to meet with him, his contact with Luke would be supervised in line with the FVIO and the signed written undertaking. The letter did not advise Mr Anderson that Child Protection had assessed him as posing a risk to Luke's well-being under s.162 of the CYFA. Ms Batty was not advised the letter had been sent to Mr Anderson, nor had the police been advised of this decision.

377. While there is no direct evidence to support the proposition that Mr Anderson received the letter, the DHS appropriately conceded that this correspondence to Mr Anderson was misjudged. Dr Miller opined that with hindsight, in the absence of any clear mental health diagnosis or treatment of Mr Anderson, the intention of sending the letter was based on a precarious hypothesis that he would respond affirmatively to Child Protection's position and not blame Ms Batty.

378. While this action was clearly well intended, it shifted accountability to Ms Batty, which was inappropriate given that she had been a victim of Mr Anderson's violence.

379. There was too much emphasis on the bureaucratic process of 'closing the file', and not enough urgent reflection on the risk assessment. The file was closed prematurely.

380. In her Inquest evidence, Dr Miller acknowledged that the file was closed too hastily without exhausting all efforts to engage with Mr Anderson in relation to the knife incident. I agree with Dr Miller's concession that the DHS should have worked with the police to locate and jointly interview Mr Anderson about his contact with Luke. It should have also sought to contact relevant persons involved with Luke and his mother, such as Ms Perry, Ms Wilde, the football coach and Dr Heath.

381. Critically, these were lost opportunities to assess Mr Anderson and any risk he posed to Luke.

382. I found both Ms Portelli and LDSC Charteris to be conscientious, sensitive and careful. Both were profoundly effected by Luke's death. Both were good witnesses who sought to assist my investigation. The shortcomings I have referred to, where they exist, do not affect this assessment of them and their evidence.

9 September 2013

383. On 9 September 2013 Mr Anderson's application to vary the FVIO in relation to Luke was listed at the Frankston Magistrates' Court before Magistrate Holzer. The purpose of the hearing was for Mr Anderson to establish why the FVIO should be varied to allow him to have contact with Luke in line with the original Family Court consent orders, specifically weekly contact.

384. Again, Ms Batty was unrepresented. Ms Batty's Inquest evidence was that she was confused about this hearing, as Magistrate Goldsbrough had listed the matter for a contested hearing but Mr Anderson had not provided the information (evidence for the FVIO to be varied) he was required to file with the Court.

385. While Senior Constable Dianne Davidson (**Prosecutor Davidson**) represented the police applicant, she also assisted Ms Batty. Ms Batty's Inquest evidence was that Mr Anderson presented at the Court but when Prosecutor Davidson told him that she (Ms Batty) was seeking to have the terms of the FVIO changed he lost his temper and left.[308]

386. Prosecutor Davidson's evidence was that she was assigned the matter in advance of the hearing due to her previous involvement in criminal matters involving Mr Anderson.[309] I commend an allocation policy, which ensures police prosecutors have continuity of both the criminal and civil matters.

387. In preparation for the hearing, Prosecutor Davidson made contact with the informant, SC Anderson, Ms Batty, the solicitor she understood to be representing Ms Batty,[310] Mr Anderson's solicitors and also Prosecutor Treverton regarding his involvement in the hearing on 22 July 2013.[311]

388. The purpose of Prosecutor Davidson's telephone contact Ms Batty was to discuss the case and establish what Ms Batty wanted to achieve at the hearing.[312] Prosecutor Davidson estimated that one of her telephone conversations with Ms Batty lasted approximately one hour.[313] Ms Batty said that she found the conversation helpful in terms of being able to tell the prosecutor, in advance of the hearing, what she wanted to achieve at Court.[314] Prosecutor Davidson's Inquest evidence was that during a telephone conversation she informed Ms Batty that Mr Anderson was no longer contesting Luke being on the order and that a final FVIO would be confirmed on 9 September 2013[315]. Ms Batty expressed her concern to Prosecutor Davidson about the wording of the FVIO and indicated that she wanted the

[308] Transcript, p. 46.
[309] Transcript, p 679.
[310] Statement of Senior Constable Dianne Davidson, Exhibit 38, Batty Inquest Brief, at page706.6; Transcript, p 310, lines 10-11 (Anderson).
[311] Transcript, p 677,..
[312] Statement of Dianne Davidson, Exhibit 38, Batty Inquest Brief, p706.6; Transcript, p 156, lines 17-18 (Batty).
[313] Transcript, p 156 lines 17-18 (Batty); Transcript, p 676, lines 12-13 (Davidson).
[314] Transcript, p 156, lines 19-20 (Batty).
[315] Prior to 9 September 2013, Mr Anderson's solicitors wrote to the Court advising that they ceased to act for Mr Anderson as he no longer wished to contest Luke's name being on the order. Prosecutor Davidson was also advised of this information.

meaning of 'such events' clarified and tightened because Mr Anderson interpreted the provision to allow him to attend Luke's scouts meetings.

389. Magistrate Holzer finalised the FVIO made by Magistrate Goldsbrough on 22 July 2013 amending one of the conditions from 'and such events' to 'these events' to ensure it was clear that Mr Anderson could only attend when Luke participated in football, cricket or Little Athletics.

390. On this day, Christine Allen,[316] spent approximately 20 minutes with Ms Batty providing emotional support and discussing safety, including the advisability of reporting any breaches of the FVIO. Ms Batty said that she found Christine Allen empathic, respectful and a "*really valuable resource.*"[317] Christine Allen was an impressive witness.

391. Prosecutor Davidson's evidence was that she did not consider seeking to have the 'no contact' condition revived as Ms Batty was very "*clear and precise about what she wanted from [the] hearing*" and was "*happy with the way [the order] stood*", aside from wanting the phrase 'such events' clarified to stop Mr Anderson attending scouts' meetings.[318]

392. The protected persons on the final FVIO made by Magistrate Holzer were Ms Batty and Luke. The order prevented Mr Anderson from seeing Luke other than at sporting events at the weekends. This prohibited Mr Anderson's attendance at Luke's sporting events during the week and at activities such as scouts. The Order had number of conditions, relevantly that:

> *On the weekends [Luke] plays football, cricket or engages in Little Athletics, the Respondent [Mr Anderson] is free to attend these events, and speak to [Luke] when he is there in the company of others.*[319]

393. The final FVIO order made by Magistrate Holzer did not contain clause 16 from the interim FVIO dated 22 July 2013 which stated '*on the weeks Luke plays football, cricket or engages in little athletics by agreement today in the interim, the respondent is free to attend such events and speak to Luke when he is in the company of others.*' This change to the order was not sought by Prosecutor Davidson or Ms Batty and was not discussed during the course of the hearing on 9 September 2013.

394. The order was specified to last until 31 December 2019.

395. Ms Batty was not in the Court at the time Magistrate Holzer made the final order, as she had left the courtroom upset about the way the hearing was progressing.

396. Immediately after the hearing concluded, Prosecutor Davidson spoke with Ms Batty in the Court foyer and advised her that Magistrate Holzer had changed the wording of the order from 'such events' to 'these events' as she had wanted.[320] Ms Batty's Inquest evidence in relation to her understanding of what the final FVIO provided was as follows:

> *I understood that the order meant and allowed Luke - Greg - to be able to attend cricket and football, as I had asked. What I hadn't realised was that it also removed the condition about having - being able to go to football practice. I hadn't noticed that, because on the - that*

[316] Coronial brief, p. 1566.
[317] Transcript, p. 160.
[318] Transcript, p. 680.
[319] Coronial brief, p. 1543.
[320] Transcript, p 670; Statement of Senior Constable Dianne Davidson, Exhibit 38. Coronial brief p706.7.

condition was on the second sheet of the intervention order, and there's so many different conditions, I didn't notice that until it was pointed out to me after Luke's death, that it was no longer on there.[321]

397. The FVIO remained in place and at the time of Luke's death in February 2014. Ms Batty did not report any breaches after 9 September 2013.

398. Also on this day Ms Portelli responded to a telephone message from Ms Batty and spoke to her for approximately 20 minutes. Ms Batty, understandably upset, advised Ms Portelli that she had attended the Court that morning and felt unsupported. Ms Portelli offered to attend Court with Ms Batty and suggested she speak to the Family Violence Support Officer at the Court. Ms Batty advised that she had already left the Court. Ms Portelli understood that the source of Ms Batty's distress was that she had to return to the Magistrates' Court, that Mr Anderson was seeking variations of the FVIO and then did not attend the hearing.

399. Ms Portelli noted that Ms Batty's concerns on this day did not relate to the care of Luke or any risks posed to him. Ms Batty referred to her own financial issues and her frustration that Mr Anderson was eligible for legal aid. Ms Portelli spoke with Ms Batty about obtaining legal advice and about assessments to ascertain her eligibility for legal aid. Ms Batty confirmed she had been advised that she could not access legal aid as she had equity in her property. Ms Portelli's overall impression was that Ms Batty was frustrated with the 'system' as a whole and needed to vent her feelings. Ms Batty told Ms Portelli that she had been advised to ask when Child Protection would be taking out a protection application in relation to Luke. The genesis of this query seems to have been the advice her solicitor (who she had not retained) gave to Ms Batty, to contact the DHS. Ms Portelli, while acknowledging Ms Batty's frustration, advised her that the DHS considered her to be a protective parent, that she was acting in Luke's best interests and the DHS therefore had no legislative mandate to intervene. Ms Portelli gained the impression that Ms Batty wanted Child Protection to make a protection application in relation to Luke so that she would not have the financial and emotional burden of further Magistrates' Court or Family Court proceedings. During this telephone call, Ms Portelli advised Ms Batty that she had not been able to speak to Luke's football coach, but had left messages with her name and contact details. She asked Ms Batty, who agreed, to advise the football coach, if she saw him, to give her a call.

10 September 2013

400. On 10 September 2013 Ms Portelli telephoned the Frankston Magistrates' Court and requested a current copy of the final FVIO. A copy was faxed to her the same day. It confirmed that Luke was still on the FVIO, and that Mr Anderson was only permitted to have contact, including speaking, with Luke on the weekends Luke played football, cricket or engaged in little athletics in the company of others.

[321] Transcript, p. 46.

3, 16 and 21 October 2013

401. On 3 October 2013, when intercepted for driving an unregistered vehicle by First Constable Djurdjica Calic (**FC Calic**), Mr Anderson erupted in rage with fists clenched and abuse.[322] Mr Anderson gave his address to the police officer, [address suppressed pursuant to the *Open Courts Act 2013*] and stated "*you know who I am, I report to you on bail*". Mr Anderson was very aggressive to the point that FC Calic called for, and received 'back up' assistance from other police officers.

402. When additional police officers arrived Mr Anderson calmed. The police officers were unaware of the unexecuted warrants in relation to Mr Anderson. While I do not criticise the actions of the police officer on this day, the failure to record the unexecuted warrants on LEAP was another lost opportunity to execute them, engage Mr Anderson with the criminal justice system, and hold him to account for his actions.

403. After this incident the police officers completed a 'warning flag' in relation to Mr Anderson and a circular was disseminated warning police officers to take precautions when dealing with Mr Anderson.[323]

404. On 16 October 2013, Ms Portelli wrote to Ms Batty and advised her that the DHS had completed its investigation and assessment in relation to Luke and had ceased its involvement as there was an active FVIO in place prohibiting Mr Anderson to have unsupervised access with Luke. Further, given Ms Batty had signed the Undertaking agreeing to Luke's contact with Mr Anderson being "*fully supervised.*"[324]

405. On 21 October 2013 Mr Anderson reported on bail at the Chelsea Police Station and was spoken to by Constable Shaun Rampal about continuing to drive an unregistered motor vehicle. Despite Mr Anderson's abusive behaviour Constable Rampal removed the registration plates from the vehicle. A week later the council put a yellow sticker on the vehicle requiring the owner to pick it up within 14 days. There is no evidence that Mr Anderson claimed the vehicle. From this time onwards there is no evidence that Mr Anderson had access to a motor vehicle. Despite a thorough investigation Mr Anderson's vehicle has not been located. Again, the police officer was unaware of the unexecuted warrants in relation to Mr Anderson because they were not on LEAP.

9 January 2014

406. On 9 January 2014, Mr Anderson failed to appear at the Frankston Magistrates' Court in relation to the charges laid by FC Topham and SC Anderson. The Court again issued warrants for Mr Anderson's arrest.

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[322] Anderson coronial brief, p. 723.

[323] The LEAP entry following this incident stated "*...Anderson was waving his arms around and clenching fists threatening members in relation to losing their jobs. Anderson with recent police involvement in relation to child pornography/assaults. On this instance same found in possession of children's toys. Same not on sex offenders registry as still on bail at this stage...GA on Bail and reporting at Chelsea on Mon, Wed and Fri between 60600 and 2100. Could members in watch house please keep this in mind upon attendance to sign on as he may attend in his unregistered motor vehicle. Members to KALOF due to driving offences and also same being found in possession of children's toys on 3/10/13*".

[324] Coronial brief, p. 1089.

