IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 1676

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**JOHN CAIN, STATE CORONER**
Deceased:	**ROSEMARY GIBSON**
Date of birth:	25 October 1953
Date of death:	14 April 2016
Cause of death:	I(a) Gunshot wounds to the head
Place of death:	30 Airfield Road, Traralgon, Victoria

Amended pursuant to s.76 of the *Coroners Act 2008* on 22 February 2021 by order of Judge John Cain. Paragraph 56(b) was amended to correct the date of death.

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HIS HONOUR:

BACKGROUND

1. Rosemary Gibson (**Mrs Gibson**) was 62 years old at the time of her death. Mrs Gibson was born in Maffra, Victoria to Bronwyn and Kenneth Siacci, and was the second eldest of four sisters. She is survived by her four children.

2. Mrs Gibson grew up in Heyfield, Morwell and Traralgon areas and attended both primary and secondary schools in Traralgon. She left school after completing Year 10 and engaged in various forms of employment including a position as a salesperson at a local jeweller, before being self-employed as a business administrator with her husband.[1]

3. Mrs Gibson met Alan Charles Gibson (**Mr Gibson**) at the Methodist Youth Fellowship Group in 1970 and before marrying on 9 October 1971.[2]

4. The couple lived together in Mr Gibson's family owned "*Glenlee Caravan Park*" in Traralgon, before moving to the family home at 30 Airfield Road, Traralgon.[3] Mr and Mrs Gibson had four children, two daughters and two sons.

5. Mr Gibson was self-employed and owned a building firm called "*A.C. and R. Gibson*" which he continued to run with the assistance of Mrs Gibson until 2014, when they both retired.[4]

6. Mr and Mrs Gibson were both well-known volunteers in their local community. Mr Gibson was a life member with Apex and a part of the Traralgon Historical Society. Mrs Gibson volunteered with Meals on Wheels, Apex and the local Rotary Club.[5]

7. Mr Gibson had aspirations of travelling in retirement, but was constrained by their commitment to look after their grandson, AA, who had been living with them for over 12 years, and Mrs Gibson's commitment to care for her elderly parents who lived in Sale.[6] Mr Gibson's parents were in an aged care facility in Traralgon. An attempt to place Mrs Gibson's parents in the same facility three months prior to the fatal incident had been unsuccessful[7]

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[1] *Coronial Brief*, Statement of Phillip Gibson dated 14 April 2016, 59
[2] *Coronial Brief*, Statement of Penny Gibson dated 14 April 2016, 47
[3] *DPP v Gibson* [2019] VSC 328, 4-5
[4] Ibid
[5] *Coronial Brief*, Statement of Phillip Gibson dated 14 April 2016, 59
[6] *Coronial Brief*, Exhibit 53 – Police record of interview transcript, 253-260
[7] *Coronial Brief*, Exhibit 53 – Police record of interview transcript, 267-270; Statement of Penny Gibson dated 14 April 2016, 48

THE PURPOSE OF A CORONIAL INVESTIGATION

8. Mrs Gibson's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[8]

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[9] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[10]

10. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[11] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[12] or to determine disciplinary matters.

11. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

12. For coronial purposes, the phrase "*circumstances in which death occurred*,"[13] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

13. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

14. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[14]

[8] Section 4 Coroners Act 2008
[9] Section 89(4) Coroners Act 2008
[10] See Preamble and s 67, *Coroners Act 2008*
[11] *Keown v Khan* (1999) 1 VR 69
[12] Section 69 (1)
[13] Section 67(1)(c)
[14] Section 72(1)

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[15] and

(c) 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.[16] These powers are the vehicles by which the prevention role may be advanced.

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[17] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[18] The effect of this and similar 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.

16. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

17. On 20 April 2016, Brian Gibson identified the body of the deceased as his mother, Rosemary Gibson, born on 25 October 1953.

18. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

19. On 15 April 2016, Dr Victoria Francis, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Francis provided a written report dated 16 August 2016 and concluded that Mrs Gibson died from gunshot wounds to the head.

20. Dr Francis commented on the following in her written report:

(a) Postmortem examination revealed two pathologically distant range gunshot wounds in the right parietal scalp and the right frontal scalp. There was evidence of extensive

[15] Section 67(3)
[16] Section 72(2)
[17] Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152
[18] (1938) 60 CLR 336

damage to the brain tissue with bullet fragments noted within the brain tissue. No exit wounds were identified.

(b) There was no evidence of significant injury to the hands or other defensive type injuries.

21. Toxicological analysis of samples of postmortem blood detected the presence of trace amounts of paracetamol (less than 5.0 mg/L) which is consistent with therapeutic levels of dosage.

