Coroners Act, 1996
[Section 26(1)]

Western *Australia*

Inquest into the deaths of:

THIRTEEN CHILDREN AND YOUNG PERSONS IN THE KIMBERLEY REGION, WESTERN AUSTRALIA

Warning: The contents of this finding may be particularly distressing to some readers. Aboriginal and Torres Strait Islander peoples are warned that this finding refers to multiple deaths of young persons in the Kimberley Region. References will be made to geographical locations however there will be no references to persons' names, to avoid causing offence or further distress to some readers.

Coroners Act, 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref Nos: 25/2017

I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the deaths of:

***Thirteen children and young persons in the Kimberley Region of Western Australia**, with an Inquest held at Perth Coroners Court, Central Law Courts, 501 Hay Street, Perth 26 June - 4 July 2017, 4 September – 8 September 2017 and 12 September - 15 September 2017; Broome Court, Hamersley Street, Broome, 17 July - 20 July 2017; Fitzroy Crossing Court, McLarty Road Fitzroy Crossing 2 August - 4 August 2017; Kununurra Court, 96 Coolibah Drive Kununurra 14 August - 18 August 2017; and Halls Creek Court, Great Northern Highway Halls Creek 25 August 2017, find that the identity of the deceased persons were -*

- *Name suppressed, female child referred to in Case 1, and that death occurred on 8 January 2013 at Kalumburu as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, male child referred to in Case 2, and that death occurred between 4 and 5 April 2015 at Broome as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, young man referred to in Case 3, and that death occurred on 7 May 2015 at Broome as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, female child referred to in Case 4, and that death occurred on 6 March 2016 at Looma Aboriginal Community as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, female child referred to in Case 5, and that death occurred between 14-15 February 2013 at bushland at Wyndham as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, male child referred to in Case 6, and that death occurred between 7-8 January 2014 at Mud Springs Community via Kununurra as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, male child referred to in Case 7, and that death occurred on 26 September 2014 at Kununurra as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, male child referred to in Case 8, and that death occurred on 12 December 2014 at Kununurra as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, young man referred to in Case 9, and that death occurred on 24 March 2016 at Mud Springs Aboriginal Community, Kununurra as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, young man referred to in Case 10, and that death occurred between 19-20 November 2012 at Violet Valley Station via Warmun as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, male child referred to in Case 11, and that death occurred between 11-12 January 2014 at Halls Creek as a result of Ligature Compression of the Neck (hanging);*

- *Name suppressed, young man referred to in Case 12, and that death occurred on 5 January 2015 near Wungu Community via Halls Creek as a result of Ligature Compression of the Neck (hanging),*
  and

- *Name suppressed, young man referred to in Case 13, and that death occurred on 22 May 2015 at Halls Creek as a result of Ligature Compression of the Neck (hanging)*

in the following circumstances:

Counsel Appearing :

Mr Philip URQUHART counsel assisting the State Coroner

Mr Sarouche RAZI, with **Ms Hannah LEVY** and **Ms Carol WEI** (Kimberley Community Legal Services (KCLS)) appearing on behalf of the families of the following children and young persons, namely: the aunt of the ***female child referred to in Case 1*** (in collaboration with ALS); the mother of the ***male child referred to in Case 2*** (in collaboration with ALS); the mother of the ***young man referred to in Case 3***(in collaboration with ALS); the mother of the ***female child referred to in Case 4*** (in collaboration with ALS); the father of the ***female child referred to in Case 5***; the mother of the ***male child referred to in Case 7***; the aunt of the ***male child referred to in Case 8***; the aunt of the ***young man referred to in Case 9***; the mother of the ***young man referred to in Case 10***; the mother and aunt of the ***male child referred to in Case 11***; the mother and brother of the ***young man referred to in Case 12***; the sister of the ***young man referred to in Case 13*** (in collaboration with ALS).

At the time of filing their submissions, KCLS instructions were extended to include the families of all of the above.

Mr Paul GAZIA with **Ms Alice BARTER** and **Mr Alexander WALTERS** (Aboriginal Legal Service (ALS)) appearing on behalf of the families of the following children and young persons, namely: the mother of the ***female child referred to in Case 1*** (in collaboration with KCLS); the mother of the ***male child referred to in Case* 2** (in collaboration with KCLS); the mother of the ***young man referred to in Case 3*** (in collaboration with KCLS); the mother and aunt of the ***female child referred to in Case 4*** (in collaboration with KCLS); the sister of the ***young man referred to in Case 13*** (in collaboration with KCLS).

Ms Carolyn THATCHER with **Mr David HARWOOD** and **Ms Jennifer O'MEARA** (State Solicitor's Office (SSO)) appearing on behalf of the Department of Communities (incorporating the former Department of Child Protection and Family Support, Department of Housing and Regional Services Reform Unit); the Department of Premier and Cabinet (incorporating the former Department of Aboriginal Affairs); the Commissioner of Police; the Department of Justice (incorporating the former Department of Corrective Services); the Department of Education; the Department of Health; the WA Country Health Service; the office of the Chief Psychiatrist; the Mental Health Commission; the Director of Liquor Licensing; the Department of Local Government, Sport and Cultural Industries (incorporating the former Department of Racing, Gaming and Liquor).

SUPPRESSION ORDERS

Suppression of all the deceaseds' names from publication and any evidence likely to lead to their identification (save that locations may be referred to).

Suppression of evidence concerning the details of the children's dangerous behaviour (Case 7)

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INTRODUCTION

1. The deaths of 13 Aboriginal children and young persons in the Kimberley Region were investigated at the one Inquest because there were similar circumstances, life events, developmental experiences and behaviours that appear to have contributed to making them vulnerable to suicide.

2. The deaths are profoundly tragic, individually and collectively. I have found that 12 of the 13 deaths occurred by way of Suicide. In one case, I have made an Open Finding.

3. To focus only upon the individual events that occurred shortly before their deaths would not adequately address the circumstances attending the deaths. The tragic individual events were shaped by the crushing effects of intergenerational trauma and poverty upon entire communities. That community-wide trauma, generated multiple and prolonged exposures to individual traumatic events for these children and young persons.

4. In order to take account of the longitudinal impact of the traumatic events, inquiry was made of their physical health and medical history, their home environments, any mental health treatment, and school attendances, together with an investigation into the events occurring shortly before their deaths.

5. Twelve of these children and young persons, in their own individual ways, and by reason of an accumulation of life stressors, reached a point of despair that led them to form the intention to take their lives.

6. Most of the children and young persons had no contact with the mental health services prior to their death and it is known that the majority of persons who die by suicide have not been diagnosed with a mental illness. Most of the children and young persons had previously voiced suicidal ideation or intent prior to death but, save for one child, they had not been directed to a primary health service (a GP) or the mental health services.

7. Some of the children and young persons had voiced threats of self harm more frequently, in the setting of alcohol intoxication. In some cases the behaviour was treated as having become "*normalised*" for that person, so they were not directed to a GP or the mental health services by friends or family. It has also become apparent that their friends and family would not necessarily have apprehended the seriousness or known who to turn to for help. This raises the need for suicide awareness within

communities, teamed with accessible professional and culturally appropriate mental health services.

8. The Inquest considered the role that Foetal Alcohol Spectrum Disorder (FASD) may have played in the deaths of these children and young persons. None were diagnosed with FASD, and I have not found that any of them had FASD (diagnosing it is a complex process requiring assessment by several health professionals). However, there is sufficient information to consider that some of them might have had FASD based on the history of maternal alcohol abuse and their early developmental difficulties. The devastating effect that FASD has on an individual, the community and future generations cannot be underestimated.

9. The investigation of the medical histories reflected that many of the children and young persons who were reviewed suffered from largely preventable medical conditions. Eight of them suffered recurrent skin infections and ten of them, recurrent gastrointestinal infections, that can be directly related to substandard living conditions. Six of the children had been diagnosed with failure to thrive, six with anaemia, and eight with recurrent ear infections.

10. Some of these conditions can have a significant negative impact on a child's long term health and development. Skin and throat infections with Streptococcal bacteria can lead to serious kidney disease (post streptococcal glomerulonephritis) or rheumatic fever. Poor maternal nutrition, failure to thrive and unhealthy childhood diets increase the risk of developing Type 2 diabetes. Early onset of this condition can result in suffering and premature death among the Aboriginal population, from conditions such as ischaemic heart disease and renal failure. Recurrent ear infections can lead to hearing loss, impairing a child's language development and school achievement. Low iron an anaemia can affect brain development and learning ability in the critical early years.

11. Layered on top of their physical ill health, the children and young persons often experienced a dysfunctional home environment. Unfortunately, alcohol abuse and domestic violence within the home was a common feature. Seven of the children directly witnessed domestic violence in the home and some of it was chronic and severe violence. All of it will have had a lasting and profoundly disturbing effect on them, in addition to the traumas suffered by the victims themselves. Three of them went on to have their own relationships marred by domestic violence when they grew up, during their very short lives as somebody's partner.

12. Almost all of the children and young persons grew up in homes marred by the effects of high levels of alcohol abuse, and this was

also deeply unsettling for them. For nine of the children, the level of alcohol abuse in the home compromised the ability of the parents to properly care for their children to such an extent that they were informally placed into the care of other family members for extended periods of time.

13. In many cases the extended family placements were not fully assessed for suitability, and in some cases, the children remained at risk of ongoing harm. The raises the need for dysfunctional families needing support so that they can better care for their children, and even more critically, the need for very early supports so that these high levels of dysfunction can be avoided.

14. A number of the young persons (including a four of the children) had abused alcohol or other drugs from a young age. Some of the children had presented to hospital emergency departments for treatment of alcohol related trauma during their teenage years. In seven of the cases there was significant alcohol use in the lead up to the deaths, and at least two of the young persons had very high blood alcohol levels when they died. Regrettably they were able to buy large quantities of "*take away*" alcohol during the day and night of their deaths.

15. In three cases, cannabis derivatives were detected in the blood after death. Methylamphetamines were not detected in samples from any of the deceased. Community drug use changes and evolves over time. Given the increasing use of methylamphetamines, it is reasonable to suspect that methylamphetamine usage will feature in future deaths.

16. Sexual abuse was alleged in respect of two male children and it was extra-familial. Attempts to support them in disclosing further information were unsuccessful and no legal proceedings ensued. Sexual abuse is often not reported. Without appropriate supervision, children risk becoming vulnerable to abuse. Other than the two instances referred to above, there is no evidence before me of sexual abuse of the other children or young persons.

17. At the time of their deaths, a number of the children and young persons had siblings or relatives who, to their knowledge, had previously died by suicide. Two of the female children whose deaths have been investigated were half-sisters, with the older child dying three years before the younger one. Two of the males whose deaths have been investigated were cousin/brothers, one a child, one a young man, and they had suffered the trauma of other suicides and premature deaths in that family. By the time another one of the young men died, he had already suffered the premature deaths of both parents and a brother.

18. Trauma, premature death and grief are experienced at disturbingly high rates in Aboriginal communities. There is a growing preparedness within Government and the community to accept that colonisation had severe and deleterious impacts upon this ancient and traditional culture.

19. The Department of Premier and Cabinet, through its lawyer the SSO, acknowledges that colonisation and a number of past government interventions have had a negative impact on Aboriginal people. They also acknowledge that, for Aboriginal people, disadvantage is shaped by the accumulated life experiences of social, economic and cultural inequality and exclusion. Disadvantage is also shaped by historic experiences such as the loss of lands and languages, and the forced removal and relocation of children from family and cultural settings, the trauma of which continues to affect individuals and families today. This impacts on the ability to draw on the cultural and collective strength of family and community to enable self-determination.

