IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004890

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	JNY
Date of birth:	[redacted]
Date of death:	Between 1 and 4 September 2020
Cause of death:	1(a) Unascertained
Place of death:	[redacted]
Keywords:	Homicide; family violence; child protection

INTRODUCTION

1. On 4 September 2020, JNY was 68 years old when he was found deceased by his neighbour.

2. JNY married his wife, RBT, in 2006. JNY had three children from a former relationship and RBT had four children from previous relationships, one of whom has sadly passed away. Together, JNY and RBT lived with their two children, one of RBT's sons from her previous relationship, ASW as well as one of JNY's sons from a previous relationship. From late-2007, the family lived in a remote town in regional Victoria.

3. RBT left the relationship twice in 2008 and 2012 due to family violence perpetrated against her by JNY. Whilst RBT lived elsewhere in 2012, an unrelated woman named QUP moved into the home to live with JNY. QUP had an acquired brain injury and an intellectual disability.

THE CORONIAL INVESTIGATION

4. JNY's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned Sergeant Mark Berens to be the Coronial Investigator for the investigation of JNY's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, neighbours and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of JNY including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

9. On 7 September 2020, Coroner John Olle made a formal determination identifying the deceased as, JNY, born [redacted], via fingerprint identification.

10. Identity is not in dispute and requires no further investigation.

Medical cause of death

11. Forensic Pathologist Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 5 September 2020 and provided a written report of his findings dated 7 January 2021.

12. The post-mortem examination revealed decomposition changes with extensive blackening of the skin, bloating and skin slippage. There was no significant injury or internal pathology likely to have led to death.

13. Toxicological analysis of post-mortem blood samples identified the presence of ethanol, temazepam, codeine, paracetamol and amlodipine. Toxicological analysis of post-mortem urine did not identify the presence of ethanol, but identified the presence of temazepam, diazepam, oxazepam, codeine and its metabolite morphine, paracetamol and amlodipine. Analysis of the stomach contents detected temazepam, diazepam and codeine.

14. Dr Bedford explained that the temazepam was detected at an elevated level and provided two possibilities for the cause of death. He explained that the high level of temazepam in the blood and stomach contents would have led to a decreased conscious state and possibly death. Alternatively, the deceased may have fallen unconscious and died as a result of being wrapped and placed in a poor oxygen environment in a freezer.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

15. Dr Bedford provided an opinion that the medical cause of death was *unascertained* and that the death was *not* due to natural causes.

16. I accept Dr Bedford's opinion as to the medical cause of death.

Circumstances in which the death occurred

17. On 29 August 2020, RBT contacted ASW's 16-year-old school friend, and asked her for the recipe for lemon biscuits that she had previously eaten at her house. RBT used the recipe to make a batch of biscuits the next day.

18. On 1 September 2020, RBT made a second batch of biscuits and crushed up some temazepam tablets using a mortar and pestle and put them into the icing of one biscuit. She set aside the biscuit to give to her husband. JNY was last seen alive outside the family home at about 1.30pm that afternoon. That evening, RBT gave the lemon biscuit to JNY, which contained at least seven tablets of temazepam.

19. JNY fell unconscious, so his wife wrapped him up in a blanket, knotted the ends and sealed them with duct tape. RBT believed that he was already deceased when she wrapped him in the blanket.

20. RBT moved the body outside and placed it into a large chest freezer that was non-operational. She sealed the freezer door with two tie-down straps and moved the freezer to the back end of the backyard.

21. On 2 September 2020, RBT left the family home with QUP and two of her children. She lied about JNY's whereabouts and sent a text message from JNY's phone to her own phone which suggested that JNY was leaving her for someone else and asked RBT to look after their children.

22. On the morning of 4 September 2020, RBT called her neighbour and informed them that her freezer had broken down, it was full of rotten meat and asked her neighbour if she could store the freezer in their backyard as someone was coming to collect it. Later that day, the neighbour's son became suspicious about the freezer, decided to open it and discovered JNY's body inside.

23. RBT was arrested that same day for the murder of JNY. RBT pleaded not guilty to murder and pleaded guilty to manslaughter in the presence of the jury. At her trial, RBT gave evidence about the violence and abuse perpetrated by JNY towards her and that when she gave JNY the

biscuit, she only intended to sedate him so that she could have a break from his abuse and denied intending to kill him or cause him really serious injury.