17 January 2014

407. On 17 January 2014, Mr Anderson failed to appear at a committal mention hearing at Melbourne Magistrates' Court on the child pornography charges issued by DSC Cocking. This resulted in a further warrant to arrest being issued.

24 January 2014

408. On 24 January 2014, XYZ attended in person at the Frankston Magistrates' Court and applied for an interim intervention order against Mr Anderson. The incident giving rise to XYZ's application involved knife threats by Mr Anderson to XYZ. The threats were not reported to police.

409. On the same day, Ms Batty consulted with Dr Farlow, during which a discussion was had regarding Ms Batty and Luke's recent holiday to the United Kingdom and what a wonderful time they had. Ms Batty told Dr Farlow that it was lovely to not have to keep looking over her shoulder all the time, to which the doctor asked if it would have been best if they had stayed there or whether they should consider moving back to the United Kingdom permanently.

410. Dr Farlow's evidence was that Ms Batty stated that Luke would never agree to moving to the United Kingdom because he wanted to be near his friends and his father with whom he loved.[325]

411. Dr Farlow did not take this discussion any further given previous discussions she had had with Ms Batty of how she felt it was important that Mr Anderson have ongoing contact with Luke despite his behaviour towards her.

27 January 2014

412. On 27 January 2014 Mr Anderson was served by police officers from the Chelsea Police Station, without incident, with the interim intervention order at [address suppressed pursuant to the *Open Courts Act 2013*] naming XYZ as the protected person. The police officers also assisted in removing Mr Anderson from the property where he was living as to remain there would have resulted in a breach of the intervention order. The interim intervention order precluded him from being at or within 200 metres of [address suppressed pursuant to the *Open Courts Act 2013*]. The return date for the interim intervention order was 14 February 2014, two days after Luke's death.

413. The address police located and served Mr Anderson was in LEAP and the same address he provided to the Court when being released on bail on 11 June 2013. The Chelsea police officers were not aware of the unexecuted warrants because they were not on LEAP. This was a major system failure and yet another lost opportunity to bring Mr Anderson to account.

414. Prior to Luke's death Ms Batty was not aware of the interim intervention order made in relation to XYZ and XYZ was unknown to her. In my view she should have been informed of that intervention order, so she could assess the risks Mr Anderson posed to her and Luke.

415. Ms Batty's Inquest evidence, in response to a number of question of what she would have done differently, had she known about the interim intervention order relating to XYZ stated:

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[325] Coronial brief, p. 3776.

Ms Ellyard: *My question is, had you known that, what would you have done with that information?*

Ms Batty: *Um, I think to really understand that he was threatening somebody, to the degree of decapitation, um to understand he was subjecting somebody else to that degree of threatening intimidation, would really help me understand what else he did outside of what I knew he did.*

Ms Ellyard: *So do you think it would have made you act differently on the day of Luke's death?*

Ms Batty: *Definitely.*[326]

416. This is a telling point in the narrative.

417. The Inquest evidence was that LEAP did not link risks assessments arising from different intervention orders. Risks assessments or L17s were episodic, not holistic, nor did they take into account dynamic risk factors. This is an issue of fundamental importance. This case has made it clear that police officers need access to updated case specific information (through the LEAP or similar system). This would enable them to deal far better with the risk factors as which in cases like this are dynamic, not static.

5 February 2014

418. On 5 February 2014, DSC Cocking contacted Ms Batty and asked whether she knew Mr Anderson's current address. Ms Batty told him that she did not know either his telephone number or his address. At the time of this telephone call, Ms Batty was aware of the non-attendance of Mr Anderson at various Court hearings and that a number of warrants had been issued by the Court for Mr Anderson's arrest.

419. Later that day, Mr Anderson called Ms Batty, in breach of the FVIO, and asked her to get Luke to ring him later in the evening. Ms Batty asked Mr Anderson where he was living and he provided his address. Ms Batty's evidence[327] is that she immediately called DSC Cocking and advised him that Mr Anderson was residing at 19 Culcairn Drive, Frankston South.[328] DSC Cocking had lost Ms Batty's email address so she sent him an email on this day confirming the details.

420. Ms Batty's evidence was that she requested DSC Cocking to use his discretion about his approach to Mr Anderson, but left it with him. The essence of Ms Batty's evidence on this point was that she was concerned about any reaction against her if Mr Anderson knew that the information identifying his location had come from her. She did not want it to look like she had immediately dobbed Mr Anderson in.[329] DSC Cocking conceded that he had the information about Mr Anderson's current address for some days, perhaps half a week. DSC Cocking's evidence was that he gave priority to protecting Ms Batty over apprehending Mr Anderson and out of concern not to reveal her as the source information of his new address. Ultimately, DSC Cocking's evidence was that it was his intention to wait a period of (up to a couple of weeks) before arresting Mr Anderson.

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[326] Transcript, p. 124.
[327] Coronial brief, p. 1511-1512. Transcript, p. 136-138 and 240.
[328] This investigation established that Mr Anderson was in fact living at 19 Culcairn Drive, Frankston South for approximately three weeks prior to 12 February 2014.
[329] Transcript, p. 136.

421. I accept DSC Cocking's evidence as to his reasons as to his reasons for waiting to arrest Mr Anderson. But, after he was recalled to give further evidence and referred to the LEAP records, he agreed there was an address on LEAP that would have allowed him to locate Mr Anderson *before* Ms Batty gave him the address in February 2014. DSC Cocking also conceded in evidence that there were other ways of arresting Mr Anderson that would not reveal Ms Batty as the source of his new address, such as arresting him away from his house. DSC Cocking's evidence was that such steps were not taken in early February because, in his view, it was not an urgent matter[330] when balancing the issues of '*cost*' and '*manpower availability.*' [331] In my view, this revealed a disturbingly relaxed attitude and a failure to accord an appropriate degree of urgency to the situation.

422. However, as a matter balance I note that at no time was DSC Cocking was made aware of the knife incident. This may have affected his view as to the urgency of the matter but I was left unconvinced by his evidence that it necessarily would have made a difference. In any event proper information sharing would have meant that DSC Cocking would have already known of the knife incident.

423. DSC Cocking agreed that it would have been both possible and "*perfect*"[332] for Mr Anderson to have been arrested in relation to the unexecuted warrants on 27 January when the Chelsea police officers served the IVO in relation to XYZ.

424. Clearly the Chelsea police officers should have been in a position to execute the outstanding warrants when they served the IVO in relation to XYZ on 27 January. I cannot speculate as to what would have happened once the warrants (and charges) were dealt with in Court, but the execution of them, against the background then known in this case, may have led to a period of remand in custody for Mr Anderson, whatever might have been the ultimate sentencing outcome on the outstanding charges. The non-execution of those warrants on 27 January 2014, when Chelsea police served the IVO on Mr Anderson, with apparent ease at his address, was another, critical, missed opportunity to intervene and hold Mr Anderson hold him to account. It was after all a mere 16 days out from Luke's death.

425. In the same week of 5 February 2014 Mr Anderson telephoned Ms Batty again and requested to speak to Luke. While the FVIO prohibited Mr Anderson from speaking with Luke by telephone, Ms Batty allowed the contact given that they had been away on holiday and Luke had not seen Mr Anderson since he returned to Australia. Luke went into his bedroom and shut his door to speak to Mr Anderson. After finishing the telephone call Luke told Ms Batty that Mr Anderson was living in Frankston with people he did not like and was very unhappy. Luke told Ms Batty that Mr Anderson was upset with him for not contacting him after he had returned from England. Ms Batty's evidence was that Luke told her:

Normally I put the phone down on Dad- this time he put the phone down on me.[333]

[330] Transcript, p. 1116- 1117.
[331] Transcript, p. 1107.
[332] Transcript, p. 1117.
[333] Coronial brief, p. 1512.

What was known by Ms Batty, as at 12 February 2014, of the potential risk Mr Anderson posed to Luke

426. Aside from the threats Mr Anderson made to Ms Batty, as at 12 February 2014 she knew:

(a) of the child pornography charges laid against Mr Anderson;

(b) that Mr Anderson had threatened Luke's football coach;

(c) Mr Anderson had recently failed to appear at Court and that warrants were issued for his arrest;

(d) where Mr Anderson was living and that the police had (through her intervention) his new address;

(e) Mr Anderson had hung up on Luke during a recent telephone conversation;

(f) that the FVIO variation made by Magistrate Goldsbrough in July 2013 was confined in its operation to public contact at Luke's football, cricket and Little Athletics (although she was unclear as to which days he could attend); and

(g) that Luke had been interviewed by the DHS and police, and that they had determined to take no action arising from the knife incident.

427. Of equal importance was the fact that Ms Batty did not know that in the month prior to Luke's death XYZ had taken out an intervention order naming Mr Anderson as the Respondent after Mr Anderson made threats to him involving a knife. She was also unaware of Mr Anderson's aggressive behaviour towards police officers on 14 August 2013 and 3 October 2013.

428. Ms Batty's own assessment of the risks Mr Anderson posed to Luke was informed by her long experience of Mr Anderson and that she believed he loved Luke. Her belief about the level of risk posed to Luke, by Mr Anderson, altered dramatically in April 2013, after Luke disclosed the knife incident. Although clearly very worried, Ms Batty maintained that Mr Anderson would never hurt Luke because Mr Anderson loved Luke.

429. Tragically, Ms Batty has paid a terrible price for her best efforts to facilitate Luke's relationship with his father, even when it was difficult and risky for her to allow that contact to continue. Ms Batty accepted that she knew this. Her Inquest evidence, was that with the benefit of hindsight, she would have been assisted in managing the risks posed by Mr Anderson by having someone consistently assisting her as she dealt with the various engagements with the system. Her Inquest evidence was:

> *I don't think anybody that's been involved in any of the organisations and friends and family, would ever, ever have expected Greg to do what he did. I now believe people are capable of anything after going through this. But what I -I wish there was a way that people work with you through a journey of - instead of isolated incidences, no-one really looks at a journey that you're going through I don't think. You're just reacting to what's happened, and then you've got delays about going to court, and then they get adjourned, and it seems to me that every time you get adjourned, you lose something. You lose something and, you know, certainly being fully aware of Greg's behaviour, you know, so that you can make informed decisions. I think that would be really helpful, and something I regret not knowing. I think the other thing too, is that you really need support to kind of understand that if you're going to step up to somebody who is*

terrifying you, to say "No, you can't see your son ever again" you need more support than what are currently there for you, because really you're just alone, to enforce all these things.[334]

What was known by various family violence agencies, as at 12 February 2014, of the potential risk Mr Anderson posed to Luke

430. Ms Batty's submissions[335] invited me to find that by February 2014, there were identifiable 'red flags', which indicated that the level of risk posed by Mr Anderson was escalating. They were:
    (a) specific threats to harm and kill Ms Batty and / or her animals between 2002 and 2013, including a threat to cut off her foot;
    (b) possible threat to harm Luke or, alternatively, threat of self-harm or suicide made in Luke's presence in about April 2013 ('the knife incident');
    (c) Mr Anderson had demonstrated and repeated disregard for civil and criminal justice system processes designed to make him accountable for his behaviour, including charges in relation to family violence and child pornography and failures to appear at Court;
    (d) increasingly aggressive and hostile behaviour directed toward a number of police members in a number of separate incidents;
    (e) threats to Luke's football coach;
    (f) threats to XYZ, culminating in an IVO being served on Mr Anderson in late January 2014;
    (g) social and economic circumstances spiralling downward, including homelessness, and unemployment combined with potential mental health issues.
431. The point of the submission is that the system – the agencies assisting or working with Ms Batty – did not collectively, in real time, know and share and consolidate the discreet pieces of information applicable to her situation. This is a fundamental point. Real time updated information sharing between agencies (including Victoria Police) is a key element in a fully integrated system, and in my view, is a necessary precursor to interventions which can be taken to promote safety and save lives. In summary then, I agree with this submission.
432. I note that the evidence reveals that prior to Luke's death there was a concerning knife theme in Mr Anderson's various threats. However, it is important to contextualise these threats and acknowledge that before 12 February 2014:
    (a) there had been no attempt by Mr Anderson to physically harm Ms Batty for more than one year;
    (b) with the exception of the allegations surrounding the knife incident, there was no known history of Mr Anderson making threats of harm to Luke;
    (c) Ms Batty firmly believed that Mr Anderson loved Luke and it was important for Luke to have a relationship with his father;
    (d) Mr Anderson abided by the terms of the FVIO;

[334] Transcript, p. 67.
[335] Submissions on behalf of Ms Batty, page 27 (para. 76).

(e) Mr Anderson was not formally diagnosed with any mental illness.

SUBMISSIONS

433. On 16 February 2015, I received written submissions from counsel for Ms Batty, the DHS, the Chief Commissioner of Police and counsel assisting. All submissions were exchanged between the parties and the replies were filed by 27 February 2015. I thank the parties for their very detailed and constructive submissions.

CONCESSIONS

434. The DHS, through Dr Miller, made the following acknowledgements (concessions):

(a) that Ms Batty made 'extraordinary efforts' to keep Luke safe and 'create a good life for him'. Ms Batty was described as a 'very protective parent and an attuned and loving mother.'[336] I agree.