20. The Department of Premier and Cabinet also acknowledges that the fundamental importance of culture and spiritual wellbeing on physical, emotional and mental health outcomes for Aboriginal people must be understood and applied more widely.

21. Senator Patrick Dodson is a Yawuru native title holder and senior law boss-director of the Yawuru Prescribed Body Corporate. He was the executive director of Nyamba Buru Yawuru Ltd from August 2011 to December 2014. Senator Dodson prepared a report for the coroner, stating:

> *"current public sector arrangements that promote service delivery by non-Indigenous NGOs with no regard for the mabu liyan [one's cultural and spiritual wellbeing] of their clients essentially remain assimilationist, utilitarian and cost risk adverse."*[1]

22. This Inquest has laid bare the urgent need to understand the deep inequalities giving rise to the current poor state of wellbeing of Aboriginal people in the Kimberley Region and to address the factors that elevate the risks of Aboriginal suicide at a community-led level, with genuine consultation and collaboration with Aboriginal communities.

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[1] Exhibit 1.3, Tab 18.

THE KIMBERLEY REGION

23. The deaths investigated at the Inquest all occurred in the Kimberley Region of Western Australia and it is important that I outline some of its unique characteristics, that reflect upon its rich cultural history and some of the challenges involved in delivering essential services to the region.

24. The region is ruggedly beautiful, with large areas of wilderness, ancient mountain ranges, steep gorges and an enviable and largely untouched coastline. It is referred to as one of the world's largest wilderness frontiers, but its pitfalls for the unwary are not to be underestimated. Road access can be limited. There are extreme temperatures, it is one of the hottest parts of the country, and it can be prone to flooding during the wet season.

25. The Kimberley Region encompasses an area of 424,517 square kilometres and represents one sixth of Western Australia's land mass. It is sparsely populated, with an estimated population of 36,230 people (as at 2017). It includes major population centres such as Broome, Kununurra, Derby, Halls Creek, Wyndham and Fitzroy Crossing as well as over 250 remote Aboriginal communities representing more than 30 language groups.[2]

26. The West Kimberley region has 127 remote Aboriginal communities with an estimated population of 4,200 people. Eight of those communities have populations of more than 100 permanent residents. There are a further 36 communities with an estimated population of approximately 2000 residents in the Fitzroy Valley sub-region, with the six largest communities accounting for approximately 80% of those permanent residents. The East Kimberley region has 94 remote Aboriginal communities with an estimated population of approximately 3,200 people. Seven of those communities are home to 60% of those residents.[3]

27. Of the 30 language groups in the Kimberley Region, several do not have speakers within living memory, several have one or two fluent fist language speakers (with others who know the language as an additional one to their own) while other language groups have first and second language speakers numbering over 1000.[4]

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[2] Exhibit 1.6, Tab 57; https://kdc.wa.gov.au/the-kimberley/.

[3] https://regionalservicesreform.wa.gov.au/pr/west-kimberley; https://regionalservicesreform .wa.gov.au/pr; /fitzroy-valley; https://regionalservicesreform.wa.gov.au/pr/east-kimberley

[4] http://klrc.org.au/languages.

28. The Kimberley Region overall has a very high proportion of Aboriginal people at 43% of the total population as compared to the State proportion of 3.2%. The Aboriginal population of the Kimberley Region is younger than the non-Aboriginal population, with nearly half the population aged under 20 (43% compared with 21% for non-Aboriginal).[5]

29. The Aboriginal people have a unique connection to country. The Kimberley Land Council, in its land and sea overview, describes the cultural, spiritual and social connection to country that Kimberley Aboriginal people have, and that adapts with time and place: "*Indigenous law, culture, language, knowledge, traditions, stories and people are embedded in the landscape. They are interconnected and dependant on each other. Kimberley Aboriginal people have a responsibility to look after country, just as it looks after them.*"[6]

30. Related to connection to country is the Aboriginal concept of "*Mabu Liyan*" which was explored at the Inquest. I am assisted by the Kimberley Aboriginal Law and Culture's outline of the meaning of mabu liyan in its response to the *Closing the Gap Refresh*, public discussion paper. The liyan concerns the Yawuru and other Aboriginal peoples' view of wellbeing:

> "*Liyan is about relationships, family, community and what gives meaning to people's lives. Yawuru people's strong connection to Country and joy in celebrating culture and society is fundamental to having good liyan. When we feel disrespected or abused our liyan is bad which can be insidious and corrosive for both the individual and community. When our liyan is good our wellbeing and everything else is in a good space. Mabu liyan was once at the centre of Yawuru society and culture. It informed our obligations to family, community and Country.*"[7]

31. A culture of interconnectedness, spanning thousands of years in the Kimberley Region, means that individual wellbeing is perceived more holistically, as a matter that affects, and is affected by, the wellbeing of the community. The information before me reflects that wellbeing, for many Aboriginal people, is not concerned solely with the treatment of one person's symptoms. Illness is not divided strictly into physical or mental

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[5] Exhibit 1.6, Tab 57.
[6] https://www.klc.org.au/land-and-sea-overview/.
[7] https://closingthegaprefresh.pmc.gov.au/sites/default/files/submissions/kalac.pdf

ill health. For this reason, in order to be effective, healing needs to occur at the community level, as well as the individual level.

32. The Kimberley Region is one of seven health regions within the Western Australian Country Health Service (WACHS). The WACHS focusses upon the health and medical treatment of individuals. Community healing programs are outside its remit.

33. The poor health of many Aboriginal persons within the Kimberley Region is influenced by social factors beyond the control of the WACHS, such as poor education outcomes, paucity of employment opportunities, endemic unemployment, consequential lack of income, poor access to culturally appropriate health services, poor living environments and social exclusion. Collectively, these factors are known as social determinants of ill-health. These social determinants play a critical role in health from the time of conception, through pregnancy, to the post-natal period, and beyond.[8]

34. The high rates of chronic health conditions in the Aboriginal community, often noted at an unexpectedly young age, may indicate premature frailty, disability and functional decline in the older Aboriginal population. The high rate of mortality is significantly beyond that expected for the non-Aboriginal community.[9]

35. At the Inquest, numerous Aboriginal witnesses spoke of the importance of working collaboratively with Government agencies to co-design and implement community-led programs that foster the health and wellbeing of Aboriginal people, and that may prevent future deaths by way of suicide. These sentiments have found expression in the recommendations that I have made.

36. It is also also clear that many governmental and non-governmental service providers in the Kimberley Region, Aboriginal and non-Aboriginal, are highly dedicated, and in some cases, wholly devoted in their efforts to assist in alleviating the plight of Aboriginal people in their region and in their communities. I acknowledge their extraordinary efforts, but many of them are under-resourced. Some, but by no means all, of these efforts are referred to in the course of this finding.

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[8] Exhibit 1.6, Tab 57.
[9] Ibid.

THE INQUEST

37. The deaths of the 13 children and young persons were reportable deaths within the meaning of s 3 of the *Coroners Act* 1996 (the Coroners Act) and they were reported to the coroner as required by the Coroners Act.

38. By reason of s 19(1) of the Coroners Act I have jurisdiction to investigate. The holding of an Inquest, as part of the investigation into each death was desirable, within the meaning of section 22(2) of the Coroners Act. I directed that the deaths be investigated at one Inquest, under section 40 of the Coroners Act. The Inquest into the cluster of deaths by apparent suicide of the 13 children and young persons was able to draw upon similar evidence that gave context to those deaths, in a way that could not have been achieved by separate investigations. It also served to draw attention to the existence of conditions which, if un-remedied, may lead to deaths in similar circumstances in the future.

39. I held the Inquest into the 13 deaths and heard evidence from 91 witnesses.

40. I received 656 exhibits into evidence, between 26 June 2017 and 11 July 2018 as follows:

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41. My primary function has been to investigate the deaths. It is a fact-finding function. Pursuant to s 25(1)(b) and (c) of the Coroners Act, I must find if possible, how each death occurred and the cause of each death.

42. Pursuant to s 25(2) of the Coroners Act, in this finding I may comment on any matter connected with each death including public health, safety or the administration of justice. This is the ancillary function.

43. Section 25(5) of the Coroners Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

44. Pursuant to s 44(2) of the Coroners Act, before I make any finding or comment adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

45. After the evidence was taken at the Inquest, submissions were provided to me for the purposes of s 44(2) of the Coroners Act, between 4 December 2017 and 2 March 2018 by counsel assisting, KCLS, ALS and SSO. Further evidence was subsequently gathered and the parties were provided with an opportunity to view it, upon application.

46. In making my findings below I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336 per Dixon J at 361-362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities. The more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and the more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

THE FAMILIES

47. The 13 children and young persons who died all had parents, relatives or carers who loved them very much. Unfortunately, many of the parents were unable to care for their children because their own lives were marred by the effects of long-standing trauma. They were unable to provide a safe and nurturing environment for their children. The effects of unabated trauma led some of them to chronically abuse alcohol, as an

attempt to deal with their distress. This exposed them to a range of risks to their physical and mental wellbeing and it some cases it fuelled shocking instances of domestic violence.

48. Nine of the 13 children and young persons who died had been placed by informal family arrangement into the care of relatives or community members due to their parents' inability to safely care for them. In many cases, the care arrangements changed over time, because the carers themselves had their own difficulties in managing the additional responsibilities of caring for more children. The carers were all well-intentioned. However, the fragmented care arrangements were, at the very least, unsettling for the children.

49. Twelve of the thirteen families were represented by lawyers. One of the families remained too traumatised and did not feel able to take part in the Inquest, and in their case an offer of care was extended through Anglicare at the behest of the Coronial Counselling Service.

50. The twelve families who were represented by the lawyers were also offered the assistance of the Coronial Counselling Service and the Court Companion Service. The Court acknowledged the difficulty in participating under these very tragic circumstances and having regard to the material before me, the families were given the option of choosing to participate in the Inquest to the extent that they wished to. They remained free to change their minds, and it was made clear at the outset that there would be no compulsions. They were provided with the opportunity to nominate a person to speak on their behalf. They were also offered the opportunity to propose a less formal setting for talking to the coroner, if the courtroom was felt not to be a conducive forum. The offer of interpreters was made.[10]

51. The families were also offered the opportunity to make a statement or to write a letter to me to express their views or feelings. A number of the families chose to write a letter and I have received the letters into evidence.[11]

52. One of the families elected to have an informal meeting with me at one of the courthouses. Their lawyers attended the meeting and the lawyers for the other interested persons were invited to

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[10] ts 8 to 10; ts 803 to 807.

[11] ts 807; Exhibit 2, Tab 30; Exhibit 3, Tab 41; Exhibit 4, Tab 24; Exhibit 5, Tab 24; Exhibit 8, Tab 12A.

attend. The meeting was not recorded. Notes of this meeting were taken and I received them into evidence.[12]

53. Suicide is preventable but it is difficult to predict. A purpose of the Inquest was to better understand the longitudinal factors that contributed to the pre-existing vulnerabilities of the children and young persons. Those pre-existing vulnerabilities can impact upon capacity to regulate emotion and manage ongoing trauma and stress.

54. The children and young persons experienced some temporally proximal events shortly before death, such as an argument, a relationship breakdown, or other disappointment. Such events may not ordinarily have caused or contributed to a suicide, but in a person with those pre-existing vulnerabilities, it has the potential to act as a precipitant to self-harm and suicide.