24. Following the trial, the jury was satisfied that when RBT gave her husband the biscuit laced with temazepam that she intended to kill him or at least cause him really serious injury, rejecting RBT's evidence. On 1 June 2023, RBT was sentenced to term of 16 years imprisonment, with a non-parole period of 10 years.

25. RBT sought leave for an extension of time to appeal both the conviction and the sentence. At appeal, her application to appeal the conviction was refused. However, she was granted leave for an extension of time to appeal the sentence. Her sentence was reduced to a head sentence of 12 years with a non-parole period of seven years.

FURTHER INVESTIGATIONS AND CPU REVIEW

26. As JNY's death occurred in circumstances where there was a reported history of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of his death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3]

27. I make observations concerning service engagement with JNYas they arise from the coronial investigation into his death and are thus connected thereto. However, the available evidence does not support a finding that there is any direct causal connection between the circumstances highlighted in the observations made below and JNY's death.

28. I further note that a coronial inquiry is by its very nature a wholly retrospective endeavour, and this carries with it an implicit danger in prospectively evaluating events through the "*the potentially distorting prism of hindsight*".[4] I make observations about services that had contact with the family to assist in identifying any areas of practice improvement and to ensure that any future prevention opportunities are appropriately identified and addressed.

Family violence history

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] 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.

[4] *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7, [80].

29. The history of family violence in this case was extensive and appeared to be the reason that RBT left the family home on at least two occasions. The sentencing remarks noted that she was living in a dangerous and dysfunctional home, marred by family violence. Two family violence intervention orders (**FVIOs**) were taken out, listing RBT as the affected family member (**AFM**) and JNY as the respondent. One FVIO issued in 2008 was revoked shortly thereafter. A second FVIO was in place from February 2012 to February 2013 and listed RBT, their two children and ASW as AFMs. In May 2020, another FVIO was issued against JNY, listing ASW as the AFM. JNY was also the respondent into two personal safety intervention orders (**PSIOs**), issued in 2009 and 2019.

30. Evidence on the committal brief and in Child Protection records noted that JNY was aggressive and confrontational. This included information from multiple school principals and school staff, community members and former friends. He had a criminal history in New South Wales and South Australia. There was also evidence on the committal brief that RBT was allegedly aggressive and there were some concerns for her ability to parent her children.

Systems abuse

31. The evidence available on the brief suggests that JNY was able to use systems such as the family law system, to continue his coercion and control over RBT. RBT attempted to leave the relationship on several occasions and used legal means to protect herself and the children, however ultimately revoked or did not consent to orders that were not in her best interests.

32. On 9 January 2008, RBT took out an FVIO against JNY. In her application, she stated "*In the past my husband has been violent towards me and he has assaulted me on several occasions. On new years eve I tried to commit suicide by taking sleeping tablets. This was because our relationship was getting worse*". She also noted that she left the children in his care until she was able to organise accommodation for all of them. However, the FVIO was revoked only nine days later.

33. When RBT left the family home in August 2008, she took ASW and one of the sons she shared with JNY. In JNY's deposition in the family law proceedings that were occurring at that time, he requested the court consider placing all three children with him, and described RBT as aggressive, suicidal, physically violent towards ASW and unable to properly care for the children.

34. In September 2008, consent orders were made in the family law proceedings. During these proceedings, RBT did not have legal representation and alleged in her deposition that JNY had threatened to kill himself and one of their sons (who was in his care at the time) if she did not consent to the orders. The consent orders granted JNY and RBT equal shared parental responsibility over the two sons they shared together, with all three children to live with JNY. RBT returned to the family home shortly after this order was made.

35. When RBT left again in January 2012, she took all three children with her. Her deposition in the family law proceedings at that time alleged that JNY had been living between the family home and his daughter's home in NSW, leaving for weeks at a time and taking the car keys with him each time so that RBT could not leave without his consent. He also allegedly disconnected her phone. On one occasion, she was able to locate a car key and was therefore able to leave, applying for an FVIO the following day. She later alleged that during early-2012, JNY threatened to "*gas himself and the children*" if RBT did not return to him, and he offered her $20,000 to reunite. At the time, RBT only had access to the children for three hours per week. RBT returned to the family home in October 2012, thereby granting her full access to the children again.