(b) that Child Protection should have met with Mr Anderson, accompanied by police officers, to observe his presentation and mental state, ascertain his ability to appreciate the concerns raised by Child Protection in relation to Luke's safety and well being and further assess the risks he posed to Luke. I agree.

(c) that Child Protection's practice would have been enhanced by gathering further information in relation to Luke and Ms Batty by persevering in attempts to communicate with, and elicit information from Ms Batty's Windermere case worker, Ms Wilde. I agree.

(d) that Child Protection should have convened a case conference with all of the professionals involved with Ms Batty and Luke, including Luke's school, Victoria Police, Windermere, to share information in Luke's best interests. I agree.

(e) that Child Protection's decision to seek Ms Batty's agreement to an undertaking that required her to supervise Mr Anderson's contact with Luke in circumstances in which she was a victim of family violence perpetrated by Mr Anderson and a known protected family member under a FVIO made against him required reflection. I agree and note that DHS proposes to develop a practice advice in relation to the use of 'undertakings' by Child Protection;

(f) that Child Protection's decision to write to Mr Anderson to advise him of its decision to cease involvement with Luke required reflection and is currently reviewing is 'practice advice' in relation to advising parents of the outcome of an investigation. This is a positive step.

435. I also commend the DHS for implementing in April 2014 the Child Protection Specialist Practice Guide 'Working with Families where an adult is violent',[337] which stresses the value of convening case conference, sharing information and engaging with perpetrators of family violence to support risk

[336] Exhibit 108 – Expert Report of Dr Robyn Miller, p. 32.
[337] This Practice Guide has been provided to all Child Protection practitioners in Victoria and ongoing training provided in relation to its contents.

assessments and improve responses to family violence. This practice guide sets out the risk factors consistent with those contained in the L17 and the CRAF.

436. AC Cornelius in his evidence acknowledged that Victoria Police has identified that it needs to:

(a) work better with its partner agencies in relation to family violence; and

(b) address the ongoing cultural challenge ensure police officers take reports of family violence seriously and make sure that they are assertive in holding the offenders accountable.

COMMENTS

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

Filicide

437. I note that 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.

438. Professor Ogloff's expert evidence was that the prevalence of filicide is approximately 25 cases in Australia per year. Data collected in a nine-year study of homicides conducted by Swinburne University indicates that the average annual filicide rate in Victoria is 0.27 per 100,000 (approximately 1 in 400,000). The homicide rate for children in Luke's age range is substantially lower than the overall rate, most likely fewer than 1 in 800,000 to 1 in 1,000,000 per annum. Research, to date, indicates that the vast majority of filicides occur in the victim's residence, with 25 to 40% of child deaths occurring in the context of threatened separation or divorce of the child's parents.

439. Given the nature of the facts in this matter, the focus has been on male perpetrated family violence and filicide. However, it noteworthy that the statistics reveal that mothers account for almost half of filicide statistics.[338]

440. In an effort to understand filicide, clinicians and researchers have developed classification systems to distinguish filicidal perpetrators. The seminal classification system, created by Phillip Resnick,[339] has been the most longstanding and influential. It comprises the following five categories that are ultimately driven by the parents' motive to kill the child(ren):

(a) altruistic filicide;

(b) acutely psychotic filicide;

(c) unwanted child filicide;

(d) accidental filicide (in the context of ongoing child abuse); and

(e) spousal revenge filicide.

441. Professors' Ogloff and Mullen's expert evidence was that:

(a) characteristics of filicide perpetrators cannot form the basis for predicting filicide because they are too common in the general population and filicide is too rare;

[338] Exhibit 102, Expert report of Professor Ogloff, p. 9

[339] Resnick, P. J. (1969). *Child murder by parents: A psychiatric review of filicide. American Journal of Psychiatry, 126*, 325-333.

(b) while family violence is indicated in approximately 40 percent of filicide cases, due to the high incidence of family violence and the small incidence of filicide, it is not possible to differentiate those cases, which result in child homicide from those, which do not.

442. Professor Ogloff's analysis of characteristics of filicide perpetrators identified that most children killed by their parents were previously physically abused by them. Despite this, Professor Ogloff cautioned that the fact that a child killed by an abusive parent was previously abused, does not differentiate that child from the very large number of abused children who were not killed by an abusive parent. Notably, the evidence was that the fact that previous or ongoing family violence has been perpetrated against a mother and/or child is not instructive in determining which children are at risk of filicide. What flows from this is that Ms Batty's ongoing risk of family violence at the hands of Mr Anderson was not instructive in predicting the risk of filicide to Luke.

443. The Expert Panel's evidence was that existing validated risk instruments capable of assessing risks to adults living in violent relationships do not reliably discriminate between filicide and non-filicide cases and are not helpful in addressing the level of risk to children living with family violence. The Expert Panel's 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 note also the extensive research conducted by Peter Jaffe[340] which indicates that children should be considered to be at *potential* risk of harm if their mother is at risk. I agree with the Expert Panel that strengthening family violence responses generally may lead to a reduction in the number of children killed by their parents.[341]

444. I also agree with Professor Mullen that the lack of certainty about filicide does not mean we have to give up or stop assessing risk:

> *No, of course not, because we can predict which families there's likely to be a recurrence of violence and we can direct our attention and our resources to those high risk individuals. And in doing so, we may very well reduce not just minor injuries but severe injuries, and we may even reduce homicide. But you can't direct it to that, you can only direct your resources to the identified high risk group and the high risk group we're talking about is the high risk of re-assaulting their partner.*[344]

445. Professor Ogloff's expert evidence was that an implication of the poor understanding of filicide is that there are limitations on implementing effective interventions, prevention strategies and policies, but despite this all children in families where there is family violence should be in the frame when protection and safety planning are being considered.[345]

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[340] 'Paternal Filicide in the Context of Domestic Violence: Challenges in Risk Assessment and Risk Management for Community and Justice Professionals' (2014) 23 Child Abuse Review, p. 142 and 'Assessing Children's Risk for Homicide in the Context of Domestic Violence' (2012) 28 Journal of Family Violence, p. 179.
[341] Exhibit 110 – Expert Aide Memoir, p. 43.
[344] Transcript, p 1692
[345] Transcript, p. 1704.

446. Filicide should be considered as part of the broader phenomenon of family violence, rather than existing in a separate category.[346] Steps taken in response to family violence are *likely* to reduce the frequency of its various manifestations, including filicide,[347] however, it is by no means clear that steps taken in response to family violence generally, will *necessarily* reduce the incidence of filicide.

447. In her evidence Ms Batty expressed the following two alternative hypotheses as to Mr Anderson's motive for killing Luke:

    (a) Mr Anderson wanted to "*get at her*";[348] and

    (b) Mr Anderson sensed the beginning of Luke's detachment from him and he was losing control over his son.[349]

448. She may be right, but there is no clear evidence as to the reasons why Mr Anderson chose to kill Luke. One must resist the urge to speculate in order to make sense of the senseless. There is insufficient evidence to draw conclusions, with certainty, as to the true reasons why Mr Anderson killed Luke.

Family Violence

449. Dr Miller's evidence was that the DHS' reported data shows that children are increasingly being identified as victims of family violence in their own right. There was a 295.4% increase between 2004-05 and 2011-2012[350] in the number of children named as an Affected Family Members on a FVIO.

450. Each year in Victoria, approximately 40 per cent of all deaths attributed to homicide occur between parties in an intimate or familial relationship. In addition, many of these deaths occur in the context of family violence, for example a documented history of violence. While 40 per cent of homicides occur between persons in an intimate or familial relationship, not all of these occur in a family violence context (that is in the context of a history of violence, separation or child custody disputes).[351]

451. AC Cornelius' Inquest evidence was that over the last decade there has been an 82% increase of family violence-related matters reported to Victoria Police.[352] In the 2013/2014 year ESTA received approximately 820,000 calls for assistance from members of the public, just over 94,000 of those matters were categorised by ESTA as being family violence-related. After triaging these matters Victoria Police responded to approximately 65,000 family violence-related reports, with between 22,000 and 23,000 matters involving crimes against the person. AC Cornelius' Inquest evidence was that these statistics demonstrate that for front line police officers family violence is core business.[353] This is supported by SC Anderson's Inquest evidence that family violence constitutes 40% of her work load.[354] AC Cornelius' Inquest evidence was that the police region where Luke's death occurred

[346] Expert Aide Memoire Exhibit 110, per Plunkett, Humphreys, McCormack, Laing and Vlais page 2.
[347] Expert Aide Memoire Exhibit 110, per Plunkett, Humphreys, McCormack, Laing and Vlais page 3.
[348] Transcript, p. 130.
[349] Transcript, p. 146.
[350] Exhibit 108 - Expert Report Dr Robyn Miller, Chief Practitioner.
[351] Coroners Court of Victoria Annual Report 2013-14
[352] Coronial brief, p. 1520
[353] Transcript, p. 1521 (revised after listening to the audio).
[354] Transcript, p. 257-258.

consistently had the highest rate of family violence-related offences of any police district across Victoria, with approximately 46 per cent of assaults being family violence-related.[355]

452. Magistrate Goldsbrough's evidence was that in 2013-2014 there were 37,003 applications under the *Family Violence Protection Act 2008* made to the Magistrates' Court of Victoria. Of those applications 11,434 resulted in an interim order being made, 7,733 involving a least one child. 26,008 resulted in a final order being made, 10,825 involving at least one child. 6,930 FVIO contained a 'no contact' provision involving a child.

453. The State's response to family violence needs to be co-ordinated and better integrated. As has often been said, Victoria Police, the DHS, the Courts, the justice system, the corrections system and specialist family violence agencies need to work together to ensure there is effective and meaningful collaboration, co-ordination and integration to protect victims and maximise perpetrator accountability. This is a broad question and very much a matter for the Royal Commission into Family Violence, not this investigation. It will be a matter for the Royal Commission to deal with the systemic issues at a broader level, with a focus, on co-ordinated responses to family violence[356].

Issues of integration and co-ordination in this case

454. Throughout the evidence reference was made to the "integrated family violence system" operating in Victoria and the numerous protocols, codes and arrangements underpinning it to ensure the various agencies collaborate to perform their respective roles when an incident of family violence is reported. It is clear that much good work has been done to integrate the system including through the shared use of the CRAF, but as this and other cases show there is much more to be done.

455. The evidence in this case is that no single agency held or assessed all of the information for the purposes of conducting risk assessments, and managing the risks posed by Mr Anderson. There was no:

    (a) 360° information sharing;
    (b) uniform *approach* to risk assessment;
    (c) co-ordinated approach to risk management and safety planning;

456. Ms Batty, on her own behalf and that of Luke, had contact with numerous family violence agencies. Ms Batty actively sought and received assistance. However, each respective agency's involvement was episodic, limited and not integrated with other agencies. The support she received was fragmented and lacked continuity.

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[355] Transcript, p. 1521.

[356] Extract of Terms of Reference requires the Commissioners to, inter alia:

(a) Examine and evaluate strategies, frameworks, policies, programs and services across government and local government, media, business and community organisations and establish best practice, amongst other things, the prevention of family violence.
(b) Investigate the means of having systemic responses to family violence, particularly in the legal system and by police, corrections, child protection, legal and family violence support services, including reducing re-offending and changing violent and controlling behaviours
(c) Investigate how government agencies and community organisations can better integrate and coordinate their efforts;

Provide recommendations on how best to evaluate and measure the success of strategies, frameworks, programs and services put in place to stop family violence.

457. Despite Ms Batty's numerous contact with the Courts, the police, the DHS, various counsellors, and her various treating medical practitioners her evidence was that she felt alone. Ms Batty's experience was that:

> *There seemed to be no sharing of information I had supplied or police had gathered across from Victoria Police, the Family Court, the Magistrates' Court and DHS. As all these agencies have responsibilities including protecting women and children, I would have thought they would be capable of sharing relevant information to save time, improve responses and protection.*[357]

458. I agree with Ms Batty that there was an absence of effective information sharing between services and there was no comprehensive family violence risk assessment undertaken and shared. The risk assessments that were undertaken by the agencies in relation to Ms Batty and Luke were performed in 'silos' and relevant information was not shared between agencies. None of the services shared its risk assessment with any other service (other than the first page of the L1 sent by Victoria Police to Good Shepherd). Victoria Police and the DHS were unaware of the distress Luke was exhibiting in his sessions with his art therapist, Ms Perry, concerning his on-going contact with Mr Anderson. The DHS (Child Protection) and Ms Portelli were not aware that Mr Anderson had applied to vary the FVIO on 9 September 2013, to have Luke removed from the order, so as to have unsupervised contact with him. Nobody identified that there were ambiguities in the FVIO or that Magistrate Goldsbrough's suspension of the Family Court consent orders had lapsed.

459. Prior to closing Luke's file, the DHS (Child Protection) did not convene a case conference/case planning meeting in relation to risks to Luke involving all professionals involved in his life.