55. Their pre-existing vulnerabilities caused them to become overwhelmed by these events, and with varying degrees of impulsivity, in twelve of the cases, they chose to end their lives.

56. A consideration of their pre-existing vulnerabilities has required an inquiry into some aspects of the home environments of the children, their physical health, any mental health treatments, and their school attendances. The evidence frequently reflected dysfunctional home environments, a history of poor physical health, little to no involvement with the mental health services, and poor school attendance rates.

57. The purpose was not to hold the parents or carers accountable for these factors. Any such concerns were allayed at an early stage and it was made clear that there would be no adverse comment made in respect of the families. This finding traverses the devastating impacts of intergenerational trauma upon Aboriginal communities. The flow-on effects to subsequent generations cannot be underestimated. The parents' ability to adequately care for their children was severely compromised by those flow-on effects.

58. It must not be forgotten that each family has lost a child in tragic circumstances and the associated grief must be overwhelming.

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[12] Exhibit 12, Tab 31.

SUICIDE AND CHILDREN

59. Of the 13 deaths investigated by this Inquest, five were of children aged between ten years and 13 years. Three were aged 16 years or 17 years. And the remaining five were young adults aged between 18 years and 24 years.

60. One question that arose in the Inquest was whether, having regard to the young ages of some of the children, they had the capacity to form an intention to end their lives.

61. With respect to the young male child in Case 7 a further consideration was whether his death may have occurred by way of suicide or misadventure. With regard to the circumstances of the death of the youngest child (Case 4), the question arose as to whether that child would have had the ability, on her own, to configure the ligature that was used.

Intention to end their own life

62. A number of witnesses were questioned as to whether a child who has hanged him or herself could have had the capacity to form an intention to end his or her life, particularly if the child is still quite young, between the ages of 10 or 12 years, approximately. The evidence reflected that the age of the child is a relevant factor, though not the only one. Other relevant factors include the child's emotional state at the time, whether the child has been exposed to the death of family members or persons known to them, the likely effect of alcohol and/or drugs and whether they might have had Foetal Alcohol Spectrum Disorder (FASD) and/or other cognitive or developmental disorders.

63. The actions undertaken by a child in the lead up to the death, including the degree of planning, may also reflect upon their likely intention. Suicide notes are rarely left by children in the circumstances explored by this Inquest.

64. After taking account of all of the information before me, I determined that the children and young persons whose deaths were explored at the Inquest all had the capacity to form an intention to take their lives, and that in 12 of the 13 cases, they did form that intention. The evidence regarding capacity at a general level varied, and I have outlined it below, before my conclusions on the matter of capacity.

65. At the Inquest, A/Professor Carmela Pestell, a clinical neuropsychologist, opined that it is not until children reach their

late teens that they have the concept of death and the permanency of it. In her opinion young children, particularly as young as ten, who are typically developing children, would not understand the concept. That would be so even if they had a family member who had died.[13]

66. If the child had FASD, A/Professor Pestell's view was that it would be particularly difficult for them to make that association and in terms of their intention she questioned whether they fully understood the permanency of what they were doing in those circumstances.[14]

67. Associate Professor Pestell, acknowledging that it is difficult to project what might be going on in the minds of a child in a situation where that they have hanged themselves, stated that it could be (i) an attention seeking gesture with the hope that somebody would come and discover them; (ii) that they wanted to end their suffering without necessarily understanding the full consequences of what they were doing; (iii) that there might be a mistaken notion they will go to an afterlife and be reunited with their loved ones. She also pointed out the relevance of contagion with suicidal behaviour.[15]

68. Ms Rosalee Webb, who has a degree in psychology and considerable experience working in Government in the areas of child protection and family support, noted that it was a difficult to determine a child's state of mind at the relevant time. She gave evidence in connection with the young female child in Case 1, and was not able to form a view as to whether she was likely to have had capacity to form an intention to take her life.[16]

69. Mr Stuart Klose, a school teacher with 14 years' experience, gave evidence about the understanding that children in years 4 and 5 whom he taught in the Kimberley Region have of the concepts of suicide and death. Mr Klose did not believe children of those ages understood it that well and opined that there was a belief for some children that they could commit suicide and come back to life.[17]

70. Mr Mark Williams had worked as a teacher since 1998. He is the principal of Derby District High School and has had considerable experience teaching in the Kimberley Region. When asked his view as to whether children understand the finality of a completed suicide, Mr Williams stated that he had changed his opinion on that question in the time that he has taught in the Kimberley. He

[13] ts 317.
[14] ts 317.
[15] ts 317 and 318.
[16] ts 389.
[17] ts 432.

was of the view that children did not understand it was permanent. He referred to his experience of children who present with suicide ideations talking about joining their family or kin in heaven and that they talk almost in the third person about what will happen when they take their life. He was of the view that a lot of children do not realise that, if they put a rope around their neck and hang themselves, they will die. He believed that these children were in the 12 or 13 year old age bracket.[18]

71. Dr Gavin Cleland is the Senior Regional Paediatrician in the Western Australia Country Health Service ("the WACHS") for the Kimberley Region. In addition to his various medical qualifications, he also has a diploma in education. After stating that he did not have any specific knowledge around cultural understandings of death in the Kimberley Region or specific expertise in the area of child development, Dr Cleland provided his opinion. He believes that the concept of the permanence of death will vary from child to child and from time to time but that it is generally accepted that children are beginning to get a clear sense of the permanence of death by around six to seven years of age. However, that would be affected by their exposure to death and their own level of development. Dr Cleland emphasised that a child with developmental delays or intellectual impairment will clearly develop that understanding much later, if ever.[19]

72. Dr Cleland also referred to some other factors affecting a child's understanding of death. For example, a young adolescent would be at a stage where they are able to grasp the concept, but when under the influence of alcohol, they would have a much less clear grasp of that concept. Similarly a person experiencing significant psychological distress might also not be able to hold the concept of death being permanent at that time. Dr Cleland was of the view that that could occur at any age where someone is experiencing such severe psychological distress that they are not able to make clear decisions and have a clear understanding of the permanency of their factors.[20]

73. Dr Cleland concluded:

> *"So I don't believe it's an either/or that at an age you develop that understanding* [of the permanence of death] *but the younger a child is, the less clearly they are able to understand it. And the more significant their psychological distress is, the*

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[18] ts 528 and 529.
[19] ts 594 and 595; ts 610.
[20] ts 610 and 611.

less they are going to be able [to] *maintain an understanding of the permanence of their actions."*[21]

74. Ms Susan Luketina is with the WACHS as the Acting Suicide Prevention Coordinator for the Kimberley Region. She has degrees in anthropology and social work and a Master's degree in rehabilitation. Ms Luketina's view was that children in the younger teenage years often do not understand the finality of suicide. When asked if such children were wanting to escape or go away from something, Ms Luketina answered:

> *"I think quite often what we're seeing in the Kimberley is really impulsive acts and it's really poor emotional resilience and … the start* [of] *self-harm attempts or suicide threats are things like not being able to use the mobile phone in the house or they are often really minor things and it's a lack of emotional resilience to deal with those things and so acting out and self-harming is an answer. And, you know, for other children that are better adapted or have got other options, you know, for them it might be storming off or going for a walk on the beach or reading a book or going for a run or maybe a punch-up fight, but not actually going and trying to hurt yourself."* [22]

75. Dr Murray Chapman was the consultant psychiatrist and clinical director of the Kimberley Mental Health and Drug Service (KMHDS) between July 2007 and October 2016. He was asked about the capacity of 12 or 13 year old children who take their own lives by hanging to form an intention to take their lives. Dr Chapman referred to the literature regarding the concept of *"respect"* suicide where young people observe a huge outpouring of community respect and support at funerals of those who have committed suicide. Authors have expressed a view that a young person who witnesses such events might have a mindset that this is a way of gaining respect for themselves.[23]

76. Dr Chapman also noted the contagion effect that is, the clustering effect of suicide, expressing his view that this must affect the perception of a 12 to 15 year old child.[24]

77. In Dr Chapman's experience, merely looking at the chronological age will not necessarily provide the answer. A particularly mature 12 year old may have a better understanding of the permanency of suicide but a less mature 12 year old affected by FASD and

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[21] ts 611
[22] ts 870;ts 892 ts893.
[23] ts 1121; ts 1137 and 1138.
[24] ts 1138.

who struggles with the process of learning would have an impaired understanding of the permanency of the act.[25]

78. Dr Chapman also noted that acute intoxication at the time of death or prior intoxication over a long period of time would also be likely to deprive someone of a capacity to be making an informed choice to die.[26]

79. Dr Paul Simons is the first appointed child and adolescent psychiatrist by WACHS to work in the Kimberley Region on a full time basis. Based in Broome, he has held that position since January 2017. Prior to that the WACHS had locum child and adolescent psychiatrists visiting the Kimberley Region.[27]

80. On the question of whether children are aware of the finality of deliberate actions they have taken which have led to their deaths, Dr Simons noted that to some extent it depends on the age of the child. A child less than eight years old does not really have a clear understanding of the concept of death and the finality of that. He expressed the following view:

> *"...the general understanding would be from the age of about 12 that children would have some understanding of the physical finality of death."* [28]

81. Nevertheless, Dr Simons also stated:

> *"... in the moment of a child undertaking an act to end their life I am not sure that they are necessarily doing that because they no longer want to exist. I think what they may be doing is using it as a strategy to manage stress. I mean, obviously, there are going to be specific cases in which that might be different, but ... if you're highly distressed and you have limited capacity to regulate your emotional state, if you have limited resources to draw from to protect yourself in terms of ... the common protective strategies that are in built into us* [which] *are: Who am I? Am I a positive being in this world? Do I contribute positively? What are my relationships with family? Am I valued? Do I feel valued within my family? All these things that help to kind of protect us in that moment of distress, ... if you don't have a coherent, positive sense of yourself in that moment and you're highly distressed and you have limited coping resources, in that moment it's a strategy ... in an endeavour to not feel the way you're feeling. So, obviously, that's completely*

[25] ts 1138.
[26] ts 1139.
[27] ts 1285 and 1286.
[28] ts 1307.

tragic … when there's a completed suicide, because, by and large, we would take the view that those young people, if they had been given an opportunity to sit down for an hour and regulate themselves, they wouldn't be in that position."[29]

82. Dr Simons added that cannabis and/or alcohol are substances that further impact upon one's ability to regulate oneself and to rationalise the situation and are therefore significant risk factors in terms of attempted suicide.[30]

83. Dr Simons also expressed the view that when someone hangs themselves, it is an aggressive act upon the self as well as an attempt to alleviate distress.[31]

84. Depending on the age of the child who has hanged him or herself, it may not necessarily indicate that they were meaning to die.[32] In the words of Dr Simons:

> *"It's just 'I need to not be thinking or not be here to alleviate my distress.' There's no ... consideration of, 'Well, if I do this that means I don't come back.' It's just, 'Right at this point in time my distress is so overwhelming I can't tolerate it. I need to do something and all I can think to do is not to be alive'."* [33]

85. Mr Mark Adkins is a school psychologist who has spent approximately 20 years working in mental health and education. From 2014 to 2016 he was one of two school psychologists for the Kimberley Education Region.[34]

86. Based on his own experience and examining the literature, Mr Adkins was of the view that the answer to the question of what understanding a child aged between ten to 13 years had of suicide by hanging is two-fold.[35]

87. The first factor is developmental understanding which is not all about chronological age and may be affected by developmental delay. The second factor identified by Mr Adkins was intergenerational factors which may contribute to a child's level of risk, leading them to become more impulsive or dysregulated when they encounter a particular event that is unsettling them. He opined:

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[29] ts 1308.
[30] ts 1308.
[31] ts 1309.
[32] ts 1309.
[33] ts 1309.
[34] ts 1384.
[35] ts 1398.