36. I note that significant changes have been made to the family law system in Australia, in part due to the advocacy of groups recognising this type of systems abuse. In those circumstances, and given the passage of time, I am satisfied that I do not need to make a specific recommendation.

Family violence risk and contributory factors

37. The Family Violence Multi-Agency Risk Assessment and Management Framework (**MARAM**) details several evidence-based risk factors which may indicate an increased risk of the victim being killed or almost killed. The MARAM risk factors that were identified in relation to RBT and QUP include:

    a) Financial control
    b) Coercive control
    c) Monitoring/stalking, including monitoring RBT's showers and recording her weight
    d) Sexual abuse
    e) Physical assault
    f) Fear
    g) Access to weapons including a gun and crossbow

h) Isolation

i) Strangulation

j) Verbal abuse

38. JNY's control over the family also included:

a) When RBT's son was killed in 2017, JNY did not permit her to attend the funeral. He also did not allow her to have contact with ASW, when he left the family home in 2020.

b) QUP's surname was changed to JNY and RBT's surname as "*she lived with them and would always live with them*".

39. I note that branding and sexual coercion/exploitation were both factors present for RBT and QUP, however they are not presently included in the MARAM as risk factors. These issues are discussed further below.

Branding

40. Branding in a permanent manner, such as with tattoo ink, is a recognised form of violence and control used by those who perpetrate family violence[5] and/or human trafficking.[6] It is used to demonstrate 'ownership' and can be a powerful psychological method of control. Whilst it is not well-recognised in Australia, it is extensively reported in the United States and increasingly in the United Kingdom.

41. RBT had eighteen tattoos of JNY's name on her body, including on her neck, in between her legs, on her buttocks, hip, pelvis and several on her breasts. She gave evidence at her trial that JNY wanted her to be tattooed with his name, so that no one else would want her.[7] QUP had no tattoos prior to moving in with the family, however at the time of JNY's death, had five tattoos of his name on her body that could "*only be seen when she [was] naked*".[8]

Sexual coercion/exploitation

[5] Robert T Muller PhD, 'Branding Tattoos Use Ink to Violate Women' in Psychology Today https://www.psychologytoday.com/us/blog/talking-about-trauma/201607/branding-tattoos-use-ink-to-violate-women (online) .

[6] Sara Sidner, 'Old mark of slavery is being used on sex trafficking victims' CNN online, https://edition.cnn.com/2015/08/31/us/sex-trafficking-branding/index.html.

[7] DPP v RBT [2023] VSC 286, 11.

[8] Ibid.

42. Evidence available to the Court suggests that JNY 'forced' QUP and RBT to perform sexual acts on him and on each other, some of which he photographed or recorded.[9] There were also naked photographs of RBT and QUP, with evidence at the trial suggesting that these photographs were taken four to five times per week.[10]

43. It is concerning that QUP moved into the household when she was about 16 years old, and that she was 'rescued' by JNY to escape the alleged sexual abuse she was experiencing in her family home. I note that QUP's intellectual disability was significant enough that RBT was paid a carer's benefit to support her, and she gave evidence at RBT's trial that she "*needed him to help [her]*". QUP also gave evidence that she was "*sleeping*" with JNY and one of his sons from a previous relationship, during RBT's trial.

44. Although the MARAM does not recognise sexual coercion or exploitation as a known risk factor, it is clear from the experiences of RBT and QUP that it should be included. QUP was particularly vulnerable and in need of protection, given her intellectual disability and acquired brain injury. In those circumstances, I am of the view that it would be prudent to update the MARAM to include sexual coercion and exploitation as recognised risk factors. Similarly, to align with the growing international body of evidence regarding branding as a family violence risk factor, I am of the view that this should also be included in the MARAM.

45. I note that in my recent finding into the death of Samantha Fraser, I recommended that Family Safety Victoria (**FSV**) "*consider the available evidence and consider including re-partnering and pending criminal date for criminal charges brought by the victim as risk factors to be considered in the MARAM*". FSV responded:

> *A 2023 independent review of MARAM (Evidence Review) did not identify re-partnering or pending criminal charges as risk factors to be added to MARAM.*

46. FSV further noted:

> *A Data Review forms the second and complementary part of the Evidence Review. This Data Review aims to analyse data on the current MARAM evidence-based risk factors and assess their correlation to the presence and level of family violence risk, including likelihood of lethal outcomes. It is due for completion in 2025. While the Data Review is focused on examining the current MARAM risk factors, the findings*

[9] Ibid, 9.
[10] Ibid, 11.

may provide insight into any new risk factors that need to be considered for inclusion, including the ones proposed by the Coroner.