460. Critically, the agencies both internally and externally did not adequately share information or resources to locate or engage with Mr Anderson.

461. I agree with Ms Batty's submissions that there is a lack of documented clarity in relation to the role each agency plays in the family violence service system.

462. Victoria Police has commissioned a number of reviews, which have recommended greater integration in the Victorian family violence sector. As long ago as 2005, the Report of the State-wide Steering Committee to Reduce Family Violence[358] set out a number of principles to guide reform. To date these have not been implemented in full. The theme of integration emerged again in 2011, when the 'Enhanced Family Violence Service Delivery 2011 – 2014' was published by Victoria Police. That report detailed lessons learned over the previous decade, stating Victoria Police was now involved in a 'whole of Government' initiative (led by the DHS) which was trialling a multi-agency family violence risk management approach in the Hume and Greater Geelong municipalities.[359] The 2011 publication went on to state that Victoria Police was in a position to develop a standardised and consistent service delivery model for family violence prevention and response. It was said that this would incorporate the features that had "*proven effective at the local level and would achieve even greater results if*

[357] Coronial brief, p. 1514.
[358] Exhibit 99 – Statement of Assistant Commissioner Cornelius – Attachment 6 Report of the State-wide Steering Committee to Reduce Family Violence - Coronial brief p. 2835.
[359] Exhibit 99 – Statement of Assistant Commissioner Cornelius – Attachment 4 Enhanced Family Violence Service Delivery 2011 – 2014, Victoria Police Coronial brief 2810.

rolled out across the State."[360] One such initiative was a focus on reducing repeat family offenders and victims. This, it was said, would be done by targeting and monitoring recidivist offenders and conducting case management of repeat victims.[361] Again, it has been clear since 2011 that changes are required to make the system more co-ordinated and focused on perpetrator accountability.

463. The improvements identified since 2005 and called for again in 2011 should be implemented.

464. I note the submissions on behalf of Victoria Police that it has undertaken major systems review and made some significant change, culturally and operationally within the last decade and particularly in the recent years. This is clearly the case. But as this and other cases shown, there is still a lot more to be done to ensure that the family violence system becomes progressively better integrated with Victoria Police as a centrepiece of the system. One of the better recent developments has been the introduction of Risk Assessment and Management Panels (**RAMPs**). Victoria Police and the DHS and a number of other agencies are working on the roll-out of RAMPs across Victoria.

465. RAMPs are a formally convened meeting of agencies that work with victims and perpetrators of family violence to comprehensively assess the safety of individual women and children at serious and imminent risk from family violence, and to develop coordinated action plans across participating agencies.

466. RAMPs are a very positive development –likely to promote and strengthen integrated responses to family violence.

Perpetrator accountability - a corner stone of the family violence system

467. The fact is that the perpetrator ultimately controls the risks of family violence. Therefore, it is critical that perpetrators become engaged, or are forced to engage, with the family violence system and the criminal justice system at every possible opportunity to ensure they are not only held to account for their behaviour but also to ensure they receive appropriate treatment, counselling and management to assist them to change that behaviour. This case has dramatically highlighted the need for an emphasis on perpetrator accountability.

468. All cases turn on their own facts and the individual characteristics of victims, perpetrators and families. There are no simple solutions. I am aware of the limitations on what should be expected from the role of change behaviour programs and similar initiatives. Mr Anderson was able to 'play' the system. I accept Mr Vlais' expert evidence that there were a number of indicators to suggest that Mr Anderson would not willingly have attended a men's behavioural program. Mr Vlais' evidence was:

> *He had little regard for intervention orders. He did not turn up to criminal proceedings. He had a strong victim stance and obsessive ruminations which may have been strengthened by a possible delusional order, but "we see a lot of that male sense of entitlement, 'I'm the victim here', sense of betrayal, sense of revenge in many men who pose significant risk to their family members, not just those with a mental illness. The threat to kill, the assault charges, the increasing homelessness, the possession of his car, the threats to harm others, there were a*

[360] Exhibit 99 – Statement of Assistant Commissioner Cornelius – Attachment 4 Enhanced Family Violence Service Delivery 2011 – 2014, Victoria Police Coronial brief 2810.

[361] Exhibit 99 – Statement of Assistant Commissioner Cornelius – Attachment 4 Enhanced Family Violence Service Delivery 2011 – 2014, Victoria Police Coronial brief 2811.

range of factors that were building over time which suggested that for him to go to the program it would have needed a central source, possibly Victoria Police, to over time have pulled together all of these different indicators of potential dangerousness.[362]

469. However, there were other ways Mr Anderson could have been made to account for his behaviour by:

(a) his criminal matters being heard promptly;

(b) warrants being executed that may have resulted in him being held in custody pending the hearing of criminal charges;

(c) being released on bail with treatment/counselling conditions directed at his mental health problems;

(d) being required to submit to medical assessments and treatment so that the underlying causes of his behaviour could be identified and some form of interventionist treatment commenced.

Ms Batty

470. Ms Batty was an impressive, articulate and credible witness. It is clear from Ms Batty's evidence that she was a loving mother, constantly assessing the risks to Luke arising from his contact with Mr Anderson. No criticism can fairly be made of Ms Batty for not preventing Luke's death. As a victim of Mr Anderson's family violence, Ms Batty did her best to assess the level of risk and weigh it against the benefits of Luke having contact with his father.

471. In Ms Batty's tribute to Luke at the closing of the Inquest, she stated '*nobody is to blame*'[363] for Luke's death. I respectfully disagree. The evidence is that Mr Anderson, and Mr Anderson alone, was responsible for causing Luke's death, whether he was suffering a mental illness or not. On the basis of the evidence of Professors Mullen and Ogloff, and noting the evidence about various incidents revealing erratic and aggressive behaviour, it appears reasonable to conclude that he was in fact suffering, at least, an episodic mental illness or disorder. However, there is no direct evidence confirming that this was a medical fact and it was never diagnosed.

472. Mr Anderson was never interviewed in relation to the knife allegation by either the police or the DHS and each respective agency's file was closed after each was satisfied that Luke was not in danger. An important factor in that assessment was Luke's statement during interview on 5 September 2013 that he loved his father and was not frightened of him.

473. While there was a clear theme throughout the evidence was that Mr Anderson loved Luke and that Luke loved Mr Anderson. I accept Ms Batty's evidence that she could not intellectually accept that Luke was at risk of physical harm from Mr Anderson because he (Mr Anderson) loved his son. This case makes it clear that when conducting risk assessments, a parent's love for a child, should not lead to the assumption that the child is necessarily safe when in the presence of that parent.

474. The submissions on behalf of Ms Batty contend that by late January 2014 there were a number of 'red flags' present in relation to Mr Anderson that should have led to a more comprehensive risk

[362] Expert Panel, Mr Vlais, transcript, p. 1801.
[363] Transcript, p. 1621

assessment for Luke and Ms Batty, to actively risk manage family violence, including filicide.[364] I accept that, and note that in the absence of agencies working together to formulate and implement a safety plan for Luke and Ms Batty, through a co-ordinated approach based on information sharing and close consultation, the risks were not going to be adequately managed or mitigated.

Family Violence Risk Assessments - The Common Risk Assessment Framework (The CRAF)

475. A key component underpinning the family violence system in Victoria is the Family Violence Risk Assessment and Risk Management Framework, commonly known as the Common Risk Assessment Framework or 'the CRAF'. The CRAF aims to help practitioners and professionals identify and respond appropriately to risk factors associated with family violence. The CRAF is limited in that it is aimed as assessing risks to a woman and not a child or the perpetrator.[365]

476. The CRAF, being a framework and not an actuarial tool, does not weight factors to produce a result, nor does it record the level of risk determined by the assessor. It assists in identifying risks of future family violence, however, it is not instructive as to the management of those risks.[366]

477. Unlike models used in other jurisdictions, the CRAF, is not empirically evaluated.[367] In my view, this should be a priority for the government.

478. I agree with the Expert Panel's evidence that rather than a specific model of risk assessment needing to be exactly the same across all agencies, what is required is a common framework and language and a system which permits sharing of information and coordination of responses.

479. The evidence in the Inquest was that the risk assessment undertaken by the various agencies were performed in 'silos', not shared and not updated. Luke and Ms Batty were the subject of a range of risk assessments, including:

    (a) L17s undertaken by various police officers;
    (b) DLSC Charteris and her superior following the disclosure of the knife allegation;
    (c) Ms Portelli, Child Protection;
    (d) Christine Allen, in her role as Applicant Support Worker at the Frankston Magistrates' Court;
    (e) Magistrate Goldsbrough during the intervention order hearings;
    (f) Windermere.

480. I also agree with Professor Ogloff's evidence that the utility of the CRAF lies in "*triaging people*",[368] so that people at the highest end might "*end up routed through something like RAMPS*"[369] and those at the lower end might be managed in a different manner.

481. While the merit of using the CRAF was acknowledged, the Expert Panel indicated that its limitations include that it:

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[364] Submissions filed on behalf of Ms Batty, p. 20.
[365] Transcript, p. 1274.
[366] Transcript, 1817, Expert Panel evidence of Ms Plunkett.
[367] B-Safer and ODARA have been empirically validated to provide some understanding of the extent to which the identified people who go onto commit additional family violence, as opposed to those who do not. Transcript, p. 1739 (Professor Ogloff)
[368] Transcript, p. 1740–1741.
[369] Transcript, p. 1740–1741.

(a) is a tool to be used once family violence has been identified rather than a tool to identify family violence;

(b) is vague and offers insufficient guidance about how to use it and interpret results;

(c) provides no information about risk management;

(d) does not assess the risk of children or the perpetrator;

(e) has not been empirically validated.

482. I agree with Magistrate Goldsbrough that the need is for a common and shared risk management system - one which would enable a dynamic risk assessment to be started, maintained and continued (updated) for a family where family violence has been reported. It could be commenced by a police officer but added to by other agencies.

Victoria Police

483. Victoria Police use the L17, derived from the CRAF, as its primary risk assessment tool for family violence. The L17 contains numerous boxes to aid information gathering by the police officer(s) who attend a family violence incident. The L17 is a snap shot in time risk identification tool or checklist. I accept the evidence of AC Cornelius that the L17 was not designed to be a holistic and dynamic assessment, but that is what is needed.

484. While it is a lengthy document, the L17 does not provide clear guidance on how risk factors are to be weighted and how a risk management plan is to be instituted. I agree with AC Cornelius that one of the cultural challenges is to ensure police officers do not approach the L17 as merely '*a tick the box exercise*'[370] and suspend the application of professional judgment. I also agree with AC Cornelius' evidence that police officers are not social workers, their role is to focus on keeping people safe, identifying criminal offences and holding those who commit breaches of the criminal law accountable. It is for this reason that police officers have a range of tools available to them to refer both victims and perpetrators to support agencies and partner agencies for more intensive intervention. The L17 is one such tool.

485. There were at least 65,000 L17 forms generated in 2013-2014 and then disseminated to various partner agencies.

486. Senior Sergeant Alan James Courtney (**SS Courtney**) gave evidence about the process of L17 that existed before Luke's death. The L17 would be prepared by the informant / first responder to the family violence incident and then the hard copy document provided to the section sergeant who would check it for completeness, conduct quality assurance and then initial the document as being correct and forward it on to CDEB. CDEB manually entered the L17 onto LEAP. As at Luke's death, the Hastings Police Station had a dedicated family violence liaison officer (one sergeant with the standalone portfolio). The sergeant would check each L17 and identify any cases that fell into a recidivous category. A recidivist incident was deemed to relate to an Affected Family Member, an address, or a respondent, provided there was relationship between any of those three and there were

[370] Transcript, p. 1532.

three incidences within a rolling 12 month period.[371] I also note that based on the relevant criteria, it was unlikely Mr Anderson would have been deemed a recidivist offender.

487. If a recidivist family violence matter was identified the sergeant would put in a case management plan, allocate an informant to case manage the matter.

488. The introduction of LEDR MKII has streamlined the uploading of L17s in to the LEAP database. The suggestion by the Expert Panel that officers be given electronic equipment such as iPads to fill in L17s at the point of contact has considerable merit in ensuring risk assessments are contemporaneous, accurate and comprehensive.

489. On the evidence, there are flaws in the L17 system:

    (a) it does not explicitly address or assess risk factors for children exposed to or experiencing family violence;

    (b) it provides little guidance on how to weight and combine risk factors (and is better characterised as a risk identification tool rather than a risk assessment tool);

    (c) it does not provide any guidance to the officer completing it to identify the nature of the likely future harm about which a person/child is being assessed. Therefore, an assessment of likelihood of risk of harm is unable to be linked to a particular kind of harm or any narrative analysis of the assessment of those risks;

    (d) police officers do not to receive adequate training on how to conduct a family violence risk assessment.

490. The L17 is not designed to be updated or added to when subsequent events occur involving the same individuals. There is no practice of police officers consulting previous L17s on file in relation to the same victim or offender in order to build a comprehensive picture of risk prior to completing a new L17 for a fresh event of family violence. This militates against its usefulness in a dynamic environment.