> *"And so from that point of view, I feel that it may be more of a spontaneous event which could well supersede or override some of those developmental considerations, almost a short-circuiting."* [36]

88. Dr Nathan Gibson is the Chief Psychiatrist for the State of Western Australia. At the Inquest he acknowledged that whether children aged between ten and 13 years are capable of forming an intention to take their own life is a complex one.[37]

89. In Dr Gibson's opinion, citing research by Jean Piaget and Eric Erikson, by the time children are between ten and 12 years old, they are starting to get a more adult like understanding of death. However, that will depend on the individual child and what stage they are at. If a child is using drugs and alcohol or if they have intellectual difficulties or have FASD that might delay their progress in their understanding of death. Children also have a capacity to regress when they are especially stressed, and in that situation they can almost regress into a previous phase where they become very concrete in their thinking without being able to understand more abstract processes.[38]

90. Dr Gibson added that it is not just FASD, but other forms of psycho-social deprivation which can delay development of that understanding.[39]

91. Other factors identified by Dr Gibson as impacting upon intention were (i) a contagion peer effect; (ii) intoxication which leads to doing more impulsive things; and (iii) the whole component of trauma for a child attending funerals of those who have died by suicide so that it becomes a cultural norm.[40]

92. In Dr Gibson's experience, by attending funerals, children see the deceased getting lots of love and they see an outpouring of grief. Children may view this as a way to get love and to be given some sense of place in the community. This can override the fact that they are actually going to be dead and not appreciate that fact. The fantasies that a child has of punishing others because they have been mean to them or that others will love them as a result of suiciding can be quite strong and override the understanding that they will not actually be around to experience the outcome of their actions.[41]

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[36] ts 1399.
[37] ts 1638.
[38] ts 1639.
[39] ts 1640.
[40] ts 1640.
[41] ts 1641, 1648 and 1649.

93. In addition to taking evidence at the Inquest on the point, I have had regard to published studies on the development of the concept of suicide in children by Brian L. Mishara and Claude Normand, more recently cited by Stephanie Jowlett, Belinda Carpenter and Gordon Tait in their 2018 article "*Determining a Suicide Under Australian Law*". I have noted the following outcomes of studies that have grappled with this question:

a. a 1999 study of children aged six to 12 years showed that children generally know enough to commit suicide with the knowledge that this will result in permanent death;

b. children acquire an understanding of suicide from a young age, even if they may not use the term "*suicide*";

c. many children aged six to seven years and almost all older children, understood the finality of death; and

d. one study suggested that children develop an understanding of suicide from discussing suicide with children their own age or older, seeing it on television, and in some cases direct experience of the suicidal death of a family member or friend.[42]

94. Added to this is the amount of unfiltered information now available to some children through social media, that further affects their comprehension of suicide and death, not all of it accurate, and some of it undoubtedly disturbing for children. Following on from the above studies in the 1990's, it is clear that the access to knowledge that children now have that develops their concepts of suicide and death can only have increased. It most certainly will not have decreased.

95. In their 2018 article, Jowlett et al refer to the Australian Senate's 2010 report "*The Hidden Toll: Suicide in Australia*", that revealed the extent of underreporting of suicides. The article outlines that, prior to 2011, Australian statistics on suicides of children under 15 years were not published due to their small numbers and sensitivities around this issue. However, that approach has changed. Given that the Senate's report identified that child suicide is a significant issue, the Australian Bureau of Statistics

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[42] Brian L. Mishara, "*Conceptions of Death and Suicide in Children Ages 6 – 12 and Their Implications for Suicide Prevention*" (1999) 29 *Suicide and Life Threatening Behaviour* 105, 117; cited by Stephanie Jowlett, Belinda Carpenter and Gordon Tait, "*Determining a Suicide Under Australian Law*" (2018) 41(2) *University of New South Wales Law Journal*; see also Claude L. Normand and Brian L. Mishara, "*The Development of the Concept of Suicide in Children*" OMEGA 25(3) 183 – 203, 1992.

has begun to release data for children aged five to 14 years. Jowlett et al reported that the Australian Bureau of Statistics is not aware of any suicides of children under the age of five years in Australia.[43]

96. I have weighed up the differing views (based upon the witnesses' experiences) and the opinion evidence regarding the development of the concept of suicide in children, which of necessity incorporates the development of the understanding of the finality of death.

97. I have placed particular reliance upon the evidence of the psychiatrists at the Inquest, and the outcomes of the studies and inquiries cited in the 2018 article by Jowlett et al. I have determined that there is no basis for finding that a child as young as ten or 12 years of age is incapable, by reason of age alone, of forming an intention to take his or her life. The question therefore is to be answered by reference to the individual circumstances, of which age remains a factor, but not necessarily the overriding factor.

98. The youngest of the children whose deaths have been investigated at the Inquest was ten years of age. I have therefore not made any findings concerning the question of capacity in respect of children younger than ten years of age.

99. Difficult as it may be for some people to accept or comprehend, it is sadly the case that some children as young as ten years of age are capable of developing in their own minds the concept of suicide, and they are able to carry it out, with the requisite intention, that is, the intention to take their lives.

100. A ten year old child may not have the depth of understanding of all of the consequences of death that an adult has. However if such a child no longer wishes to be alive, or no longer wishes to be "*here*" on this earth, and acts to take his or her life then it is open for me to find the child has formed an intention to end his or her life while cognisant of the finality of death. The belief in an afterlife does not negate a suicide.

101. The matter is complex and I recognise that there are gradations of understanding amongst children. Such understanding is affected by all of the influences in a child's life that may shape their concept of death.

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[43] Jowlett et al, Op Cit; Mishara et al, Op Cit; Senate Community Affairs References Committee, Parliament of Australia, "*The Hidden Toll of Suicide in Australia*" (2010) 26.

102. Each tragic instance is to be individually assessed for this purpose. In this finding, I have examined the acts of each child and young person that resulted in death, and I have drawn inferences concerning the intention of the particular child or young person, and whether they understood that their act would result in death.

103. Having regard to the scale postulated in ***Briginshaw*** and the distress that a finding of suicide might cause, I have only drawn such an inference where I am persuaded that it is the only reasonable inference.

104. Therefore the age of the child is a relevant factor that may impact upon capacity form an intention, but it is to be considered together with the totality of the conduct and all of the circumstances attending the death. The conduct that results in death by ligature compression of the neck (hanging) has been considered to be conduct that is "*nearly incontrovertibly suicidal*". This may be distinguished from, for example, a death by gunshot wound in circumstances where one inference may be that a child or young person was recklessly playing with a rifle, without an intention to die by suicide. A similar distinction may be made where a child or young person engaged in high risk conduct, not caring whether they lived or died.[44]

105. In order to find that the manner of death is suicide, I am required to find that the child deliberately engaged in an act or omission that resulted in death, while knowing that the foreseeable consequence would be death, and by that act or omission, intending to take his or her life.

ABORIGINAL SUICIDE

106. In its "*Report of the Inquiry into Aboriginal youth suicide in remote areas: Learnings from the Message Stick*" the Education and Health Standing Committee outlined its reasons for reporting that Aboriginal suicide is different to non-Aboriginal suicide.[45]

107. The Standing Committee referred to the following evidence of Dr Tracy Westerman. Whereas in the general population there is a strong correlation between depression and suicide for Aboriginal people there is a strong element of impulsivity:

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[44] Ibid

[45] Exhibit 1.1, Tab 2.

[…] for those non-Indigenous people who died by suicide, 80 per cent of them had a psychiatric diagnosis of depression. This is not the case with Indigenous people … what we have established is that there is actually a different nature to Aboriginal suicide. It seems to be much more impulsive and it seems to be the case – well, not seems to be; we know that it is the case – it is highly impulsive. The other thing, too, is that it is often triggered by an intimate relationship breakdown. We are talking about people who lack the capacity to self-soothe and calm, and that is also a by-product of trauma."[46]

108. A consideration of the element of impulsivity assists with understanding the circumstances attending Aboriginal suicide, and gives some insight into why, in many cases, there is no history of contact with mental health services. The element of impulsivity is also a relevant consideration when formulating effective suicide prevention strategies.

109. Professor Pat Dudgeon, project director of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) and co-author of the 2016 ATSISPEP Report gave evidence at the Inquest. The ATSISPEP report is entitled "*Solutions that work: what the evidence and our people tell us.*"[47]

110. Professor Dudgeon is from the Bardi people of the Kimberley. She is a psychologist and research fellow at the School of Indigenous Studies at the University of Western Australia. Her areas of research include Indigenous mental health and social and emotional wellbeing, and suicide prevention. She occupies leading roles in advisory groups in this area, and is project leader of the National Empowerment Project, an Indigenous suicide prevention project working with 11 Aboriginal communities across Australia.[48]

111. Professor Dudgeon is a Mental Health Commissioner of the National Mental Health Commission and has a deep understanding of mental health issues within the context of Indigenous culture:

"*Indigenous culture has for a long time had a holistic understanding of mental health. Within this are the concepts of the cultural importance of the connection between the*

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[46] Ibid.
[47] Exhibit 1.1, Tab 1.
[48] Exhibit 1.1, Tab 1A.

mind and body as well as the land, ancestors and other spiritual connections."[49]

112. The ATSISPEP Report summarises the evidence-base for what works in community-led suicide prevention. They identified three types of suicide interventions, as being success factors in the area of suicide prevention - Universal, Selective and Indicated interventions, as follows:

a. Universal interventions are usually aimed at the whole and "*well*" population, directed towards Indigenous community-wide activity and preventions, rather than targeting the whole Indigenous population, and include:
   i. primordial prevention that aims to prevent the risk factors for suicide, by addressing "*upstream*" risk factors for suicide such as alcohol and drug use reduction, family dysfunction and other challenges to wellbeing;
   ii. primary prevention that aims to prevent a completed suicide or suicide attempt occurring, for example community education to support help-seeking behaviour;

b. Selective interventions – aimed at groups who are identified as being at higher risk of suicide, and this includes Indigenous children and young persons; and

c. Indicated interventions – aimed at individuals who are identified as being at higher risk of suicide, or who have attempted suicide. Accessibility of services could be life-saving and access to Indigenous or culturally competent staff may also be important to the success of an intervention or response.[50]

113. At the Inquest Dr Gibson, the Chief Psychiatrist, outlined the impact of historical and social factors contributing to stressors endured by Aboriginal persons:

"*As an example, historically, Aboriginal people didn't have a single word for depression, so, you know, they saw mental illness in a very different context. The – we know that Indigenous people get the range of severe and enduring mental illnesses that other cultural groups get. We also know that there is, as has been mentioned, I'm sure, numerous times, significant vulnerabilities that they face, which include intergenerational trauma, psychosocial disadvantage,*

[49] Ibid.
[50] Exhibit 1.1, Tab 1.

dispossession, etcetera. So when you put that in context – and drug and alcohol use, I think it's important to say – so when you put that in context, whilst Indigenous people get a range of mental illnesses that are very similar to other cultural groups, they have particular vulnerabilities which mean that often managing those is complex and challenging, and preventing those is equally complex and challenging."[51]

114. The Chief Psychiatrist explained that there are Aboriginal persons who do not have a mental illness, and they suicide, as is the case with a number of non-Aboriginal persons who suicide. In the case of Aboriginal persons, those prior vulnerabilities may impact on emotional capacity, such as the capacity to manage ongoing trauma and stress, placing them at risk in his view.[52]

115. Emeritus Professor Atkinson and Professor Wilkes (whose evidence is addressed later in this finding) referred to factors identified by the Western Australian Aboriginal Child Health Survey that may contribute to a child's vulnerability or resilience. These factors included poor physical and mental health of carers (compounded by substance misuse), poor parenting and family functioning, poor physical and mental health of the child, economic deprivation and exposure to racism, discrimination and social marginalisation.[53]

116. I have taken account of the evidence concerning the different, impulsive, nature of Aboriginal suicide, in drawing my inferences regarding the intention of the children and young people to end their lives. The impulsivity does not negate a suicide. The fact that an act is impulsive should not be taken to mean that the person cannot adequately form an intention to take his or her life.