47. I remain of the view that significant and distinct risk factors, such as branding and sexual exploitation being included in the MARAM would assist professionals whose primary role is not family violence, such as general practitioners. General practitioners and other medical practitioners would likely be exposed to evidence such as multiple tattoos of someone else's name. I therefore intend to recommend that FSV consider how best to integrate the evidence demonstrated by this case and other research into the MARAM, its tools and training.

Child Protection involvement

48. Whilst various services involved with the family recognised the family violence that was occurring in the family, the children's experiences of violence were not consistently explored.

2013 notification

49. In April 2013, a notification was made to Child Protection (**CP**) in relation to the children witnessing their parents having intercourse, and JNY reportedly made RBT and QUP walk around the house naked. The notifier also advised that JNY disclosed allegations of taking sexual advantage of girls with disabilities when he was younger.

50. CP notified the Sexual Offences and Child Abuse Investigation Team (**SOCIT**). CP visited the family at home and spoke to the adults, however the children were not at home at the time. The adults all denied any sexual activity between QUP and JNY and denied any exposure to nudity. CP checked JNY's criminal history, gathered information from the children's school and monitored the SOCIT investigation. CP did not speak to the children on this occasion, however submitted that while CP can and often does interview children, it needs to consider the impact when there is an ongoing police investigation (as there was in this case).

51. As a result of the information obtained by SOCIT through the course of their investigation and after consulting with the children's school, CP determined that sufficient follow-up had been undertaken which indicated that there was insufficient risk of harm to warrant further statutory intervention or action. CP submitted that the actions taken in April 2013 were appropriate and in accordance with CP policy and practice.

52. I note the significant passage of time since this incident and make no comment or criticism regarding CP's involvement on this occasion.

2014 notification

53. In May 2014, CP received a notification from ASW's school when he was 11 years old. The school reported concerns about ASW displaying significant behavioural issues including defecating in the school yard, being aggressive and controlling, attending school the year before with red marks on his neck which he initially said were caused by JNY (although later changed his story), and a 'no touching' rule being implemented at school as a result of his behaviour. The notifier also reported concerns about JNY being a violent person and that the children appeared "*skin and bone*".

54. CP followed up with Victoria Police who advised JNY had several complaints from community members and that RBT "*does what she is told*". CP made a notification to Child FIRST (now The Orange Door) for parenting support and closed the report at intake.

55. Given the passage of time between this notification and the fatal incident, I make no criticism or comment about CP.

2020 notifications

56. CP became involved again in April 2020, receiving notifications on 8 and 24 April 2020.

57. On 8 April CP were notified as a result of a FVR L17 submitted by police when ASW left the home.

58. On 24 April CP received a notification from a community member alleging that ASW had left the home as a result of being pressured to have sex with an older woman staying at the home, and after his refusal, being threatened by JNY.

59. On 5 May, when CP contacted ASW, he confirmed allegations that JNY was pressuring him to have sexual intercourse with QUP.

60. The CP records show that JNY and RBT's two sons did not report witnessing any nudity, sexual behaviour or violence, when they were asked by CP. CP also interviewed JNY, RBT and QUP who denied the claims. CP contacted The Orange Door, who had been in touch with the children's school, and were informed that the school had advised "*staff only deal with RBT in relation to ASW as JNY is difficult to deal with and staff are anxious when speaking with him. However, JNY is fine regarding the other children and is proactive. ASW and his brother would get in fights at school and were generally difficult*".

61. CP also contacted the school directly and were advised of no behavioural issues, and no known family violence beyond town rumours. CP closed the matter, noting that ASW had moved out of the family home. Unfortunately, it does not appear that CP were made aware of a subsequent third-party report made to Victoria Police in June 2020, which contained additional allegations, given that L17s were not submitted in relation to that report, nor of the sexualised behaviours exhibited by the children in 2017 at school. This is discussed in detail further below.