491. As the L17 is a document provided to external agencies, any L17 that does not clearly document the risk assessment process is unlikely to be of any useful assistance and require those agencies to start from the beginning with the victim. A victim repeating their story to each agency is counterproductive to combating family violence.

492. I accept the evidence from various the police officers who gave evidence that they are constantly risk assessing in their roles, and to that extent there is an inherent dynamism is the risk assessment an individual officer, or team, undertake as they go about their work. However, the L17 is a more specific risk assessment and different to the Operational Tactics and Safety Training[372] risk assessment. The evidence of police officers who used the L17 as part of their response to Ms Batty demonstrated a lack of confidence about what risk they were assessing and how the risk factors identified were to be weighted in the making of an assessment of future risk. FC Topham's evidence was there was no

[371] Transcript, p. 457.
[372] Commonly referred to as OTST.

specific L17 training that covered how he was to weigh the different factors that appear on the form when making an assessment of future risk. The evidence demonstrated that there was confusion as to what the future risk the form was identifying (i.e. whether it is the risk that the perpetrator would do the same thing again or something different). This should not be construed as criticism of the individual police officers, but serves to identify a training issue for Victoria Police.

493. While the evidence revealed system gaps, there was much to be commended in the way individual police officers responded to Ms Batty, Luke and Mr Anderson. FC Topham made considerable efforts not only to apprehend Mr Anderson but also to keep Ms Batty informed of events. Prosecutor Cathie went to great lengths to try to ensure Mr Anderson was brought back to the Court to account for his actions. SC Anderson's work was diligent and proactive.

The DHS

494. The DHS did not use the CRAF or any other 'check list' risk assessment tool, preferring the 'Best Interests Case Practice Model' (**BICPM**), which requires a Child Protection Practitioner to exercise his/ her best professional judgement in analysing the available information in relation to the child or family. I agree with the DHS submissions that Ms Portelli's risk assessments were focused on the risk that Mr Anderson posed to Luke and were in accordance with the BICPM. I agree that these risk assessments are evidenced in the DHS documents and demonstrate the process by which she formed her conclusions. I also accept the DHS submissions that its decision not to use a 'risk assessment tool' but rather rely upon the BICPM framework has been a carefully considered decision taking into account the most appropriate model of risk assessment for children, as it emphasises professional judgment in assessing the dynamic nature of children and families.[373]

495. During the joint interview on 5 September 2013 Luke said both that he feared his father intended to kill him and that his only fear was that his father would harm himself. This contradiction or tension was never resolved with Luke. There have been different possible versions and interpretations of what was said. Ultimately, that is not the issue. Both versions (Luke's and his mother's) were scenarios capable of frightening, upsetting and confusing Luke and both versions should have put DLSC Charteris and Ms Portelli on notice that Mr Anderson was not a protective parent and should have triggered a comprehensive assessment of Mr Anderson's continuing contact with Luke. I agree with the Expert Panel evidence:

> *The distress shown by Luke towards the end of the interview was grounds for further therapeutic follow up. In addition, it would have been best practice to conduct a further interview with Luke to try and obtain more clarity about his 'retraction'(if retraction it was) and about the precise timing of the incident, which always remained somewhat vague. The ideal person to follow this up was the art therapist, Kate Perry. DHS was left with an ambiguous position and needed a bridge to follow that up.*[374]

496. Victoria Police and the DHS relied too heavily on assumptions made about the level of fear expressed by a conflicted 11 year old. As Mr Vlais noted:

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[373] Submissions in reply on behalf of the DHS, p, 19.
[374] Expert Aide Memoire Exhibit 110, p.66.

Sound risk assessment practice would suggest that where there is ambiguity or inconsistency in verbal reports of fear, and in particular where one has been engaging in behaviours suggesting fear (e.g. feeling too afraid to sleep alone at night) that the risk assessment errs on the side of caution that the person is significantly afraid.
This is no less the case for children's reports of fear. Children are often conflicted, finding it difficult to integrate love for their father with the danger he presents to himself and the family. It can be very difficult for children to admit to themselves, or to others, the danger that their father presents given these conflicted and confused feelings.[375]

497. I agree with the Expert Panel evidence that it would have been good practice to have conducted more of the interview with Luke on his own, having regard to the fact that Luke like most children in circumstances of family violence can feel protective of both parents.[376]

498. There should have been further investigation with Luke, by speaking to him again about the knife incident.[377] As the DHS conceded, at the end of the interview they should have checked with Ms Batty what she thought Luke meant by his interjection and apparent retraction of what he had told her.

499. Ms Portelli's risk assessment was based on the following factors:

(a) a FVIO was in place which no longer allowed unsupervised contact between Mr Anderson and Luke;

(b) Ms Batty reiterated that Luke was not at risk of being physically harmed by Mr Anderson;

(c) the knife allegation had been assessed by Victoria Police as not requiring a criminal charge;

(d) a period of time had elapsed after the events giving rise to the knife allegation without the occurrence of any further adverse incident(s);

(e) Ms Batty had demonstrated her capacity to seek protection for Luke by reporting matters to the DHS, Victoria Police and obtaining a FVIO;

(f) Ms Batty was aware of Child Protection's capacity to provide her with support, should the need arise;

(g) Ms Portelli had advised Ms Batty that the Family Court was the appropriate jurisdiction to finalise contact arrangements;

(h) it appeared Mr Anderson was abiding by the conditions of the FVIO;

(i) Luke's well being and developmental needs were being addressed through counselling and his school;

(j) Luke's behaviour at school had improved;

(k) Luke's school was aware of the conditions of the FVIO and was on good terms with Ms Batty and committed to supporting Luke.[378]

500. I agree with Dr Miller's critique of that risk assessment. It was not rigorous enough, was somewhat superficial and did not have the benefit of any engagement with Mr Anderson.

[375] Exhibit 105, Expert Report of Mr Vlais report para 15.1.1 – 15.1.2
[376] Expert Aide Memoire Exhibit 110 at p. 67.
[377] Expert Aide Memoire Exhibit 110 p. 66.
[378] Exhibit 108, Expert Report of Dr Robyn Miller, p. 37.

501. I note that Ms Portelli also conceded in evidence that it would have been helpful to have contacted Windermere, Luke's art therapist, Ms Batty's psychologist, Dr Heath and Luke's football coach.

502. The DHS relied on Ms Batty's own courage and strength of character in substitution for a proper safety plan for Luke's safety. The undertaking given by Ms Batty to supervise Luke's contact with Mr Anderson conflicted with the conditions on the FVIO in place and was not legally enforceable.

503. The statement of Dr Miller contains a useful analysis of where different or better decisions could have been made by the DHS in its dealings with Luke and Ms Batty:

(a) there should have been a greater effort made to contact and involve Mr Anderson in the process. The failure to make contact with him and to assess him not only removed a valuable potential source of information for the DHS investigation, but also allowed him to remain absolved of potential responsibility for his conduct in relation to the knife incident;

(b) it would have been useful and appropriate to convene a meeting of all those providing services to Luke and Ms Batty, to ensure that all aspects of their needs would be supported after DHS' withdrawal. Importantly, this could have included Ms Perry, whose art therapy sessions with Luke produced considerable and concerning evidence of Luke's experiences and fears;

(c) there should have been follow up, perhaps by way of a second meeting with Luke, to determine when the knife incident occurred and what its context was. Without that follow up there remains, particularly with the knowledge of how Luke died, a distressing uncertainty about what was said to Luke by his father, when it was said, and how he felt about it. That he feared his father would kill him is a serious matter that could not be adequately explained by his having been told about, or seen, a horror movie. It demanded further investigation;

(d) the DHS should have undertaken further investigation with Luke, by speaking to him again about the knife incident.

504. The DHS also closed the file after Ms Batty agreed to sign the Undertaking. Dr Miller conceded:

> *With hindsight, Ms Portelli and her supervisor agree that requiring Ms Batty to sign an undertaking in these terms was not the most appropriate decision In the circumstances. Ms Batty was in fear of Mr Anderson and was not in a safe position to supervise the access even though it required 'line of sight' supervision. Nor would it be safe for Ms Batty to object to Mr Anderson taking photos of Luke. Rather, there would be an expectation that she contact police and or Child Protection.*

505. During the Inquest, the DHS conceded that at the end of the interview with Luke and Ms Batty on 5 September 2013, they should have checked with Ms Batty what she thought Luke meant by his interjection, and apparent retraction, of what he had told her. Had they done so, the DHS conceded that this would have altered their risk assessment and they would have made a recommendation that Luke not be alone with Anderson at any time.

506. In my view in cases such as this, the DHS ought go on to consider whether the other parent still poses a risk of harm to the child within the meaning of s 162 of the CYFA. If the answer to that question is

'yes', then DHS ought supply evidence and / or support to the protective parent in family violence and family law proceedings where the right of the other (non protective parent) to have contact with the child is in issue.

507. This accords with Expert Panel's evidence.[379] The Expert Panel agreed that over the years, Ms Batty had demonstrated that she was willing and able to be a protective and loving parent. But some members of the Expert Panel said that Ms Batty was 'willing but unable' due to the surrounding circumstances, rather than any deficiency in her, and required assistance.[380] I agree that the DHS' mandate should be clarified to ensure it is able to intervene in these circumstances.

508. However, I note the very limited contact Mr Anderson was having with Luke at the time of the DHS' involvement. I accept that there is also no certainty that had the DHS taken these further or different steps identified by Dr Miller, there would necessarily have been any difference in the outcome of their investigation.

Christine Allen's risk assessment

509. Christine Allen assessed Ms Batty pursuant to framework contained in the CRAF. Christine Allen gave the following evidence in relation to the CRAF that:

    (a) while she found it useful, it was not particularly directive;

    (b) as the CRAF has no outcome, someone from outside the family violence sector may find it unhelpful to receive a copy;

    (c) given the role of an Applicant Support Worker in the Courts and the large number of people seen, she thought the CRAF was better suited to those working with women in case management roles where they can meet on more occasions;

    (d) it was most effective once a level of trust had been built with a woman as it relies on eliciting initiate information;

    (e) it is an assessment only for a particular moment in time and risk can change very quickly;

    (f) she would not provide the document to others such as Victoria Police or counselling services without the woman's consent.

510. Christine Allen's experience illustrated the episodic quality the CRAF based risk assessments can have, in the absence of sharing the information.

Good Shepherd

511. The Good Shepherd, being a specialist family violence service, undertakes its risks assessments based on the CRAF. In Ms Batty's case, such a formal risk assessment was not completed because Ms Batty only attended the service once. Evidence was given by Ms Blakkarly, that Good Shepherd provided a case management service whereby a woman (and child) is assigned a support worker to provide them with emotional support, advocacy, to help them to identify the range of issues that they may need to address such as housing, to legal support, to referrals, to other services such as counselling, and

[379] Expert Aide Memoire Exhibit 110, page 53.
[380] Expert Aide Memoire Exhibit 110 page 54.

advocacy with the police. Due to there only being two staff members Ms Batty was placed on a wait list for case management. Ms Batty was advised to speak to her doctor for a mental health plan and advised of Gordoncare, a supervised access centre to supervise and monitor access visits with parents. Ms Batty did not take up this option.

512. Ms Blakkarly's evidence was that Good Shepherd was unable to make an informed risk assessment of Ms Batty and Luke's situation because Good Shepherd did not have any knowledge of anything that was happening past June 2012. They did not receive any information from Victoria Police or the DHS. She said if they had identified Ms Batty as at risk, they would have been more proactive with the police and with Child Protection and with Ms Batty in terms of identifying for her what that risk meant. Good Shepherd was not advised of the DHS' involvement with Ms Batty and Luke.

513. The strong message arising from this inquest was that collaboration between the family violence organisation needs to be strengthened, and not just the high-risk cases. There is too much reliance on individual relationships. Ms Blakkarly's evidence was:

> *There's too much reliance at the moment on individual relationships between - between agencies and services rather than that systemic approach, I think the systemic approach is really useful.*[381]

Judicial risk assessments

514. During the hearings on 24 April 2013 and 22 July 2013, Magistrate Goldsbrough referred to the risk factors, which she perceived to be present in relation to Luke and Ms Batty. Magistrate Goldsbrough's evidence was that while she was not using a specific risk assessment tool she was making a risk assessment.[382]

515. Magistrate Goldsbrough's evidence was that she took a broad approach to the issue of risk and she did not confine her assessment to the harm alleged in the application, but rather to risk of any future family violence given the provisions of the legislation. Magistrate Goldsbrough's Inquest evidence was that she asked questions of Ms Batty based on her experience and advised that she was '*fortunate enough to be experienced enough to ask the right questions*'.[383] Magistrate Goldsbrough's assessment, while she did not verbalise it in Court was that Ms Batty and Luke were at risk of harm or even death at Mr Anderson's hands.

516. It was for these reasons she ordered that there should be no contact between Luke and his father, modified by the decision on 22 July 2013 allowing Mr Anderson to attend Luke's football where other adults would be present, but he would not be permitted to speak to Luke.