117. I have taken account of the evidence-base for community-led suicide prevention in formulating my recommendations.

SUICIDE IN THE KIMBERLEY

118. The Australian Government's 2017 report into *"Aboriginal and Torres Strait Island Health Performance Framework"* outlines that among Indigenous Australians, suicide is the leading cause of death from external sources. Indigenous Australians experience

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[51] ts 1628 to 1629.
[52] ts 1629.
[53] Stephen Zubrick and Sven Silburn et al., *Western Australian Aboriginal Child Health Survey: Improving theEducational Experiences of Aboriginal Children and Young People* (Curtin Research Publications, 2006); Exhibit 1.3, Tab 13.

higher levels of morbidity and mortality from mental illness, psychological distress, self-harm and suicide than other Australians.[54]

119. The KCLS on behalf of the families, points to the information concerning the suicide rate in the Kimberley Region. In the period 2009 to 2013, it was three times the national average, with the rate of suicide by Aboriginal people, particularly youth, amongst the highest in the world. [55]

120. Between 2007 and 2011, Indigenous children and young persons sadly accounted for 30% of the total suicide deaths under 18 years of age. Between 2011 and 2015, for those aged 15 to 24 years the Indigenous suicide rate was almost four times the non-Indigenous rate.[56]

121. Research cited in the Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, showed that the most common stressors reported by Aboriginal people in 2014 to 2015 involved the death of a family member or close friend (28%), inability to get a job (18%), serious illness (12%), and mental illness (10%).[57]

122. I accept the KCLS submission that the prevalence of suicide in the Kimberley Region cannot be explained by a medical model of causation alone. The impact of colonisation makes the aetiology of Aboriginal youth suicide distinctive. Unresolved trauma, entrenched socio-economic disadvantage and cultural disruption are unique factors impacting the social and mental well-being of Aboriginal people in the region. Systemic social exclusion and disempowerment compound the cumulative effects of these issues even further, adding to the distress experienced by Aboriginal communities.

123. I also accept their submission that due to the extended kinship system, the stress of loss, and grief experienced by a family in one community can permeate and affect people in other areas of the region. Constant attendance at funerals and the protracted

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[54] Exhibit 1.4, Tab 31.

[55] Australian Health Ministers' Advisory Council, 2017, *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report,* AHMAC, p 76; McHugh, C., Campbell, A, Chapman, M. et al, '*Increasing Indigenous self-harm and suicide in the Kimberley: an audit of 2005-2014 data*' (2016) 1 Med J Aust 205, 33.

[56] National Children's Commissioner, 2014, *Children's Rights Report 2014*, Australian Human Rights Commission; Department of Health, *National Suicide Prevention Strategy*.

[57] Australian Bureau of Statistics, cited in Australian Health Ministers Advisory Council, "*Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*" (2017) AHMAC 76.

mourning associated with "*sorry business*" can add to the distress experienced by communities, families and individuals.

124. In May 2016 the Kimberley Aboriginal Health Planning Forum (KAHPF) prepared a "*Suicide Position Paper*" that detailed the current situation, underlying causative factors, protective factors and steps to improve primary health responses.[58]

125. KAHPF noted that in the Kimberley Region most people that die by suicide do not have a diagnosed mental health condition and that of the suicides between 2005 and 2014, 71% had no previous engagement with Kimberley Mental Health and Drug Service (KMHDS). This reflects the situation outside the Kimberley Region also, and is consistent with the observations outlined by the Standing Committee in *"Learning from The Message Stick"*.[59]

126. The KAHPF paper posited that the Kimberley experience is that alcohol and other drug use/misuse, relationship difficulties and/or family conflict/violence often trigger a suicide or suicide attempt. However it suggested that these proximal causes were overlayed on more fundamental problems. The underlying causes of the high suicide rates in the Kimberley were issues such as historical trauma, racism, economic disadvantage and cultural breakdown rather than mental illness or alcohol abuse. They also identify other major contributory factors such as family relationships compounded by the poor living conditions, and boredom and hopelessness.[60]

127. The KAHPF paper concluded that:

> *"Suicide and self-harm are tragic symptoms not of mental illness, but of underlying inter-related social/historical /political factors which are not modifiable by the mental health interventions currently available in the Kimberley. To prevent further suicides a broad response which builds resilience and addresses causal factors, and is designed and implemented by local Aboriginal people, has to be the way forward. In addition, it should be noted that it would be unproductive to consider suicide in isolation from other related issues such as child sexual abuse, alcohol abuse/other addictive behaviours, jealousing, family/domestic violence and incarceration in prison. All these issues have vastly elevated rates across the Kimberley, and this is no*

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[58] Exhibit 1.6 Tab 57 Annexure 4 Report No. 11, November 2016, Legislative Assembly Parliament of Western Australia.

[59] Exhibit 1.1 Tab 2.

[60] Ibid, p 24.

coincidence. They each share very similar or identical causes and feed into each other in a relentless and perpetual cycle."[61]

128. The Chief Psychiatrist noted that only roughly 25% to 30% of all suspected suicides in this State had links to any mental health service. With regard to the children and young people whose deaths are the subject of this Inquest, only three had any significant contact with mental health services. It is unclear how many, if any, received mental health care from non-government organisations and individuals.[62]

129. The Chief Psychiatrist referred to two recent strategies that have been rolled out in the Kimberley Region to attempt to address the suicide rate. As at the time of the Inquest they were yet to be evaluated, but in his view they held promise:

a. In April 2017 a Suicide Prevention Coordinator was appointed by KMHD to:

   i. Coordinate suicide prevention programs across the Kimberley;
   ii. Implement local prevention activities that reflect the Suicide Prevention 2020 campaign message;
   iii. Develop and maintain a key stakeholder network to support a collaborative approach to suicide prevention;
   iv. Raise public awareness; and
   v. Improve coordination and delivery of post-vention responses.

b. The Kimberley is now one of the 12 federally funded and Primary Health Networks' administered suicide prevention trial sites, using the Lifespan systems approach to suicide prevention model developed by the Black Dog Institute. They are utilising a number of evidence based suicide reduction strategies.[63]

130. The underlying causative factors outlined in the KAHPF paper have been borne out in the individual investigations into the deaths of the thirteen children and young people. Looked at together, those factors contributed to an environment that was characterised by relentless and perpetual cycles of despair.

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[61] Exhibit 1.6 Tab 57.4.
[62] As defined in the *Mental Health Act 2014* (WA) s 4; Exhibit 1.5 Tab 51A.
[63] Exhibit 1.5 Tab 51A; Ex 1.5 Tab 51B2.

131. The Inquest was held with a view to better understanding the underlying causative factors, because the proximal events do not adequately address how death occurred in each case. In other words, the proximal events do not address all of the circumstances attending these deaths.

132. In formulating my recommendations, I have taken account of the unassailable fact of the disturbingly high suicide rate in the Kimberley Region, and the KAHPF's urging of a broad response having regard to the underlying social, historical and political factors.

COMMUNITY VISITS

133. As part of the Inquest, the Court sought and obtained permission from four Aboriginal Communities in the Kimberley Region, to visit those communities, and if community members wished, for there to be discussions about matters of concern for them. The arrangements were made with the assistance of the Department of Justice's Manager of Aboriginal Advisory Services (now the A/Assistant Director, Aboriginal Engagement), who accompanied the Court during those visits. Her role was to assist the Court in understanding and taking account of Aboriginal cultural protocols.

134. Under the same arrangements, the Court visited a Cultural Centre and an Indigenous Organisation.

135. The Aboriginal Communities, Cultural Centre and Indigenous Organisation were identified following consultations between counsel assisting, the ALS and KCLS, and with the involvement of the Manager of Aboriginal Advisory Services.

136. Court was in session during the visits. Lawyers for the interested persons were invited to attend. The visits were not recorded, nor photographed. The meetings were managed primarily by the relevant community Chairperson. Counsel assisting's written notes of those visits were provided to the parties' lawyers for comment, and then taken into evidence.[64]

137. The Court visited the following Aboriginal Communities:

a. Pandanus Park Community;

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[64] Exhibits 15A to 15G.

b. Looma Community;

c. Mirima Community;

d. Koongie Park Community.

138. These Aboriginal Communities are alcohol free, or subject to alcohol restrictions, prohibiting the sale, supply or provision of alcohol into the community.

139. The Court visited the following Cultural Centre and Indigenous Organisation:

a. Nyamba Buru Yawuru Centre (Broome);

b. MG Corporation (representing the Miriuwung and Gajerrong people) and BBY (Binarri-binya yarrawoo, Empowered Communities) (Kununurra).

140. At the request of KCLS, the Court was able to observe the location of One Mile Community and Kennedy Hill Community (Broome area).

141. The Court was significantly assisted by the visits to the Aboriginal Communities, Cultural Centre and Indigenous Organisation. At all stages during the visits, the deep and abiding connection between the Aboriginal people and their land was demonstrated. This placed into sharper focus the damage occasioned by the dispossession and cultural dislocation of Aboriginal people.

142. The Court commends the efforts of the Aboriginal Community leaders who spoke movingly and with candour about their determination to hold their communities together, to advocate for essential services, and to preserve and pass on their cultural heritage. Some community leaders are performing these roles on a fully or partially unpaid basis. Some are incurring costs on behalf of the community that are not being reimbursed. They all displayed an unwavering commitment to their community's wellbeing, advancement and cultural identity.[65]

143. The Court received a traditional welcome to the Nyamba Buru Yawuru Centre. The Court commends the efforts and achievements of this Centre in the area of family support, parenting programs, capacity building of parents, early childhood development programs, youth programs, revitalisation of language, the engaging of young people, and youth development in general to create young leaders of the

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[65] Exhibits 15A, D F and G

future. The Centre is developing forums for young people in the areas of cultural development, educational attainment, employment training and leadership. Programs are developed, and continue to be developed that are aimed at reconnecting the community back to the land, and offering cultural healing. They involve the vital contributions of Elders and senior members of the community. They see cultural healing as a preventative program that can work in conjunction with more conventional western styled medical treatments.[66]

144. The Court visited MG Corporation and BBY and was informed of a range of programs designed to support families, conserve land and generate employment opportunities. They have developed programs to address alcohol and substance abuse, support for victims of domestic violence, support for men to support women, educational programs, on-country programs for children on on-country healing. These efforts are also to be commended.[67]

145. The matters of concern that were raised with the Court during the visits have found expression in the recommendations that I have made, and in particular Recommendation 42 concerning the application of the principles of self-determination and empowerment. The protective effects of cultural continuity, as outlined by Chandler, L. and Lalonde, C. are referred to in more detail under the heading "*Consultations With Aboriginal Persons*", immediately below. The outcomes of their studies resonate with the information provided to the Court during the community visits.