62. The notification in April 2020 was the fourth report about this family and was the second report where someone who had lived in the home alleged the children were being exposed to inappropriate sexual behaviour. With the benefit of hindsight, this highlights the significant challenges faced by CP and other services when investigating serious claims of family violence risk to children, in rural communities where a perpetrator of family violence is feared not only within his home, but within the broader community. It is perhaps unsurprising that all victims involved denied the allegations when asked, and unfortunately, further relevant information was not known to CP at the time.

63. CP submitted to the Court that the April 2020 reports were received during the COVID-19 lockdowns, which significantly impacted its service delivery. CP further noted that significant improvements in CP policy and practice have occurred since April 2020. This includes the implementation of the MARAM framework in September 2020 and the SAFER Children's Framework in November 2021.

64. In circumstances where significant changes have been made to CP policy and practice, in combination with the significant passage of time that has since elapsed, I make no further comment or recommendation.

Victoria Police

65. Following JNY's death, given the history of family violence and police contact, Victoria Police completed a Family Violence Related Death Assessment (**FDA**). The FDA is a desktop review completed by police after a fatal family violence-related death and is completed in a vacuum, absent the competing demands and time pressures facing frontline members.

66. There were four reports to Victoria Police in 2020. These are considered in further detail below.

7 – 8 April 2020

67. On 7 April 2020, ASW left the family home following an argument with JNY during which JNY allegedly threatened to assault him. RBT reported ASW was missing to police later that day, after he failed to return home. Police investigated ASW's disappearance and spoke to some of ASW's friends in the local area. One of ASW's friends and his friend's mother reported that they heard about violence occurring in the family home, perpetrated by JNY.

68. ASW was located at his friend's house the next day and was returned home. Police spoke to ASW who disclosed that during the argument the day prior, JNY reportedly said "*fuck off or I'll hit you*", and noted a previous argument about 12 months earlier that resulted in JNY allegedly slapping or hitting him, and he left the family home in fear of being assaulted again.

69. A member of the public separately reported to police that JNY was a recidivist family violence offender, and that RBT regularly attended their home in tears. The person noted they were very concerned about the children in the home.

70. In response to the 7 April 2020 incident, police completed an L17 report, conveyed ASW to alternative accommodation, applied for an FVIO against JNY (to protect ASW) and notified CP.

28 April 2020

71. CP notified SOCIT on 28 April 2020 regarding allegations that ASW was being pressured to have sex with a female in the care of RBT. CP received a notification on 24 April 2020 that ASW left the family home after his stepfather allegedly tried to make him have sex with an older woman who was staying at the same residential address (QUP). The report advised that ASW allegedly refused to have sex with the woman and JNY became angry and threatened to hit ASW. The report noted that ASW had moved to NSW and was staying with his uncle.

72. The CP intake report was provided to SOCIT, who replied by email *inter alia*:

> *There has been previous investigation into alleged sexualised behaviour of JNY and RBT which was found to have no substance.*
>
> *There have been previous FV reports regarding JNY's controlling behaviour towards RBT however no IVO on [sic] place between them. Current IVO with immediate neighbour regarding ongoing dispute.*
>
> *The fact that* [redacted] *is a small and isolated community would be a contributor to under reporting of any incidents. Information received from [ASW] that he is afraid*

of his step-father and no longer wants to live in the house may indicate there being issues with JNY's behaviour.

I recommend further investigation from DHHS regarding welfare of remaining children and to liaise with police at [redacted] *to assist if required. Unless further information is received I do not propose to undertake an investigation at this time.*

73. CP interviewed ASW on 5 May 2020, and he confirmed the allegations of being forced to have sex with QUP. It is unclear if this information was provided to SOCIT. When interviewed by CP, QUP, JNY and RBT all denied the allegations. It does not appear that the SOCIT member submitted an L17 in relation to this incident, and it is unclear what, if any, further action was taken. As this report was not uploaded to LEAP, it was not available for members to consider when the 3 June 2020 report was made (below). This would have been critical context for members to be aware of when considering how to respond to the 3 June 2020 report.

74. In response to this concern, Victoria Police submitted that it was not possible to ascertain which incidents ASW was referencing (i.e., historical, recent or current events). It further submitted that this Child Protection report was made about 20-21 days after the first April report when ASW went missing and suggested that the SOCIT police member might have considered this existing documentation when formulating their response.