Overview of family violence related risks assessments

517. I note the suggestion made by the Expert Panel that there be a common database, managed by a central agency, to which relevant family violence agencies have access. The central agency would have primary responsibility for coordinating and managing information and responses to reports of family

[381] Transcript, p. 1280.
[382] Exhibit 100 – 'Notes as to what I can say in response to questions posed by Judge Gray', p. 7.
[383] Transcript, p. 1713.

violence. This in my opinion is completely sound in principle and the experience of this and other cases would strongly support it. However, the resource implications would obviously be significant and it is a proposal best left for the Royal Commission into Family Violence to consider.

518. The Expert Panel unanimously agreed that an integrated system is essential when managing family violence incidents, however, the various members of the panel differed on how that was to be done. Ms Beth Allen took the view that integration and a common approach to risk assessment does not necessarily mean there is one risks assessment tool that has to be universally applied. Her evidence was:

> *...so integration includes strategies and approaches that aim to support common language that see people coming together to collaborate, to plan, to develop strategies, to address issues together, to undertake initiatives like."* [384]

519. I agree with AC Cornelius' Inquest evidence that reform in this area must recognise the various roles each organisation has within the system. Police officers as frontline responders are called upon to make an assessment, largely based on their operational and their practical policing experience and their training. Consequently, the risk assessment tool Victoria Police uses needs to have the focus on rendering the parties' safe, and ensuring that there are some effective policing interventions at first instance which secure a safe outcome for all concerned, and allows Victoria Police in a position to both notify and engage its partners to ensure a more considered response.

520. A clear message arising from the evidence, in particular the Expert Panel, was the importance of information sharing between agencies. While that occurs to some extent by way of L17 sharing with support agencies, there is no circle of information sharing which provides updates back to police and limited opportunities for risk assessments to be reviewed and kept current rather than being a moment in time. AC Cornelius' evidence on information sharing was:

> *The key point I think that needs to be understood about information systems is that information systems need to absolutely be based upon a very clear understanding of why that information is being collected and how that information is to be used.*

I agree.

Individuals doing their best to compensate a flawed family violence system

521. Despite the lack of integration in the family violence system, the evidence revealed numerous examples of individuals who did their best to assist Luke and Ms Batty despite being constrained, or even thwarted, by 'the system' and by Mr Anderson's evident capacity to 'play' the system.

522. I particularly commend FC Topham and Prosecutor Cathie for going to great lengths to ensure that Luke and Ms Batty's safety were paramount.

Legislative Impediments and Gaps

Section 162 of the Children, Youth and Families Act 2005

523. Section 162 of the CYFA outlines the criteria for when a child needs protection. The following criteria were relevant to Ms Batty's report to the DHS in relation to Luke's risk of harm from Mr Anderson:

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[384] Transcript, p. 1481.

(a) the child has suffered, or is likely to suffer, *significant harm*[385] as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;

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

(c) the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type.

524. The criteria in section 162 should be clarified to ensure that when the DHS (Child Protection) assesses whether a mother is protective, it ought to take into account the possibility that a mother is willing as Ms Batty was, but unable to prevent the other parent harming the child. If that is the case then the DHS ought to go on to consider whether the other parent still poses a risk of harm to the child within the meaning of s 162 of the CYFA. If the answer to that question is 'yes', then DHS ought supply evidence and / or support to the protective parent in family violence and family law proceedings where the right of the other (non-protective parent) to have contact with the child is in issue.

525. This accords with Expert Panel's evidence. [386] The Expert Panel agreed that over the years, Ms Batty had demonstrated that she was willing and able to be a protective and loving parent. However, some members of the Expert Panel said that Ms Batty was willing but unable due to the surrounding circumstances, rather than any deficiency in her, and required assistance.[387] I agree and the DHS' legislative mandate should be clarified to ensure it is able to intervene in these circumstances

Privacy legislation

526. The evidence revealed confusion in the application of privacy legislation. I note, the Commissioner for Privacy and Data Protection's submissions (**Privacy Submissions**) to the Royal Commission into Family Violence, which address the competing issues, related to privacy, information sharing and ensuring the safety of individuals affected by family violence.

527. The Privacy Submissions acknowledges that while 'privacy' is often cited as a barrier to necessary and appropriate information sharing, Victoria's privacy laws do not prevent the sharing of personal information where there is a serious and imminent threat to the health or safety of an individual or the public.

528. The Privacy Submissions confirms that Victoria's privacy laws allow information sharing in both emergency and day-to-day operational programs for the prevention and response to family violence. The right to privacy does not outweigh the right to personal safety. I agree more needs to be done to

[385] The harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances.
[386] Expert Aide Memoire Exhibit 110 per Panel, p. 53.
[387] Expert Aide Memoire Exhibit 110 p. 54.

ensure that the information sharing needs of frontline service delivery workers are clarified and simplified.

The Bail Act - The effect a warrant has on bail conditions

529. The purposes of bail include reducing the likelihood that an accused may:
    (a) fail to attend in accordance with his or her bail and surrender into custody at the time and place of the hearing or trial;
    (b) commit an offence while on bail;
    (c) endanger the safety or welfare of members of the public; and
    (d) interfere with witnesses or otherwise obstruct the course of justice in any matter before the Court.

530. The issue of bench warrants had the unfortunate, and no doubt unintended, consequence of cancelling Mr Anderson's obligations which effectively lapsed at that point.

531. The fact that Mr Anderson was not legally required to report on bail once a bench warrant was issued has exposed a major flaw in the system. It is one that worked heavily in favour of Mr Anderson - a man who was notoriously difficult to locate. This meant that any delay in the service of a warrant resulted Mr Anderson being at large in the community without obligations to report or comply with bail conditions.

532. This in turn undermined the hard work that police officers such as FC Topham achieved by having Mr Anderson prohibited from attending the township of Tyabb, which was for Ms Batty and Luke's safety.

533. Mr Anderson appeared to be aware of this anomaly and used it to his advantage. In my view, the Bail Act should be amended to rectify this anomaly and I will recommend accordingly.

The Bail Act – Re-introducing section 4(c)

534. Prosecutor Cathie's evidence was that there are approximately 120 to 130 mention matters per day at Frankston Magistrates' Court. Of those, he estimated a minimum of ten warrants per day relate to people who do not attend (i.e. do not answer bail). His evidence was that in the circumstances where a person fails to answer bail, the options for prosecutors are limited since the repealing of section 4(2)(c) of the *Bail Act* (as it was prior to the 2004 amendments to the *Bail Act*).

535. Section 4(2)(c) provided that the person failing to answer bail was required to satisfy the Court that the failure was due to causes beyond his or her control. Prosecutor Cathie suggested that this should be reinstated.

536. In evidence, Prosecutor Cathie hypothetically applied this to the facts of Mr Anderson's bail application on 11 June 2013. It was his opinion given Mr Anderson had reported at the Malvern Police for bail on 22 April 2013, Mr Anderson, "*would have had a very poor case in saying to the Court that*

failing to answer bail was due to causes beyond his control. Malvern's on the same train line as Frankston."[388]

537. In the family violence context, in particular where the failure to answer bail was related to a breach of a FVIO or family violence related charges it is critical in sending a clear message that the alleged perpetrator will not 'get away' with avoiding the criminal justice system. It will also improve the capacity of the police and the Courts to monitor offenders who fail or refuse to adhere to the conditions imposed upon them – those conditions intended, among other things, to supply the police with the capacity to ensure the safety of the victim of the offending.

Breach of a FVIO and breach of bail

538. FC Topham's evidence highlighted the challenges that police officers face when dealing with family violence perpetrators. In this case, FC Topham sought to have tight bail conditions for Mr Anderson. As he put it

> "*in terms of what would be better for Rosie, the more times we could get this guy in front of a court, the better. If we can get more conditions on his bail that we'll, essentially, be able to breach him on and put him before a magistrate on every occasion, in my mind that's a much better tool to use than clocking up little summary charges against him for a breach of intervention order*".[389]

I agree. This approach is strongly supported by the evidence in this case.

539. The more times a family violence perpetrator is put before the Court, the more opportunities there are for the Court to assess risks and address those risks with appropriate orders, including program based obligations/conditions applicable to the perpetrator/offender.

The intersection of the family law system and the family violence system

540. The legal and practical interaction between the Federal family law system and the State family violence system is complex.

541. Magistrate Goldsbrough correctly identified that the intersection between the Family Law system and the family violence system permits magistrates, if they are not satisfied that contact is safe, to prevent it. I agree with Magistrate Goldsbrough that:

> *These are challenging notions in the community for every single person who still considers that a parent has a right to have a child instead of what the legislation quite differently says under the Family Law Act that children have a right to safety and it's their need to be protected in their best interests.*[390]

542. Under section 68R of the Family Law Act, and section 90 of the FVPA, the Magistrates' Court *must* to the extent of its powers under the FLA revive, vary, discharge or suspend the FLA order to the extent that it is inconsistent with the FVIO. In a proceeding to make an interim variation of a FVIO a court suspends (varies or revives) an order under section 68R, that suspension (variation, or revival) ceases to have effect at the earlier of the:

(a) time the interim order stops being in force; and

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[388] Transcript, p. 595.
[389] Transcript, p. 378.
[390] Transcript, p. 1732.

(b) end of the period of 21 days starting when the interim order was made.

543. In other words, the power to amend any family law parenting order is not absolute and has a time constraint of 21 days at the most.

544. On 24 April 2013, Magistrate Goldsbrough determined to make a section 68R order pursuant to Family Law Act, the intended effect of which was to suspend any time Mr Anderson was to spend with Luke pursuant to the 2006 family law parenting orders. But the terms of section 68R order were not reproduced in the FVIO and Ms Batty was not given a separate order on 24 April 2013 setting out its terms. This seemed to confuse other people outside the Court as well as Ms Batty.[391] It is understandable that Ms Batty was confused and unsure about the process in which she was engaged.

545. The Family Court consent orders made in 2006 remained in place until Luke's death, despite being temporarily suspended by Magistrate Goldsbrough on 24 April 2013.

Process flaws and gaps

Family Violence Intervention Orders

546. Between 4 June 2004 and the time of Luke's death, Mr Anderson was a respondent in:

(a) five Interim FVIOs;

(b) three Final FVIO;

(c) one FVSN; and

(d) one Personal Safety Intervention Order (the one relating to XYZ).

547. In this case, the delay in serving the FVIOs was as important as the delay in executing the warrants. Victoria Police, if it has not already done so, should ensure that the same level of priority is given to FVIOs as is given to unexecuted warrants.

548. The process of applying for a FVIO and the role of police prosecutors in those proceedings is confusing and difficult for victims to understand.

549. I agree with the submissions on behalf of the Chief Commissioner of Police that an analysis of the FVIO proceedings relating to Ms Batty and Luke, highlights that they can be disorienting and stressful. Considerable efforts were made by prosecutors to alleviate the stress and to consult and take into account in a considered way the wishes and views of Ms Batty. Information was presented properly to magistrates although, as occurs in all litigation, some matters went in a direction that was not expected; some of the orders ultimately made could have been clearer in their terms and appropriate communication in a suitably sensitive and supportive way took place with Ms Batty. I also agree with the Chief Commissioner of Police's submission that the fact that multiple hearings took place in respect of FVIO sought by Ms Batty and contested by Mr Anderson was not the fault of any police prosecutors.

550. There is evidence of liaison, consistency of approach and pre-hearing preparation amongst those prosecuting the FVIOs relating to Ms Batty and Luke.

Ambiguities in FVIOs

[391] Transcript, p. 88 – 89.

551. There were ambiguities in the successive FVIOs made against Mr Anderson. The language used was unclear and the terms of the section 68R Order made by Magistrate Goldsbrough suspending the Family Court contact orders were not reproduced on the FVIO. I agree with Magistrate Goldsbrough's evidence that there is room for improving the drafting of the orders. It is important that FVIO be written in a simple and unambiguous manner. Greater clarity would assist victims, offenders and police officers to understand what the orders mean and how they are to be interpreted and enforced.

552. The most critical ambiguity was paragraphs 15 and 16 of the FVIO of 22 July 2013 that created confusion as to when Mr Anderson could see Luke when he played football, cricket or engaged in little athletics. These paragraphs appeared to allow Mr Anderson to see Luke both during the week, and on weekends, despite it being clear from the transcript that Magistrate Goldsbrough intended it to be only weekends. When the FVIO was varied on 9 September 2013 to change the words "*such events*" to "*these events*", Ms Batty was not aware that the order removed any reference to "*weeks*", thus confining Luke's time with Mr Anderson to weekends.

Unexecuted warrants and outstanding criminal charges

553. At the time of Luke's death, Mr Anderson was facing 11 criminal charges and was the subject of four unexecuted Warrants to Arrest. Mr Anderson had contact with police officers on a number of occasions between 24 April 2013 and the time of Luke's death. There were missed opportunities, particularly in late January 2014, to execute the outstanding warrants on Mr Anderson when he was intercepted by police officers and served with the intervention order in relation to XYZ.