CONSULTATIONS WITH ABORIGINAL PERSONS

146. A recurrent and understandable theme throughout the Inquest concerned the Aboriginal people's desire that they be consulted on matters that affect them, and in particular that purported solutions not be imposed upon them in the absence of consultation.

147. The KCLS and ALS highlight the importance of a whole of Government approach that engages Aboriginal communities and organisations as partners in determining the solutions.

148. Professor Pat Dudgeon, whose evidence is referred to previously, testified as to the importance of providing services

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[66] Exhibit 15B
[67] Exhibit 15E

to Indigenous persons in the Kimberley Region through genuine and empowered relationships with local Kimberley individuals and stakeholders stating: "*Nothing about us without us*". Professor Dudgeon referred to the recent improvements in this area and she acknowledged the importance of a partnered approach:

> "*....it's not a cultural versus western. I think it's getting an empowered combination. I think the issue that we've had no other options and communities were not listened to previously. So it is about combining those two, and the Chandler model definitely, there's our evidence base which most – well, all Aboriginal people and service providers, Indigenous service providers, that resonates with them, because it is about self-determination and cultural reclamation. Otherwise it is always going to – we're going to be putting band aids on the issue rather than looking at a long term cure. So there's certainly a place for non-Indigenous clinicians and service - there's a place for non-Indigenous service providers, providing they are undergoing cultural competence training.*"[68]

149. Professor Dudgeon provided this response within the context of adopting the six protective factors identified by Chandler and Lalonde when they examined suicide among British Columbian (Canadian) First Nations' young people and it is referred to in the ATSISPEP Report. In the late 1980's and early 1990's Chandler and Lalonde mapped suicides in 197 communities in British Columbia and found that communities that achieved all six protective markers had no cases of suicide. In communities that achieved none of those protective markers, youth suicide rates were many times higher than the national average. Those six protective markers were:

a. Achievement of a measure of self-government;

b. Have litigated for Aboriginal title to traditional lands;

c. Accomplished a measure of local control over health;

d. Accomplished a measure of local control over education;

e. Accomplished a measure of local control over policing services;

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[68] ts 244 to 246.

f. Have created community facilities for the preservation of culture.[69]

150. A later study by Chandler and Lalonde between the 1990's and 2000 included two other indicators and found similar results to those of the first study. Those two further indicators were:

a. A measure of local control over child welfare services;

b. That they are characterised as having elected councils composed of more than 50% women.[70]

151. Chandler and Lalonde argued that cultural continuity forms a critical back-stop to the ordinary process of identity formation, and in that case: "…. *it also follows that community-level rates of youth suicide should ordinarily vary as a function of the degree to which particular Indigenous communities find themselves bereft of meaningful connections to their traditional past.*"[71]

152. Chandler and Lalonde's study is referenced by the Education and Health Standing Committee in its report of the inquiry into Aboriginal youth suicide in remote areas "*Learnings from the Message Stick*", that recognises the need for young people to develop a robust sense of personal identity in order to "*withstand the expectable ravages of time.*"[72]

153. Professor Ted Wilkes is a Nyungar man with connections to the Perth Metropolitan area and the South-West of Western Australia, and he gave evidence at the Inquest. He has worked primarily in public health and held numerous leadership positions, including Chair of the National Indigenous Drug and Alcohol Committee and CEO of Derbal Yerrigan Health Service in Perth. He has had significant involvement with the Telethon Institute for Child Health Research, and is co-program leader of the Indigenous Australian Research Program at the National Drug Research Institute.

154. Professor Wilkes addressed the dangers of normalising "*alcohol and drug poverty*", the futility of dictating pathways out of poverty to Aboriginal people, the importance of Aboriginal

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[69] ts 244; Exhibit 1.1, Tab 1; Chandler, M. and Lalonde, C. (2008) "*Cultural Continuity as a Protective Factor Against Suicide in First Nations Youth*" Horizons 10(1), 68 - 72

[70] Ibid.

[71] Chandler, M. and Lalonde, C. (2008) "*Cultural Continuity as a Protective Factor Against Suicide in First Nations Youth*" Horizons 10(1).

[72] Exhibit 1.1, Tab 2.

people being supported to control the pathways out of poverty, and the need for a collaborative effort:

> "*We need non-Aboriginal professionals to be working with us and those who have the right compassion, but we need Aboriginal leaders now to be given the right to control the pathways out of poverty. If you own the right, if you own the pathways out of poverty, you're more likely to make them succeed. But let me again exemplify the fact that we can't do it on our own. We need the support of mainstream players that work and are confident to work in this field.*"[73]

155. Dr Elise Klein is a lecturer in Development Studies at the University of Melbourne and she gave evidence at the Inquest concerning consultations with Aboriginal people. Development Studies is an area of the social sciences that looks at the processes of community change, including economic and social development. Dr Klein spoke of the importance of including as many people as possible, of having a genuine intention to consult, and of the need to consider whether consultation ought to be done in the people's first language. She outlined that a lot of time and resourcing is involved:

> "*....proper community development and consultation is not an easy task at all, but it's done because there's a commitment to empowering and engaging with the diversity of – of views, as well as, you know, a genuine care in bottom up development, which means that whatever the intervention in mind by those that are doing the intervening, they have to be open to that their idea may have to be aborted or it may have to change significantly.*"[74]

156. Numerous Government Department and Agency witnesses were questioned at the Inquest on the need for increased consultation with Aboriginal people and communities. From their oral and documentary evidence before me it is clear that there have been extensive efforts made towards consultation with Aboriginal people in some areas, to the point of concerns being expressed about an excess of consultation. In the course of the review of one particular consultation process, it transpired that the Warmun community had had 400 visits

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[73] ts 107 to 108.
[74] ts 1013.

from State Government agencies in one year (which appears to be 2016).[75]

157. Despite this, the Aboriginal witnesses' concern about a lack of consultation persists, suggesting that a different approach may be needed, and that it is not necessarily achieved through sheer number of visits.

158. The Department of Premier and Cabinet through its lawyer the SSO, submits to me that the Western Australian Government seeks to adopt a new way of working together, by ensuring Aboriginal Western Australians have input into place - based policy formation, government priorities, commitments and practice. This includes Aboriginal engagement in co-identification of place-based priorities, future targets and overall indicators of positive change. They outline that this represents a significant shift in policy and practice for government agencies and informed me that it will require time to nurture and embed in the public sector new ways of working with Aboriginal people and communities.

159. This approach is consistent with and supportive of the matters outlined by Professor Dudgeon and Professor Wilkes.

160. On the question of the desirability of consultations and the reality of Aboriginal persons holding divergent views as to proposals that may affect them, Mr Ian Trust, a Giga man from the East Kimberley/Halls Creek area, and Chair of the West Australian Aboriginal Advisory Council, responded as follows:

> "*Well, I think it's about leadership. If you take the alcohol restrictions in Halls Creek and Fitzroy 10 years ago, those restrictions were led by four or five women. Ninety-nine per cent of the community didn't support that and I think if you're going to go to a democratic process, well, you know, going to all the people who've got a drinking problem, asking them if they want to change, obviously the answer is going to be [say no]. So I think that sort of strategy would be doomed for failure because the masses don't arise tomorrow and say, "We're going to change." It's all based on the leadership. Leadership is when people stand over and say, "Enough's enough. We're going to have to do something different here otherwise 50 years from now,*

[75] ts 1752; Exhibit 1.5, Tab 52.

people are going to still be living in poverty and that's not good enough."[76]

161. Mr Trust's comments about leadership from Aboriginal persons in the consultation process are very apposite. The challenge will be to ensure, as far as is possible, that the appropriate persons and entities are consulted, having regard to their standing in their communities, and the diversity of Aboriginal peoples and communities.

162. An example of the benefits of a successful consultation is to be seen in the outcomes of the Lililwan Project ("*Making FASD History*") regarding the Foetal Alcohol Spectrum Disorder (FASD) prevalence study in Fitzroy Crossing that is also referred to later in this finding in the *Recommendations* section. Dr James Fitzpatrick (FASD expert) observed that the Project was built on the willingness of the Fitzroy Crossing community to do something about FASD. Ms Emily Carter, Chief Executive Officer of Marniwarntikura Women's Resource Centre and the Nindilingarri Cultural Health Services in Fitzroy Crossing outlined the rationale for the success of the collaboration:

> "*The Lililwan Project was effective because the community was involved in the design, consultation and delivery of the project. It was such a successful project because it was community driven and researched, collaborated and consulted effectively with the community participants.*"[77]

163. In mid-2016 the State Government published: *"Resilient Families, Strong Communities: A roadmap for regional and remote Aboriginal communities."* Also referred to later in this finding, at this point it is relevant to note that the roadmap sets out a direction for reform, priority actions for the first two years and areas for consultation with a focus on:

a. Improved living conditions that enable families to prosper and do not hold them back;

b. Supporting families to build their skills and overcome any barriers to doing so, through improved service redesign and delivery;

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[76] ts 1372.
[77] Exhibit 1.4, Tab 30; ts 303.

c. Education, employment and housing opportunities, and support for families to take them up.[78]

164. Mr Grahame Searle, Director General of the Department of Communities outlined an underpinning principle of the Regional Services Reform Unit's Roadmap for regional and remote Aboriginal Communities, namely that there are things only Government can do, things only communities can do, things only families can do, and things that require cooperation.[79]

165. The Department of Premier and Cabinet through its lawyer the SSO sounds a note of caution about "*consultation fatigue*" in some Aboriginal communities, and supports instead the principle of "*co-design*".

166. The Regional Services Reform Unit visited remote communities and regional towns to talk with Elders community members, organisations and people from all levels of Government to better understand the complex issues facing remote Aboriginal communities, to inform the future direction of Government funding and support. One of the purposes was to give local community leaders and residents a voice. This is outlined in their August 2017 report on "*Key insights from consultation with remote Aboriginal communities in Western Australia.*"[80]

167. The Regional Services Reform Unit reports that they consulted with communities that in total are home to more than 90% of the population understood to live in remote Aboriginal communities throughout Western Australia. One of their key observations was the consultation fatigue they experienced in communities in all regions. Some of the responses were as follows:

a. Community members told them they were tired of being asked for their views, only for those views to be ignored;

b. Some leaders questioned their authenticity and authority to make change;

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[78] Exhibit 1.5, Tab 52, Annexure B.
[79] Exhibit 1.5, Tab 52.
[80] Ibid.

c. Others asked what was going to be done with the information;

d. Some exhibited a mistrust and wariness of Government.[81]

168. The Regional Services Reform Unit also reported that many community leaders told them that meaningful and ongoing engagement is key to the empowerment of their community in the decision making process. The Unit believes that empowering and supporting Aboriginal people in regional and remote areas to make change is critical in improving life outcomes, and that the consultation process and its learnings are just the beginning.[82]

169. A theme that runs through the outcomes of the Regional Services Reform Unit's consultations is the centrality of connection to culture, country and kin, and a desire among Aboriginal persons to see it continue for many generations. It is also recognised that the Aboriginal youth need to be able to "*walk in both worlds.*"[83]

170. Superintendent Allan Adams is in charge of the Kimberley District Office, and he gave evidence at the Inquest. The Superintendent has been in the Western Australia Police Force since 1994 and he provided a report to the coroner. On the topic of consultations and the empowerment of Aboriginal communities, Superintendent Adams referred to an impending memorandum of understanding between the Kimberley Police and the Kimberley Empowered communities backbone organisations Anja (West Kimberley) and Binarri-binya yarrawoo (BBY) (East Kimberley) to provide monthly crime related data for sharing with Kimberley communities. He explained that the intent is to help communities identify and implement solutions to crime related problems in consultation with police, and to take a degree of *"ownership"* of these challenges.[84]

171. At the Inquest Superintendent Adams outlined his experience of the preparedness of community leaders to take more responsibility, their desire to do so, and the importance of supporting that within the context of the provision of the monthly crime related data:

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[81] Ibid.
[82] Ibid.
[83] Ibid.
[84] Exhibit 1.8, Tab 59.