75. I accept that it is difficult to know or understand the SOCIT member's thoughts or reasoning at the time, given that there are no contemporaneous notes regarding same. This reinforces the need for members to contemporaneously document all family violence related incidents, even if they are not investigated further.

76. However, given the passage of time, obtaining a statement from the member more than five years later would be of limited forensic benefit. I therefore cannot take this issue any further and make no criticism.

3 June 2020

77. This report was submitted by a third-party and contained information regarding ongoing family violence within the home, suggested that the children appeared depressed when at home with JNY and allegations of possible sexual exploitation of a 'foster child' (QUP) when she was 16 years old. The report alleged that ASW and QUP were forced by JNY and RBT to make pornographic videos which were later sold by JNY, that JNY had been having sexual

intercourse with QUP since she was 16 years old and that QUP was largely confined to her bedroom and only left to shower, to eat and to have sex.

78. On this occasion, an L17 was not submitted, however the information was provided to SOCIT in the form of an Information Report (**IR**). SOCIT allocated an informant and commenced an investigation into the information. On 5 June 2020, the informant spoke to the member of the public who made the report. The community member noted that the concerns about the family were about two years old, and the person had not had any direct contact with the family for some time. The reporter had a longstanding feud with the family; therefore, police considered their report to be 'questionable'.

79. Despite concerns about the quality of the report, the informant liaised with New South Wales Police and asked them to speak to ASW. On 16 June 2020, NSW Police confirmed they spoke to ASW who stated that when he lived with JNY and RBT, JNY told him that he "*needed to start having sex with older women in order to become a man*". Victoria Police attempted to contact ASW that same day but were unable to speak to him.

80. The informant received further information from NSW Police on 6 July 2020, identifying the 'older woman' as QUP, ASW's younger brother witnessed JNY and QUP having sex in a caravan and he never saw any other young people or children attend the house, or anyone else have sex with QUP.

81. On 6 August 2020, the informant outlined a plan to facilitate joint attendance by local and SOCIT members at the family household to speak with the potential complainants, including QUP, however they were awaiting sufficient resourcing and rostering to be able to facilitate same. Due to resourcing at the local station, this attendance was postponed to early-September 2020.

82. As noted above, Victoria Police did not submit an L17 in relation to this incident. The FDA recommended training to address this issue and a review of IRs across Victoria to determine whether this was a systemic issue. Victoria Police also conceded that best practice would have involved speaking to QUP and the children, which did not occur. Victoria Police submitted that while the failure to submit an L17 in relation to this incident might have been a missed opportunity, it noted the difficulties the organisation faced during the COVID-19 pandemic. It also reiterated that while an L17 report was not submitted, there was nevertheless an active SOCIT investigation on foot.

83. I acknowledge the difficulties faced by many organisations during the early stages of the COVID-19 pandemic in Victoria, however given the gravity of the allegations, coupled with the fact that similar reports had been made in the past, I am of the view that a more expedient response was warranted.

84. I also note that Victoria Police has undertaken further work in this area since early-2020. In its submissions to the Court, Victoria Police noted that it is committed to improving its overall response to family violence. Since 2021, such work has included improvements to family violence training to ensure that police members are equipped with the skills to investigate and respond to family violence effectively and appropriately.

85. Since its establishment in 2017, the Centre of Learning for Family Violence (**CFV**) has developed a substantive curriculum and facilitated learning at the Victoria Police Academy, as well as via webinars, both online and face-to-face, across Victoria. The CFV delivers:

    a) Foundation (recruit) training which prepares recruits with the knowledge, skills and behaviours to respond to family violence incidents;

    b) A Family Violence Specialist Operative (**FVSO**) module, which is designed for police members of all ranks working in Family Violence Investigation Units (**FVIUs**).

86. Additionally, the Centre for Crime Investigation delivers the Advanced Diploma of Police Investigation (**ADPI**) qualification, which is designed for all detectives. This course takes 12 to 18 months to complete, and on completion, members are awarded the Advanced Diploma and the official designation of 'Detective'.

87. In response to the FDA recommendations, Victoria Police noted that between 2021 and 2023, the organisation has:

    a) Developed and delivered risk assessment training to frontline members, including compliance and supervision practices within the dedicated FVSO training package; and

    b) Developed an organisational compliance dashboard.