554. While SC Anderson was not advised of Mr Anderson's address after the 11 June 2013 bail hearing and noting the difficulties SC Anderson said she had in locating Mr Anderson to execute the warrants, it should be recognised that SC Lynch of Chelsea police was able to serve Mr Anderson on 27 January 2014, with relative ease having located his address on LEAP, with the interim IVO obtained by XYZ,

555. The warrant system in place prior to Luke's death provided that the physical warrant went back to the police informant who issued the charges to execute within 28 days. Within the 28-day period, it was expected that the police informant would execute the warrant. During this time, the warrant was not loaded onto the LEAP system. Consequently, if the person the subject of warrant was intercepted by other police officers the existence of the warrant did not show up on LEAP. The warrant would only be entered onto LEAP after the police informant filed the warrant with CDEB. This was a glaring deficiency in the system.

556. I accept the evidence of AC Cornelius that this has been rectified. Since Luke's death, Victoria Police has changed its system for managing warrants for arrest to ensure they are loaded onto LEAP within two days of being issued by a Court.

557. The failure to executed warrants promptly were lost opportunities to engage Mr Anderson with the criminal justice system and potentially with the mental health system. Hypothetically, had the unexecuted warrants been executed on Mr Anderson in a timely way, he would have been brought

before a Court and the question of bail would have arisen. Had he been remanded in custody he would have been unable to be present at the Bunguyan Reserve on 12 February 2014.

558. However, given the nature of the charges and the fact that he had served some time on remand in 2013, he may have been released on bail by 12 February 2014. The warrants processes, while extremely satisfactory, cannot realistically be described as contributors to Luke's death. However any opportunity to create some level of accountability through bail conditions needed to be taken – and I note the evidence that Mr Anderson had a tendency to be compliant with enforceable bail conditions (for example his reporting on bail at Malvern over time).

559. I agree with Magistrate Goldsbrough that when warrants are filed with CDEB they should be clearly marked 'Family Violence related charges'. Mr Anderson should have been arrested as soon as possible after 24 April 2013, as Magistrate Goldsbrough clearly intended.

560. Prosecutor Cathie, appropriately, made notations on his brief cover sheet that Mr Anderson was to be brought before the Court upon the execution of the warrants. Prosecutor Cathie also contacted Malvern Police Station to ensure execution of the warrants could be done on 29 April 2013. Despite these efforts the legislative and process gaps allowed Mr Anderson to avoid arrest, execution of warrants and service of the FVIO. Two critical opportunities to execute warrants on Mr Anderson were missed in early 2014; namely

    (a) on 27 January 2014 when Constable Lynch and four others attended the Chelsea address to serve the IVO in relation to XYZ;

    (b) in the period between 5 and 12 February 2014 because of Ms Batty supplying Mr Anderson's new address to DSC Cocking. [392]

561. In addition, because the FVIO made by Magistrate Goldsbrough on 24 April 2013 was not served, Ms Batty and Luke did not have the protection of the order and any breaches could not be prosecuted.

562. The evidence revealed a misunderstanding by some police officers that warrants needed to be on LEAP before they could be executed. This resulted in lost opportunities to arrest Mr Anderson, particularly on 14 August and 3 October 2013 and 27 January 2014.

563. DSC Cocking's evidence was correct that any police officer who had a "*reasonable belief that there's an active warrant in existence, and it doesn't even apply to the State of Victoria*"[393] could arrest a person in relation to the warrant without having the physical document.

564. Therefore, any police officer who had been told by FC Topham or DSC Cocking, or had knowledge, of an unexecuted warrant in relation to Mr Anderson had the power to arrest him regardless of whether they had physically seen it or that it was unavailable on LEAP.

565. This, however, would not have helped those police officers who had no knowledge of warrants which were not on LEAP. For these offences, the warrants were invisible to other police officers.

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[392] Transcript, p. 62.
[393] Transcript, p. 528.
[395] Transcript, p. 373.

566. The evidence AC Cornelius, which I accept, is that the system governing warrant execution was reformed very soon after Luke's death.

Bail in the context of family violence incidents

567. The evidence touched upon bail hearings in relation to Mr Anderson and whether the granting of bail contributed to Luke's death. In the 18 months prior to Luke's death Mr Anderson was bailed on a number of occasions, including remand hearings on 5 January 2013 and 11 June 2013.

568. On 4 January 2013 police formed the view that Mr Anderson was in a show cause situation, given the matters with which he had been charged on 16 May 2012. Mr Anderson was granted bail, as I understand the evidence, on the basis that the charges arose from one person's account of what had occurred the residence, did not involve physical injuries, the he did not have prior convictions, and he had nominated a place of residence. In order to protect Ms Batty, the Magistrate precluded Mr Anderson from entering anywhere within the suburb of Tyabb. This constituted the extension of a significant measure of protection to Ms Batty. After Mr Anderson was bailed, FC Topham informed Ms Batty of the outcome of the bail proceeding.

569. FC Topham's evidence in relation to there being a need for a formal process for informant's to be contacted before a bail application is heard before a Magistrate is important. FC Topham summed up the issues surrounding Mr Anderson getting bail

> *You've got a guy that's got no criminal priors and ultimately the evidence that we have against him is, unfortunately, the victim, Rosemary Batty's word against his. There is no individual corroborating evidence. Although I'm frustrated and disappointed that he gets bail, I'm also a realist to say that I don't think he ever would have got anything but bail.*[395]

570. Victoria Police should consult with the informants before any remand application.

571. Mr Anderson's bail was not opposed by the police prosecutor on 11 June 2013 and the Magistrate was not told any details of his bail history or the nature of his charges. It appears this resulted from a combination of factors, which included the unavailability of the primary informants, a lack of knowledge on the part of the prosecutors of the significant evidence previously given by Ms Batty, and the pressures of a busy list.

572. Police prosecutors have access to both the criminal file and the family violence file, but they are generally not kept together. To ensure continuity of evidence they should be kept together, to ensure the prosecutor has an appreciation of all of the matters related to the application.

573. Similarly, where an informant is not able to attend a remand application there should be a clear policy on who will attend in their place to ensure relevant information is supplied to the Magistrate.

574. While this bail hearing (11 June 2013) occurred well before the events of 12 February 2014 and cannot be seen as connected to Luke's death, it did provide an example of the system failing to respond to Mr Anderson in a way that might have brought home to him the seriousness of the charges he was facing. It also meant that there was a lost opportunity to, as part of the bail process, to consider the imposition of conditions that might have encouraged, or compelled better behaviour from Mr Anderson and which may have allowed him to be assessed by a psychiatric nurse. Bail hearings are important aspects of the

criminal justice system. Prosecutorial rigor is necessary and is expected by courts. When a prosecutor believes there is a proper basis for opposing bail, bail should be opposed. In the setting of family violence the protective aspect of bail, and the potential of bail to control behaviour through the use of conditions can promote public safety.

Lack of continuity including a family violence advocate

575. I agree and endorse the Expert Panel's evidence supporting a formalised advocacy role for women navigating the family violence system. Ms Fiona McCormack and Ms Plunkett noted that the capacity of family violence services to undertake advocacy roles for women is limited due to the increase in referrals.[396] Professor Humphreys explained that in the United Kingdom the role of the Domestic Violence Advocate is a formalised position and evaluations which have been conducted of the use of that position indicate that for 57% of women who have been supported by such an advocate, there is a near cessation of abuse following three or four months of contact. "*There was a clear link between the number of services offered and the abuse ceasing... the [advocacy system] because it's got a greater authorisation within the UK system did have the potential to deliver some greater safety and some greater accountability*".[397]

576. Dr Laing stated:

> *[A] good domestic violence advocacy to me would be a joint discussion between the woman and the advocate and often the way that comes about is through a process of risk assessment".*[398] *Through the process of sharing all the available information, an advocate might assist a woman to best appreciate the level of risk.*[399]

577. I will recommend accordingly.

The Magistrates' Court of Victoria's Pilot of Family Violence matters

578. I note Magistrate Goldsbrough's evidence:

> *Vast amounts of family violence intervention orders are breached, and we know the police are now taking very strong and appropriate courses of action in relation to bringing those to the Court. For example, in Frankston we've had the highest level of breach (997) in the last year, higher than any other place, which means there's either a lot of very bad behaviour down there at the moment, or police are doing a very fine job. I suspect it's a mixture of both. ..... In relation to breaches, they also do need to come to the court very quickly, which will hopefully be part of this faster tracking system, I see that as perpetrator accountability. ... So breach of an intervention order, you've broken the rules of the court, you come to the court and you're there quickly I think is an important element of the entire criminal justice system response:*[400]

579. Both Magistrate Goldsbrough and AC Cornelius gave evidence about the changes made by the Magistrates' Court of Victoria, in a pilot at the Dandenong Magistrates' Court, to expedite the listing of charges arising out of family violence incidents. I note Practice Direction No. 8 of 2015 issued by the Chief Magistrate of Victoria and dated 18 September 2015. This sets out the 'fast tracking' listing processes to apply at two courts, Ringwood and Ballarat, consistent with those already applied

[396] Transcript, pp. 1783 and 1778.
[397] Transcript, p. 1780–1781.
[398] Transcript, p. 1807.
[399] Transcript, p. 1808 - 1809.
[400] Transcript, p 1804 - 1805

where the system has been implemented. I note that having started in December 2014, the system operates in three of the Magistrates' Courts twelve regions – Dandenong, Broadmeadows and Shepparton. I also note that it is intended to commence the same program in the Frankston region early in 2016.[401] This is an excellent development and reflects the well known fact that if pubic authorities, including courts, do not act quickly in respect of intimate partner violence, then further incidents are likely to occur and become more serious, potentially fatal.

580. I received detailed and helpful submissions from the parties in this case. I received a number of proposed recommendations, including from Ms Batty, the Expert Panel and the Commission for Child and Young People. A number of those have been incorporated within the recommendations I am making. The Chief Commissioner of Police made a submission and did not propose any particular recommendations. However, I note that the evidence makes abundantly clear that Victoria Police has continued to undertake a significant and ongoing program of reform of aspects of its policy and processes over a number of years in response to the increasing incidence of family violence in this State. I note in particular the reforms referred to by AC Cornelius in respect of the execution of outstanding warrants. Nonetheless, it is important to make specific recommendations arising from this investigation to promote further reform, particularly in relation to the issue of coordination, and information sharing, within the agencies (including Victoria Police) operating in the family violence sector. In brief, there are further specific changes that need to be made to maximise information sharing, coordination and ultimately integration of the family violence system in Victoria.

RECOMMENDATIONS

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

The State of Victoria

The following recommendations are directed to the State of Victoria through the agency of the Secretary of the Department of Premier and Cabinet.

1. I recommend that the State of Victoria undertake empirical validation of the Common Risk Assessment Framework (**the CRAF**), including consideration of other family violence risk assessment measures in other jurisdictions (for example, South Australian family safety framework), and the risk assessment tools based upon it, such as the L17, to determine the extent to which they accurately identify a:

    (a) person's (including a child's) risk of being the victim of family violence;

    (b) perpetrator's risk of repeat and/or escalating family violence.

    As part of this validation process, consideration should be given to whether:

    (a) greater weight ought be given to the victim's own level of fear in assessing the risk posed to her and any children;

[401] I was informed of these developments after the Inquest.

(b) there should be a rating and/or weighting of risk factors to assist the person undertaking the risk assessment to identify the risk of family violence to women and/or children as low, medium or high. Any tool or system which rates or weights risk factors should be standardised across agencies dealing with family violence, taking into account the unique mandate of each agency.

2. Noting that some agencies use the CRAF, but that others do not, I recommend, the State of Victoria ensure *all* agencies, including the Magistrates' Court of Victoria, operating within the integrated family violence system:

(a) use the CRAF (once validated), including risk assessments aligned to the CRAF. This includes ensuring that those agencies that use external service providers (e.g. the DHHS) incorporate in service agreements with service providers, a requirement that the CRAF be used when dealing with family violence related matters;

(b) undertake risk assessments that are reduced to writing, shared with, and accessible to all elements within the integrated family violence system dealing with a particular family, for the purposes of:

i. ensuring risk assessments are dynamic, collaborative, comprehensive and up-to-date. That is, once commenced, a risk assessment considers all the information available to all relevant agencies, is updated and maintained for a family where family violence has been indicated or reported;

ii. ensuring risk assessments are accessible by police officers when:

- making an application for a family violence intervention order;
- bringing charges against a perpetrator for family violence related offences;
- responding to a bail application for a person charged with family violence related offences;
- informing presiding magistrates of the outcome of relevant risk assessments.

iii. coordinating the response directed at perpetrators;

iv. coordinating the support given and safety planning provided to victims of family violence;

v. identifying common risk management strategies.

3. I recommend the State of Victoria, and where appropriate, in conjunction with the Office of the Victorian Privacy Commissioner, ensure *all* agencies operating within the integrated family violence system:

(a) have clear rules and education about their respective capacity and obligation to lawfully share information between agencies and/ or to members of the public;

(b) implement clear policies with respect to the *Privacy and Data Protection Act 2014* to inform respective staff members of the circumstances within which they may provide information to members of the public and other government agencies. Such policies must include circumstances where a police officer may inform a parent of any criminal charges laid against another parent (biological or other) or FVIOs, of the same child which indicate a risk to that child; and

(c) adequate training with respect to these policies.