22. I accept the cause of death proposed by Dr Francis.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

23. On 12 April 2016, Mr Gibson's sister, Penny Gibson (**Penny**), flew from Brisbane to visit Mr Gibson and their parents who lived in an aged care facility in Traralgon. Penny stayed with Mr and Mrs Gibson at their residence at 30 Airfield Road and noticed that there was tension between the two and that they did not appear to be communicating with each other.[19]

24. On the morning of the 13 April 2016, Mrs Gibson went to Sale to look after her parents. Penny invited Mr Gibson to join her for lunch with their parents, but Mr Gibson elected to stay home alone and Penny did not return to the residence until around 7.30pm.[20]

25. When Penny returned to the residence, she noticed that Mr Gibson was complaining of back pain after reporting to have cleaned up items stored under their billiard table that Mrs Gibson had been storing for a long time. Mr Gibson was reported to have taken the items to the backyard and set a bonfire to burn it all.

26. Mrs Gibson returned to the residence around 8.00pm and not long after, had a heated argument with Mr Gibson about her belongings being burnt and cleared from underneath the billiard table. Mrs Gibson spoke to Penny later that evening, confirming that she had had enough. Mrs Gibson said to Penny that she had had a hard day with her parents and could not 'take it' anymore.[21]

27. The next morning between 6.30am and 7.15am, Penny heard two sounds like, "*bang, bang*", coming from the kitchen/dining area but did not think much of it. She joined Mr and Mrs Gibson's grandson, AA, in the kitchen and saw Mrs Gibson sitting on a lounge chair with a

[19] *Coronial Brief*, Statement of Penny Gibson dated 14 April 2016, 47-49
[20] Ibid, 49
[21] Ibid, 50

blanket pulled up to her chin and her head turned sideways.[22] The room was dark and the blinds were drawn so Penny decided not to disturb her and went to see her mother.

28. Between 7.30am to 7.47am, shortly after Penny left the residence,, AA tried to wake Mrs Gibson but noticed some blood.[23] AA tried to get Mr Gibson but found that the bedroom door was locked and he rang emergency services for assistance.

29. Ambulance paramedics arrived at 7.53am and attempted to resuscitate Mrs Gibson without success and she was confirmed deceased at the scene. Ambulance paramedics then attempted to open Mr Gibson's bedroom door and were able to gain entry at approximately 8.15am. Upon entry, Mr Gibson was found lying unconscious with blood by his head and a firearm on the floor next to the bed.[24]

30. Ambulance paramedics were able to detect vital signs from Mr Gibson and he was transported to Latrobe Regional Hospital for treatment. Mr Gibson was later interviewed on 4 May 2016 and admitted to shooting Mrs Gibson and attempting to kill himself.[25]

Criminal investigation

31. On 16 May 2019, in the Supreme Court of Victoria, Mr Alan Gibson was found guilty and convicted and sentenced to 15 years' imprisonment with a non-parole period of 10 years for the murder of Mrs Gibson.[26]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

32. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.

33. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mrs Gibson and Mr Gibson was one that fell within the definition of '*family member'*[27] under that Act. Mr Gibson's act of fatally assaulting Mrs Gibson constituted '*family violence'*.[28]

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[22] Ibid, 51
[23] *Coronial Brief*, Exhibit 52 – VARE police record of interview transcript
[24] *Coronial Brief,* Statement of Robert Stuart Iremonger dated 27 April 2016, 76-77
[25] *Coronial Brief*, Exhibit 53 – Police record of interview transcript, 267-269
[26] *DPP v Gibson* [2019] VSC 328, 11
[27] Family Violence Protection Act 2008, section 8(1)(a)
[28] Family Violence Protection Act 2008, section 5(1)(a)(i)

34. In light of Mrs Gibson's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[29] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[30] A review of the available evidence unfortunately did not identify any evidence of reported family violence history or proximate service contact with Mr and Mrs Gibson other than support provided by Child Protection.

Family violence risk factors

35. To determine the presence of any family violence risk factors in the circumstances leading up to the fatal incident, I have referenced the *Family Violence Risk Assessment and Risk Management Framework*, also known as *The Common Risk Assessment Framework* (**CRAF**)[31].

36. The CRAF was first introduced in 2007 to assist service providers from a wide range of fields to understand and identify risk factors associated with family violence and respond consistently. Practitioners like Child Protection workers, Victoria Police members, mental health clinicians and medical professionals utilise the content in the CRAF as a best practice model for identifying risks and responding consistently in services provided to family violence victims or perpetrators.