88. Furthermore, Family Violence Training Officers (**FVTOs**) continue to ensure that frontline supervisors are aware of issues of poor compliance and the value of the risk assessment within the FVR.

The Orange Door

89. The Orange Door attempted to engage with both JNY and RBT during 2020, however both denied any family violence occurring. I have not identified any deficiencies in relation to The Orange Door.

Department of Education

90. The children attended two schools: the local Primary School until 2014, then the local Secondary School. It appears that the Primary School closed in [redacted] and at the time of closure, only had minimal students. Whilst the Secondary School was a larger school, the school records indicated that staff experienced challenges in managing the children's behaviour within a small school of limited resources.

91. Records indicate that the Department of Education was aware of the following issues with the children:

    a) Injuries to ASW's neck in 2013, resulting in red marks. He initially reported that these were caused by JNY, but later changed his story. Neither parent was spoken to by the school for fear of safety and these injuries were not reported to CP until 2014. When the 2014 notification occurred, the notifier advised that the delayed reporting was the result of threats to a previous school principal who was on stress leave as a result of threats made by JNY.

    b) Extensive behavioural issues demonstrated by the children, including sexualised behaviours. ASW was suspended in 2017 due to persistent behaviour perceived to be threatening towards females in his class, including blocking their path, brushing up against them and making inappropriate comments in class. The records indicated that ASW "*did not understand why he could not touch female students or chase them into the bushes at school*". One of the other children was also suspended in 2017 for using obscene and sexual language towards a girl at school.

    c) Indications of neglect or dysfunction included a 2017 school assessment of ASW noting that he often had dirty hands, clothes that had not been washed for days and poor hygiene. An undated, partially completed referral form noted that ASW presented with increasingly sexualised behaviours towards female students and that he was ignored by JNY and RBT, as they favoured their two biological children.

d) Concerns were raised by the school community about their safety, including an incident in November 2017 where another local family reported being approached by JNY and RBT at the bus stop. They claimed the other family had been telling students that the family were not nice and if that continued, their sons would hit them. The other family were advised to contact police, and a call was made to JNY to explain that he was not permitted to accost children getting off buses or on their way home from school.

92. Both the local Primary School and Secondary School made numerous attempts to support and engage the children, and to manage the problematic behaviours exhibited by the children. They arranged for a psychologist to visit the local Primary School and engage with ASW, and they arranged for specialist assessments of all the children's intellectual capabilities and speech. Staff also developed other strategies including one-on-one support with ASW, implementing a teacher's aide and individual learning plans. I acknowledge the difficulties faced by both schools, in attempting to address the children's challenging behaviours, within a small community and with limited resources. I do not intend to criticise either school for their management of the children.

93. Since April 2021, after the fatal incident, the Victorian Government introduced information sharing schemes to assist in the sharing of information between services, called the Family Violence Information Sharing Scheme (**FVISS**) and the Child Information Sharing Scheme (**CISS**). Victorian schools were not prescribed under the FVISS and CISS at the time of the fatal incident, however this has since changed, and staff would be able to request or share information about children in a similar situation. In those circumstances, I am satisfied that there is no need for a recommendation regarding information sharing, as new mechanisms now exist.

FINDINGS AND CONCLUSION

94. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was JNY, born 5[redacted];

b) the death occurred between 1 and 4 September 2020 at [redacted], [redacted], from *unascertained* causes; and

c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That **Family Safety Victoria** consider how best to integrate the evidence of branding and sexual coercion/exploitation demonstrated by this case and other research into the MARAM, its tools and training.

I convey my sincere condolences to JNY's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

[redacted], Senior Next of Kin

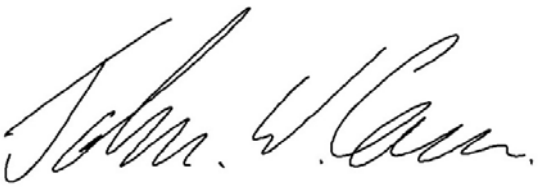
Department of Education

Family Safety Victoria

Victoria Police (C/- Victorian Government Solicitors Office)

Sergeant Mark Berens, Coronial Investigator

Signature:



Judge John Cain
State Coroner
Date:18 August 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after

the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.