As part of this process consideration should be given to whether the criteria and/or thresholds for sharing personal and/or health information are appropriately calibrated to allow for dynamic, up to date risk assessment in a family violence context.

4. I recommend the State of Victoria identify legislative, or policy impediments to the sharing of relevant information, and remove such impediments, so that all agencies, including the Magistrates' Court of Victoria, operating within the integrated family violence system, are able to share relevant information in relation to a person at risk of family violence.

5. I recommend the State of Victoria ensure *all* agencies operating within the integrated family violence system are:

   (a) clearly identified and their respective roles and responsibilities for responding to family violence are contained in legislation and/or documented in publically available policies;

   (b) provided operational advice and assistance to develop clear policies, procedures and risk assessment tools aligned to the CRAF, to identify and manage a person's:

      i. risk of being the victim of family violence; and

      ii. risk of perpetrating family violence.

6. I recommend the State of Victoria expand access to the Family Violence Court Division (FVCD) of the Magistrates' Court of Victoria across the State. I note the operation of the Family Violence Court Division at Ballarat and Heidelberg Magistrates' Courts. I recommend also that the Court Integrated Services Program (CISP) be made available at those court locations at which the FVCD is applied.

   This would provide equitable, coordinated and integrated responses to families affected by family violence when dealing with the multiple jurisdictions with which they are engaged including family violence, crime, family law, child protection and VOCAT. Most importantly criminal and family violence cases involving the same parties can be dealt with at the same time.

   I accept that there will always be need a tailor or modifying a program availability at certain court locations, depending on the case volume and case mix at that court. However, the point is that Magistrates' Courts deal with a extremely high volume of family violence cases. Many of thousands of intervention orders are made annually. They are made to protect applicants. They are far more likely to be ultimately successful if magistrates are in a position to make orders which combine protective elements, and the engage applicants and respondents with services (including the

compulsory attendance by perpetrators men's behaviour change program) and, and, if necessary, with mental health treatment providers. The elements in the system should therefore include:

(a) specialist family violence case management for all matters, involving families at high risk of family violence;

(b) a Senior Specialist Family Violence Registrar to coordinate the listing of all matters for the one family and manage the family violence team of registrars;

(c) registrars interviewing and initiating/processing in person applications have core competencies in family violence including risk assessment;

(d) family violence Applicant and Respondent support workers and family violence trained CISP case managers at all courts;

(e) the capacity to mandate perpetrators' timely access to and participation in Men's Behaviour Change Programs;

(f) dedicated police prosecutors and civil advocates, family violence outreach workers and access to legal representation (for both applicants and respondents).

(g) resourcing of the system to meet the requirement for legal representation (free legal aid) depending on demand at court locations.[402]

7. I recommend that the State of Victoria, ensure *all* agencies operating within the integrated family violence system are sufficiently supported to provide their respective staff training and professional development to undertake CRAF based family violence risk assessments. Such training and professional development should include, but not be limited to, recognising, understanding; and responding to family violence. Each agency's staff, at all levels, should be educated in the dynamics of family violence, with specialist training provided to those employees whose primary role is to have contact with victims and perpetrators of family violence.

8. I recommend that the State of Victoria, implement Risk Assessment and Management Panels (RAMPs) in all police regions as soon as possible.

9. I recommend that the State of Victoria, ensure there is a process that triggers a compulsory referral to a Risk Assessment and Management Panel when a family violence agency and/or the Magistrates' Court of Victoria, assesses a person's risk for family violence as 'high'. Such a process should include, but not be limited to:

(a) an initial case management conference during which the panel members use the CRAF to undertake a multi agency case review and risk assessment of the affected person (and where relevant their children) using all information and all past risk assessments undertaken by the individual agencies;

(b) immediate safety action plans;

[402] I note that there is already a substantial legal aid and support service system of provision at Magistrates' Courts dealing with family violence cases with some differentiation between those services court to court.

(c) longer term case management, including risk management strategies, for the affected persons, and establishment of ongoing case management of the care of the affected persons;

(d) providing the referring family violence agency and/or the Magistrates' Court of Victoria with details of the outcome in writing.

10. I recommend that the State of Victoria give consideration to the creation and resourcing of a Family Violence Advocate service to provide advocacy services for women and families modelled on the UK Domestic Advocate position.

The Attorney General of Victoria

11. I recommend that the Attorney General review the *Bail Act 1977* and give consideration to the following legislative amendments:

(a) re-enact the former section 4(2)(c) of the *Bail Act* (as it appeared prior to the 2004 amendments to the *Bail Act*) to require bail to be refused where an accused person is in custody for failing to answer bail unless the accused person satisfies the court that the failure was due to causes beyond his or her control;

(b) require bail to be refused where an accused person is in custody for failing to answer bail in relation to family violence related offences unless the accused person satisfies the Court that the failure was due to causes beyond his or her control;

(c) ensure that bail conditions continue to operate until a warrant for arrest is executed. The new legislation should close the loop hole which presently results in persons who fail to attend Court to answer charges and a warrant is issued is subject to no bail conditions after their bail has been cancelled by virtue of the issuing of the warrant.

Family Law Council

12. I recommend that the Family Law Council consider the merits of amending section 68R of the *Family Law Act 1975* to provide that where a parenting order is suspended, revoked or varied pursuant to section 90 of the *Family Violence Protection Act*, that such suspension, revocation or variation operates until further order of a Court, and is not time-limited.

Chief Commissioner of Police

13. I recommend that the Chief Commissioner of Police amend Victoria Police Manual and other relevant operating instructions and if appropriate, the Code of Practice for the Investigation of Family Violence to require police officers:

(a) to provide all completed L17s relevant to an affected person to all relevant agencies operating in the family violence system;

(b) completing an L17 to review previous L17s relating to the same offender and where possible to contact the authors of previous L17s to ensure information regarding risk is shared and considered;

(c) to check LEAP prior to completion of an L17 to ensure relevant criminal history, or other matters capable of affecting the risk assessment (including but not limited to other acts of violence with which the perpetrator has been charged, intervention orders obtained by other persons to which the perpetrator is the Respondent) are considered.

14. I recommend that the Chief Commissioner of Police cease to use the current definition of 'recidivist' family violence offender and develop criteria for identifying 'high risk' family violence perpetrators that require intensive management. The definition of 'high risk' should be uniformly applied and responded to in all police regions to bring about:

(a) a warning flag in LEAP;

(b) more intensive monitoring of the offender, including bail conditions;

(c) execution of all warrants with respect to the offender to be treated as a priority.

15. I recommend that the Chief Commissioner of Police amend Victoria Police Manual and other relevant operating instructions and if appropriate, the Code of Practice for the Investigation of Family Violence to require:

(a) a police prosecutor appearing in a remand/bail application to have available all previous L17s in relation to the offender to assist them in deciding whether to oppose bail and /or submissions with respect to bail conditions if bail is granted;

(b) where practicable the informant in all family violence matters should be in court, or have communicated to the police prosecutor his or her views as to the future risk of family violence by the perpetrator, prior to any remand/bail application relating to the perpetrator;

(c) all FVIOs be served on the Respondent with priority and where service can not be effected substituted service from the Court be obtained within 24 hours;

(d) all warrants issued in relation to family violence related incidents be executed with high priority and entered onto LEAP within 24 hours of issue;

(e) a benchmark period for the:

i. Commencement of a prosecution of family violence offences;

ii. Authorisation of charges for the breach of an intervention order or family violence safety notice.

(f) police prosecutors, or other designated police officers to ensure affected family members are kept informed in relation to the progress and outcome of all FVIO proceedings, warrants, bail applications and criminal proceedings which relate to them and any other protected family members.

That whenever possible the same police prosecutor be assigned to both the criminal (including bail), and the family violence (civil) matters listed for Magistrates' Courts when the parties are the same in both – that is the applicant/victim and the perpetrator/accused.

The Department of Health and Human Services

16. I recommend that the DHHS incorporate in its Intake Phase practice where family violence services report family violence, that Child Protection requests a completed CRAF as part of its risk assessment and analysis.
17. I recommend that the DHHS introduce a requirement that CRIS notes include the full text of all CRAF risk assessments undertaken in relation to children for whom files are opened.
18. I recommend that the DHHS introduce a requirement that prior to, or when, undertaking a CRAF risk assessment, the DHHS obtain from Victoria Police all L17s relating to the child and their parents and any CRAF risk assessment undertaken by a specialist family violence service.
19. I recommend that the DHHS introduce process whereby all CRAF risk assessments which indicate high risk of family violence to a child be provided to Victoria Police for consideration of bringing an application for a FVIO.
20. I recommend that the DHHS discontinue the practice of asking women at risk of family violence to enter into undertakings, which require them to supervise or manage the behaviour of the perpetrator of the family violence.
21. I recommend that the DHHS include in its standard practice of working with reports of family violence, such as where one parent is believed to be non-protective, a professional case conference be convened before closing a file. Such a requirement must exhaust (all best) efforts to:
    (a) interview the alleged perpetrator of family violence to determine whether harm in relation to a child has been substantiated;
    (b) engage all agencies involved with the family to remediate the issue of services working in isolation and risk assessments being made with insufficient information;
    (c) develop a comprehensive and robust safety plan with clear roles and responsibilities as required.
22. I recommend that where the DHHS assess one parent to be 'protective' but the other is not, that the DHHS provide support to the protective parent, including in court proceedings, to manage the risk posed by the non-protective parent including, (where relevant and appropriate) by recommending that the other non protective parent have no contact with the child.
23. I recommend that the DHHS provide greater guidance to family violence agencies the circumstances in which a report to Child Protection should be made.
24. I recommend that the DHHS ensure its staff comply with its specialist practice resource '*Working with families where an adult is violent*' (2014) to ensure:
    (a) when assessing the protective capacity of the non-offending parent, by analysing the protective factors and ensuring they have been weighted against the history;
    (b) assessing pattern and severity of harm perpetrated against them;

(c) undertaking a comprehensive risk assessment of the perpetrator and their behaviour and that the department can demonstrate a robust approach to locating perpetrators that are evading service involvement or have no fixed address.

Magistrates' Court of Victoria

In addition to Recommendation 6 above.

25. I recommend that the Magistrates' Court of Victoria simplify the *'Information for Application for an Intervention Order'* form and integrate a checklist based on the CRAF for applicants to complete when making an application for a FVIO.
26. I recommend that the Magistrates' Court of Victoria implement training for Registrars who interview applicants and prepare FVIO documentation, to apply the CRAF to ensure appropriate risk information is identified and included in the Application for an Intervention Order.
27. I recommend that the Magistrates' Court of Victoria ensure its staff working in family violence matters receive specialist family violence training in relation to the CRAF and the process by which to undertake a risk assessment.
28. I recommend that Magistrates' Court of Victoria ensure its Applicant Support Workers complete the CRAF with the affected family member in Family Violence Intervention Order cases, and supply the completed risk assessment to Victoria Police.
29. I recommend that the Magistrates' Court of Victoria revise the form and content of FVIOs to ensure they are written in clear and unambiguous language. This should include clarity in relation to the operation of section 68R of the *Family Law Act 1975*.

I thank Counsel Assisting, Ms Rachel Ellyard, and all Counsel and legal practitioners representing the interested parties for their assistance in this case.

I express my sincere condolences to Rosemary Batty and Luke's family and friends.

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

1. **Rosemary Batty, Senior next of kin.**
2. **Detective Senior Sergeant, Allan Birch (Homicide Squad), coroner's investigator.**
3. **Detective Senior Constable Paul Bubb (Homicide Squad), coroner's investigator.**
4. **Magistrate Anne Goldsbrough.**
5. **Royal Commission into Family Violence.**
6. **Professor James Ogloff.**
7. **Professor Paul Mullen.**
8. **Dr Robyn Miller.**
9. **Ms Beth Allen.**
10. **Assistant Commissioner Luke Cornelius.**

11. **Detective Superintendent Rod Jouning.**
12. **Fiona McCormack.**
13. **Dr Lesley Laing.**
14. **Professor Cathy Humphreys.**
15. **Catherine Plunkett.**
16. **Rodney Vlais.**
17. **The Commission for Children and Young Persons.**

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

18. **The Honourable Mr Daniel Andrews MP, Premier of Victoria,**
19. **The Honourable Martin Pakula MP, Attorney General of Victoria,**
20. **Mr Peter Lauritsen, Chief Magistrate, Magistrates' Court of Victoria.**
21. **Mr Graham Ashton, Chief Commissioner of Police.**
22. **Dr Pradeep Philip, Secretary, the Department of Health and Human Services.**
23. **Family Law Council Secretariat, Attorney General's Department (Commonwealth).**

Signature:

JUDGE IAN L GRAY

STATE CORONER

Date: 28/9/2015.

Coroners Court of Victoria