> *"….the Empowered Communities movement is around Indigenous people taking greater control, especially around their communities, around their families. And we're looking at every opportunity to support their endeavours. And one thing that they've asked from us is some fundamental crime data. The picture I've got in my head, and definitely as a result of talking to those entities, is that it will help guide communities around the size of the problems in their particular areas and obviously help them to monitor and manage the successive of endeavours that they put in place themselves on the reduction in crime and the impact on crime. So, again, I think that's something that demands to be supported."*
>
> and
>
> *"The advice I'm getting from Empowered Communities – and the work that I do across the Kimberley and my OACs do within the Kimberley is that there is a real want by key leaders across the Kimberley to be more involved and to take more ownership. And, you know, definitely there is a strong theme of stop being told what to do. Let's take up the cudgel ourselves and move forward, which, again, as I say, demands to be respected and to be provided for."*[85]

172. The Regional Services Reform Unit has self-evidently taken significant steps towards consultation with Aboriginal persons, but it has also been met with some degree of scepticism and mistrust, possibly as a result of previous well-intentioned efforts by agencies that failed to generate any meaningful change for Aboriginal people.

173. I have specifically addressed the importance of consultations with Aboriginal communities at *Recommendation 17.* Solutions that are imposed upon Aboriginal people without appropriate consultations are not constructive, and risk further alienating the very people who, if consulted, could capably contribute to the co-design of solutions that work.

INTERGENERATIONAL TRAUMA

174. In the Australian Government's 2017 report into the "*Aboriginal and Torres Strait Islander Health Performance Framework*" it is

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[85] ts 1836.

acknowledged that for Aboriginal and Torres Strait Islander people, health is not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. In describing the reasons for the importance of social and emotional wellbeing, the report also addresses the origins of their social and economic disadvantage, describing it as being: "*interconnected with historical loss of land (which was the economic and spiritual base for Aboriginal and Torres Strait Islander communities), damage to traditional social and political structures and languages; child removals; incarceration rates and intergenerational trauma.*"[86]

175. In the 2016 report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP), referred to previously, there is discussion about the Indigenous approach to social and emotional wellbeing, recognising that it is a culturally informed concept:

> "*….it connects the health of an Indigenous individual to the health of their family, kin, community and their connection to country, culture, spirituality and ancestry. It is a deep-rooted, more collective and holistic concept of health than that used in Western medicine.*"[87]

176. The ATSISPEP project team held 12 roundtable consultations across Australia in 2015 to 2016. Commonly expressed concerns included the social determinants of health associated with suicidal behaviours, in particular: "*trauma and intergenerational trauma stemming from forced child removal resulting from and associated with practices of the "Stolen Generation", and contemporary family dysfunction, violence, sexual abuse, substance misuse and high incarceration rates among youth and adults.*"[88]

177. In connection with the ATSISPEP Youth Roundtable, the focus was on developmental factors associated with Indigenous youth suicide:

> "*Participants identified the current impacts of colonisation – intergenerational poverty, racism and social exclusion and the lack of educational and employment opportunities – as critical to understanding the high rates of suicide among young people.*"[89]

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86 Exhibit 1.4, Tab 31.
87 Exhibit 1.1, Tab 1.
88 Ibid.
89 Ibid.

178. In connection with the ATSISPEP Kimberley Roundtable, the focus was on issues critical to this region:

> "*Participants highlighted negative social determinants and entrenched, intergenerational poverty as the fundamental issues that led to self-destructive behaviours including self-harm and suicide. Crowded housing, poor health, avoidable deaths among family and friends, a high unemployment rate and lack of opportunities were aspects to be addressed in any comprehensive effort to solve Indigenous suicide in the Kimberley.*"[90]

179. Emeritus Professor Judy Atkinson gave evidence at the Inquest. She has been the Head of the College of Indigenous Australian Peoples at Southern Cross University and over the years has held significant leadership positions in the areas of Indigenous mental health and trauma recovery, national domestic violence awareness, Indigenous therapies, and was on the research committee, and author of, the Australian Institute Health and Welfare's publication "*Trauma-informed services and trauma specific care for Indigenous Australian children*" produced for the "*Closing the gap clearinghouse"* in 2013. She holds a Masters from Harvard University in Global Mental Health and Recovery.[91]

180. Professor Atkinson identifies as an Eoman (Jiman) woman from Central West Queensland, and a Bundjalung woman from Northern New South Wales, who also has Celtic and German origins. At the invitation of the Kimberley Aboriginal Medical Services, and the communities, she has travelled to the Kimberley Region on a number of occasions to deliver trauma-informed workshops and specific trauma-informed care in the tragic aftermath of a number of suicides.[92]

181. Professor Atkinson described intergenerational trauma as a collective trauma that is experienced by Aboriginal communities at the intergenerational level. It is experienced across a lifespan and passed onto the next generation. That collective trauma refers to the impact of traumatic events shared by a group of people, including whole communities, on their collective, and individual, social, emotional and psychological wellbeing: "*....collective trauma describes the disintegration of a community to care for itself.*"[93]

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[90] Ibid.
[91] Exhibit 1.1, Tab 3.
[92] Exhibit 1.3, Tabs 13 and 13.1.
[93] ts 225 to 226.

182. Professor Atkinson explains that some Aboriginal families and communities are unable to, or are still working to, heal the trauma of past events, including displacement from country, institutionalisation and abuse, the effects of the Stolen Generations and the removal of children from their natural families. In addition, children born into communities that continue to suffer from intergenerational trauma are more likely to themselves experience prolonged or multiple exposures to individual traumatic events, arising from illness, accidents, hospitalisation or death of close family members, exposure to violence, family disintegration and financial stress.[94]

183. Professor Atkinson also explains that it is well established that childhood experience of trauma can have severe and long-lasting effects. It can permanently affect brain development diminishing executive function (planning, organising, paying attention, remembering) and slowing down a child's development. In some traumatised children survival mechanisms take priority over healthy growth and development, at a high cost to their mental and physical wellbeing. Such children are more likely to go on to adopt self-destructive behaviours that include alcohol and drug abuse. Researchers have noted a link between childhood trauma and suicide.[95]

184. At the Inquest Professor Atkinson gave examples of how the effects of collective trauma can result in intergenerational trauma, thereby posing a risk to the continuity of Indigenous culture:

> "*Does trauma represent a problem for the continuity of a First Nations culture?---Yes. Absolutely, because we wouldn't be fighting like we are – we wouldn't be harming our children like we are. What the first – the first kind of benchmark of Aboriginal culture is to care for our children. The children are our centre of what we do. We're bringing our children up for those generations in the future to be able to look at – after country. And if we're traumatised, we don't care about the little baby that has just been born. We don't care about the kid that can't go to school because the kid is too stressed. We just let them run riot, and we see the pathway into prison and juvenile detention centre as okay. So yes, it's an absolute, at every level, threat to the future of our people.*"[96]

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[94] Exhibit 1.1, Tab 3; Exhibit 1.3, Tab 13.
[95] Exhibit 1.1, Tab 3.
[96] ts 230.

and, in connection with breaking that cycle of intergenerational trauma:

> "….*mums who are traumatised can start to become really good parents as they start to be – as they're supported to work through the distress state they're in and understand why they are like they are and the choices they make….not to drink, not to be with a man who's beating them up….*"[97]

185. In Professor Atkinsons' experience, the effects of intergenerational trauma upon Aboriginal persons are not generally understood in the wider community. Service providers working with population groups who are affected by trauma need to adapt their programs to account for this, in other words, the services need to be "*trauma-informed.*" In addition, children who are victims/survivors of trauma need individual therapeutic care that is "*trauma-specific.*"

186. At the Inquest Professor Pat Dudgeon also reflected on the origins of intergenerational trauma through the process of colonisation, and like Professor Atkins, described it as a "*truth*" that has only recently gained acceptance in Australia:

> "*There has been a denial of the process of colonisation and it was brutal and violent and some of that pans out and flows on to today. So there was the takeover of lands often brutal removal from countries. Forcible removal for children into missions and reserves and then for Indigenous people, we say that we weren't recognised as citizens of the country until the referendum.*"

and

> "*And it's only recently that, you know, the importance of culture has become important. So the point is if you treat a people like this – as second-class citizens and knock the stuffing out of them for generations and generations, there has got to be some consequences….*"[98]

187. At the Inquest Professor Ted Wilkes was questioned about early neurological brain development and exposure to neurotoxins in utero and the life stressors experienced by

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[97] ts 234 to 235.
[98] ts 47 to 48.

young Aboriginal persons. He addressed this by reference to the intergenerational trauma:

> "*The inference for me – just to explain that a bit more – is that these children are more likely to be the children of parents who are caught up in what we call the intergenerational spiral or intergenerational trauma that's created because of the context of alcohol since what we might call 1967, when Aboriginal people were finally able to access public places where alcohol was being sold. And consequently from 67 to 17, which is now – we're looking at 50 years, that means there might be two, maybe even three generations – touching on three generations – that have – that have had constant alcohol use within their poverty stricken families or existences.*"

and

> "*....in the West Australian Aboriginal Child Health Survey, we had findings that proved that the life stress events of Aboriginal young people was far out of kilter with anything that we thought was reasonable in this country. And there was some young people having in excess of life stress events in a year and we're talking about losing loved ones. We're talking about seeing mothers and loved ones being hurt in physical violence. We're talking about visits by authorities. We talked about being moved out of a house because of inability to pay the rent. We're talking about – so those sorts of stress events that continually occur in the life of some of these young people. And, of course, I haven't even talked about the racism and the indifference....*"[99]

188. Ms Emily Carter, Chief Executive Officer of Marniwarntikura Women's Resource Centre in Fitzroy Crossing gave evidence at the Inquest. Ms Carter's cultural background is Gija on her father's side and Gooniyandi on her mother's side. She has occupied significant leadership roles in the area of health and wellbeing for Aboriginal persons in the Kimberley Region, and in particular, Fitzroy Crossing. Ms Carter testified as to her experiences of the entrenched nature of intergenerational trauma and its impact on the well-being of Aboriginal people in the Kimberley:

> "*....what we're seeing is the trauma – the intergenerational trauma that has been transferred from*

[99] ts 127 to 128.