37. The CRAF contains several evidence-based risk factors which have been found to impact on the likelihood of family violence occurring and its severity.[32] These risk factors are divided into three categories: those which relate to the victim of family violence, those which relate to the perpetrator, and those which relate to the relationship. The CRAF also identifies several additional factors which can impact on the options and outcomes available to family violence victims.[33]

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[29] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

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

[31] The Victorian Government recognised the need for an integrated and consistent approach to providing family violence services and in 2008, commissioned a consortium composed of agencies including the Domestic Violence Resource Centre Victoria, Swinburne University and No to Violence to develop and deliver the *Family Violence Common Risk Assessment and Risk Management Framework* (CRAF).

[32] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition.

[33] Ibid, 30.

38. Following the recommendations of the Royal Commission, the Victorian Government developed the *Family Violence Multi-Agency Risk Assessment and Management Framework* (**MARAM**) to support practitioners in assessing, monitoring and managing risk of family violence.[34] This finding references the CRAF assessment as it was the current risk assessment tool used by practitioners at the time of Mrs Gibson's death.

39. In applying the CRAF to assess the level of risk of a fatal family violence outcome in this case, I note that three perpetrator specific risk factors relate to Mr Gibson. Specifically, he had access to weapons (firearms), was unemployed and had a history of mental health issues with a diagnosis of depression. Two of these risks (access to weapons and unemployment) indicated an increased risk of the victim being killed or almost killed.[35]

40. During Mr Gibson's criminal trial in the Supreme Court of Victoria, expert evidence was accepted that purported to indicate that Mr Gibson suffered from depression and frontotemporal dementia at the time of the fatal incident.[36]

41. Two relationship specific risk factors appear to be relevant to Mr and Mrs Gibson's relationship. First, several pieces of evidence suggest that Mr and Mrs Gibson were considering ending their relationship at the time of the fatal incident. On the night before the fatal incident Mr and Mrs Gibson had an intense heated argument in which Mrs Gibson said, "*that's it, I can't do it anymore, this is the last time'.*[37]

42. In his police interview on 4 May 2016, Mr Gibson further identified that at the time that of the fatal incident Mrs Gibson was reported to have said that she would "*take him to the cleaners and that she was going to take everything*".[38]

43. Investigating police members also recovered a note written by Mr Gibson that was recovered from the residence and evidences concerns he held about manipulative and controlling behaviour between the couple and concerns about being financially ruined by a separation and divorce.[39] Separation (or attempted separation) by a woman from her partner is also a time of heightened risk for family violence: "*Indeed, the period after separation can be a very*

[34] Family Safety Victoria, *Family Violence Multi-Agency Risk Assessment and Management Framework* (2018).
[35] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition, 75
[36] *DPP v Gibson* [2019] VSC 328, 10
[37] *Coronial Brief,* Statement of Penny Heather Gibson dated 14 April 2016, 50
[38] *Coronial Brief*, Exhibit 53 – Police record of interview transcript, 267
[39] *Coronial Brief*, Statement of Leading Senior Constable Tony Ruiz dated 3 August 2016, 119

dangerous time for a victim, because the perpetrator may perceive a loss of control over her and may become more unpredictable".[40]

44. In addition, Mr and Mrs Gibson were both unemployed and supporting both their grandson AA and Mrs Gibson's elderly parents at the time of the fatal incident.[41] The CRAF identifies that financial difficulties can result in financial stress which, in turn, can increase the risk of future or ongoing family violence.[42]

Child protection support

45. At the time of the fatal incident, Mr and Mrs Gibson were the primary kinship carers to one of their grandchildren, AA, who was the youngest son of one of their daughters. AA and his brother BB were placed in the care of Mr and Mrs Gibson in 2003 after the substantial involvement of Child Protection Services in Queensland and the Department of Health and Human Services (Child Protection) in Victoria. Involvement of these services largely centred around concerns for the parenting capacity of both AA and BB's parents.

46. Child Protection applied for a Custody to Secretary Order[43] which was confirmed in the Children's Court in 2004and both AA and BB have been subject to multiple child protection orders since this time. At the time of the fatal incident, AA was subject to a Care by Secretary Order and was in the full-time care of Mr and Mrs Gibson.[44]

47. BB returned to live with his mother in September 2015, but AA continued to reside with Mr and Mrs Gibson up until the fatal incident, with support provided by workers from Berry Street, Victoria and Child Protection.[45]

48. Records provided to the Court by Child Protection and Berry Street, Victoria evidence repeated incidents of significant behavioural changes in both grandchildren, particularly BB, when they had unsupervised telephone contact from their mother. Between March 2015 and September 2015, all telephone and social media contact between the mother and both grandchildren were supervised by staff from Berry Street, Victoria to support the relationship

[40] *Royal Commission into Family Violence Final Report* (March 2016), Volume 1, Chapter 2, 21
[41] Department of Justice and Community Safety, Youth Justice Case Records for Mataio Jordan Aleluia, 133-134
[42] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition.
[43] A Care by Secretary Order confers parental responsibility for a child to the Secretary of the Department of Health and Human Services, to the exclusion of all other persons. This includes determining the long-term care arrangements for a child subject to this order.
[44] Department of Health and Human Services (Child Protection) records provided to the Court, 52
[45] Ibid, 127

between Mr and Mrs Gibson and their grandchildren.

49. Whilst the available evidence confirms that on September 2015, Child Protection approved unsupervised calls between the grandchildren and their parents,[46] this decision was made in light of changed circumstances, including the fact that BB was returning to live with his mother and AA's behaviour was stable.

50. Several close family members noted the considerable burden placed on Mr and Mrs Gibson in providing long term care to their grandson AA.[47] A review of the available records provided by Child Protection however, confirm that Mr and Mrs Gibson were adequately supported by Child Protection and Berry Street, Victoria[48] throughout the duration of both BB and AA's placement with the couple.

51. The available evidence indicates that between September 2015 and the fatal incident, Mr and Mrs Gibson received financial support from Child Protection and monthly respite care for AA. Child Protection also conducted regular case management meetings involving Berry Street, Victoria and Mrs Gibson to discuss AA's development and education. Workers from both agencies also engaged in regular case planning when any welfare concerns were raised by Mr and Mrs Gibson.[49]

52. As kinship carers, Mr and Mrs Gibson received financial support from Child Protection in the form of:

    (a) fortnightly carer payments and quarterly payments to meet the educational and medical needs for BB and AA;

    (b) periods of respite care. BB and AA attended formal respite care with Kilmany Uniting Care on a monthly basis;

    (c) Mr and Mrs Gibson were entitled to associated Centrelink benefits including Family Tax Benefit; and

    (d) additional funding for psychological counselling, some recreational activities, including music lessons and school camps, gap payments for paediatric appointments, and a

[46] Ibid, 258
[47] Concerns raised in correspondence dated 17 October 2020 received by the Court
[48] Berry Street Victoria is a support service which offers information, advice, support and case management services to kinship carers and their extended family network.
[49] Department of Health and Human Services (Child Protection) records provided to the Court, 58-64

clothing allowance.[50]

53. The destabilising behaviour of the grandchildren's parents was a significant disruptive factor throughout the thirteen years during which Mr and Mrs Gibson cared for their grandchildren. Child Protection provided an appropriate buffer between the grandchildren's parents and Mr and Mrs Gibson. It is evident that both Child Protection and Berry Street, Victoria recognised and valued the consistent and loving care that Mr and Mrs Gibson provided their grandchildren, whilst supporting them with regular communication, providing a range of additional services including respite care, camps, recreational activities and psychological counselling.

54. Whilst in hindsight, there could have been more planning and support for Mr and Mrs Gibson to mitigate the cumulative stressors evident in the events leading up to the fatal incident, both Child Protection and Berry Street, Victoria were in a difficult position having to balance the priorities of both positive contact between the grandchildren and their parents, and the needs of the grandchildren's carers.

55. I am satisfied, having considered all available evidence, and that Mr Gibson has been convicted and sentenced for the murder of Mrs Gibson, that no further investigation is required.

FINDINGS AND CONCLUSION

56. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Rosemary Gibson, born 25 October 1953;

    b) the death occurred on 14 April 2016 at 30 Airfield Road, Traralgon, Victoria, from gunshot wounds to the head; and

    c) the death occurred in the circumstances described above.

57. I convey my sincerest sympathy to Mrs Gibson's family.

58. Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this finding be published on the internet.

[50] Department of Health and Human Services (Child Protection) submissions dated 18 December 2020, 7

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

a) Mr Brian Gibson, senior next of kin;

b) Mr Philip Gibson, senior next of kin;

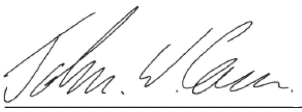
c) Mrs Yvonne Ayres, senior next of kin;

d) Ms Anna Cormack, Senior Solicitor, Department of Health and Human Services;

e) Ms Barbara de Brouwer, Special Counsel, Minter Ellison; and

f) Acting Detective Senior Sergeant Katie Johnstone, Coroner's Investigator, Victoria Police.

Signature:



JOHN CAIN
STATE CORONER
Date: 25 February 2021