> *one generation to the next. And in that transferring of the trauma, there's that continued use of alcohol and, in some cases, the drugs and the domestic violence. And they're all symptoms of people hurting…"*[100]

189. Ms Petina Pitt-Lancaster, manager of the Gawooleng Yawoodeng Aboriginal Corporation Women's Shelter in Kununurra (the Shelter) gave evidence at the Inquest. She identifies as Aboriginal and Torres Strait Islander and her children have family connections with the local Miriuwung and Gajerrong families in the Kununurra area. Ms Pitt-Lancaster has worked at the Shelter since 2003 and has had the sad experience of witnessing the effects of intergenerational trauma: "*Kids who came here as children with their mothers and grandmothers are either adults seeking refuge here or are the ones carrying out the violence that their partner flee(s) from.*"[101]

190. Ms Tonii Skeen is a young woman who works as a youth development project officer at Nyamba Buru Yawuru in Broome and she gave evidence at the Inquest. Ms Skeen has shared Aboriginal heritage of Yawuru, Bardi and Jabbir on her mother's side, and Nykina and Jaru on her father's side. Speaking from a young person's perspective, she offered her experience of the risks posed to Aboriginal youth from intergenerational trauma, and her concern that it is not well understood by her peers:

> "*….the thing is why do so many of my peers think that suicide is their only way? You know, I believe that a lot of young people don't fully understand or appreciate the history of our old people, so, you know, stolen generation was only two generations ago….and…. intergenerational trauma is core of, you know, I believe, of a lot of suicides, because it's passed on.*"[102]

191. Ms Skeen has a particularly mature understanding of the consequences of that history. If the usual bonding and nurturing processes between mother and baby are disrupted, the emotional pain can be carried through the generations. The woman who has not bonded with her own mother as a baby, experiences difficulty in nurturing her own baby.[103]

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[100] ts 737.
[101] Exhibit 1.4, Tab 45.
[102] ts 580.
[103] Ibid.

192. Dr Cleland, whose evidence is referred to previously (WACHS regional paediatrician at Broome Hospital) testified that intergenerational trauma, experienced within Kimberley communities since colonisation, is a major and driving factor behind most of the issues that he sees in his practice. In his experience, problems manifest themselves when someone has experienced significant trauma in their life that has not been adequately addressed:

> "*….if that trauma has not been adequately addressed, they have an impaired capacity for warm and reciprocal relationships with other people, including their own children. So someone who has experienced significant trauma in their life will – may have a reduced capacity to provide appropriate care to their young child and that warm relationship, but also [c]are of their physical needs. And so that can then trigger – be one part of trauma that's then experienced by that child through infancy and through their childhood and that's – that's the root of what we're talking about with inter-generational trauma….*"[104]

193. Dr Paul Simons, the Kimberley Region's Child and Adolescent Psychiatrist, employed with the WACHS' Kimberley Mental Health and Drug Service since January 2017, described the mental health and wellbeing of a lot of young people in the Kimberley Region as poor, and believes that trauma is at the core of young people's difficulties, from a mental health perspective. Dr Simons has practiced in the Kimberley Region at different times over 18 years.[105]

194. Dr Simons described a large number of people in the Kimberley experiencing the direct and indirect effects of trauma, leading to a high prevalence of developmental disorders that may have mental health comorbidity. In his opinion, many of the children with these experiences do not have a clearly defined mental illness, but they do experience significant mental ill health due to their experiences.[106]

195. Dr Simons described the origin and impact of trauma on Aboriginal persons in the Kimberley Region as follows:

a. There are communities of people traumatised by the colonisation process and the Stolen Generation issues; this is transmitted to the children, because being in

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[104] ts 615 ro 616.
[105] Exhibit 1.4, Tab 40.
[106] Exhibit 1.4, Tab 40.

traumatised communities impacts upon them and the parenting they receive;

b. Before birth, some children are exposed to high levels of stress and trauma, to alcohol and drugs, and poor nutrition; high levels of stress hormones in utero can affect the expression of genes, and these epigenetic processes can affect brain development, such that babies can be born hardwired to preferentially employ "*fight and flight*" coping strategies as they develop, at the cost of executive brain functioning, which facilitates emotional regulation;

c. After birth, if the child's parents have experienced significant trauma, the parents' capacity to manage and develop their child's emotional regulation strategies and to facilitate a positive and coherent sense of self in the world can be severely impacted;

d. The impact of traumatic attachment disturbance affects the developing brain, sense of identity, ability to cope with emotions and to develop a positive sense of self;

e. Parents and carers who have experienced trauma are less able to be protective of themselves and their children; when exposed to threats they may adopt dissociation, learned helplessness strategies or become the aggressor, and these strategies expose the child to a greater risk of abuse and victimisation.[107]

196. Dr Simons informed the Court that there is no specific infant mental health service in Western Australia and that in the Kimberley Region there is no specific perinatal or infant health system. In his opinion, infant mental health services are intensive and to be done effectively, they require staff highly trained in strategies to manage early attachment difficulties.[108]

197. Dr Simons described schools as being an important interface, and in his opinion, schools in the Kimberley Region have a high burden of children with developmental and trauma based difficulties; he believes they would benefit from additional resources to support struggling children. He provided the example of a child with learning difficulties but with an IQ over 70, not being able to access specialist support, despite having

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[107] Exhibit 1.4, Tab 40.
[108] Ibid.

had little experience of routine and reduced regulation capacity due to attachment difficulties and family circumstances.[109]

198. The dilemma faced by Dr Simons and indeed others like him, is that whilst the importance of keeping children in their communities and with their families is recognised, he considers it is inappropriate and unhelpful to provide psychological therapy to young children with ongoing experiences of significant neglect or abuse.[110]

199. In such cases, if the therapy is only provided to the child (as opposed to the family as a whole) the risk is that the child may adopt strategies that normalise the neglect or abuse (i.e turning to alcohol to cope with it). Alternatively the child might become isolated from family, with no other available support structure.

200. Time and again the evidence at the Inquest showed that seeking to address the mental ill health of children and young persons in the Kimberley Region in isolation from their family and community circumstances risks overlooking the reality of the contributory factors, and can therefore impact upon the efficacy of the treatment path.

201. In his report to the coroner Superintendent Allan Adams, in charge of the Kimberley District Office, stated that it is fully acknowledged by police that alcohol has become a coping mechanism for a large percentage of the Aboriginal community in the Kimberley Region, to deal with the historic trauma that individuals, families and communities have faced. In his experience the social issues primarily associated with family and community dysfunction are overrepresented in the Kimberley Region.[111]

202. Superintendent Adams also informed the Court that police accept that the causal factors of this dysfunctionality include inter-generational trauma that has not been resolved for a large proportion of the Aboriginal population: "*This trauma manifests, at a policing end in violence, particularly family violence, child sexual abuse, juvenile offending, alcohol related harm and self-harm.* [112]

203. The Department of Premier and Cabinet through its lawyer the SSO, recognises that an improvement in the standard of living conditions is likely to contribute to a reduction in the rate of

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[109] Ibid.
[110] Ibid.
[111] Exhibit 1.8, Tab 59.
[112] Exhibit 1.8, Tab 59.

Aboriginal suicide. They point to the Department of Communities' Regional Services Reform Unit's report *"Resilient Families, Strong Communities: A roadmap for regional and remote Aboriginal communities"*, and the examples of future strategies:

a. The Kimberley Schools Project, with the aim of accelerating student improvement;

b. Essential Municipal Services Upgrade for eight Kimberley communities;

c. Aboriginal Regional Employment Initiatives;

d. North West Housing Fund, in particular to expand on the transitional housing program;

e. Kununurra Intensive Family Support Initiative, to co-design a family-centred, earlier intervention service delivery model to support better outcomes for local families.[113]

204. An improvement in the standard of living conditions as outlined by the Regional Services Reform Unit is certainly one counter balancing factor that can assist in mediating the despair left in the wake of generations of traumatic events.

205. The effect of intergenerational trauma that I have described in this part was the primary common factor that characterised the dysfunction in the home environments of all of the children and young persons whose deaths were investigated at the Inquest. The cumulative effect of intergenerational and individual trauma in each case made them vulnerable to suicide.

206. The intergenerational trauma does not excuse some of the behaviours that in isolation, or in combination, caused or contributed to the dysfunctional home environments. It is not my role to either excuse individual behaviours, or attribute blame for the effects of individual behaviours. My role is to gain an understanding of the circumstances attending the deaths of the children and young persons. The intergenerational trauma is a factor that serves to explain why such dysfunctional behaviours have become prevalent in the Kimberley Region.

207. The next part explores the protective and counter-balancing effects of cultural continuity.

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[113] Exhibit 1.5, Tab 52, 52A and 52B.

CULTURAL CONTINUITY AND CULTURAL HEALING

208. There is a wide and respected body of research that establishes the relevance of cultural continuity to the formation of a person's identity and their own drive for self-continuity. In other words, it can help to prevent suicide. It is a uniquely protective factor that can assist in counterbalancing the social and economic factors giving rise to the vulnerability of young Aboriginal persons in the presence of adversity.

209. Senator Patrick Dodson, whose evidence is referred to previously, reported that the power of culture and country in healing young Aboriginal people should not be underestimated. Within the context of cultural continuity, he also outlined the concept of "*mabu liyan*":

> "*Liyan embodies the interconnectedness between a person's sense of self, the wider community and the natural landscape. Yawuru people's connection to country and joy of celebrating our culture and society is fundamental to having mabu liyan (good liyan). When we respect country and look after it we have a good feeling about ourselves as people and our place in the world, and this is reflected in the nature of our relationships and encounters with other human beings. Prior to Western colonisation, mabu liyan was at the centre of Yawuru cultural and social existence, informing our obligations to family, community and country. The impact of colonisation on our people has been traumatic and we are now seeking to heal and work toward building "mabu ngarrungu", meaning strong community and "Mabu buru", meaning strong country.*"[114]

210. At the Inquest Ms Tonii Skeen, whose evidence is referred to previously, referred to mabu liyan as connected with inner feeling and intuition, that guides the making of good choices:

> "*….so "mabu" in Yawuru means good, and "liyan" – it's hard to describe, but it's your – so we have got our five senses, and I guess our sixth sense is our liyan. Your liyan is your intention. You know, often when we have mabu liyan, we make decisions – you know, we make positive choices, you know. I see when we have a no good liyan that, you know, we tend to make choices, you know, to drink alcohol and take drugs and to do bad things…. So it's really, really important that we as human beings follow our*

[114] Exhibit 1.3, Tab 18.

liyan, you know, follow our intuition, and always ensuring that we're putting good things into our liyan and then doing good things."[115]

211. In his report to the coroner Professor Wilkes, whose evidence is referred to previously, addressed the challenges facing young persons in the Kimberley Region in very plain terms:

> "*The experience in the Kimberley is unique. The intimate social and cultural connections are distinct and very traditional. The need for children to achieve in a western world and hold onto their dignity as young Aboriginal Australians is a challenge. A challenge that has overwhelmed many. Many young people have been hurt. They bear this hurt throughout life. Sometimes this hurt is too much to endure.*"[116]

212. Dr Chapman was the consultant psychiatrist and clinical director of the Kimberley Mental Health and Drug Service practicing with that service from July 2007 to October 2016. At the Inquest he was asked about the concept of cultural healing, as follows:

> *"And would it be fair to say that us non-Indigenous people need to be, well, trained or taught as to the importance of this concept of cultural healing because it's something that we have difficulty understanding?---Yes, and – and – and possibly we've – we've lost the final vestiges of being able to understand that, I don't know. It's – you know, we are talking about an ancient culture that has been – that's the longest continuous culture that we have any kind of evidence to suggest has ever existed on this – this planet. It evolved over millennia and has – and – and again, I – I'm a amateur, I – I'm just commenting on what I know, there are people who can speak much more eloquently to this but the – the concept of the indivisibility of the individual from the family, from the family to the clan, from the clan to the community, from the community to the very land on which they reside and move about and tend to and care for rather than own, that, you know, that's a huge leap for someone from the outer suburbs of London, raised in the Midlands in the UK to – to – to ever be able to grasp but it's – you know, it's an essential component, the indivisibility of the people from their land. It's a different – it's a totally different*

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[115] ts 577.
[116] Exhibit 1.3, Tab 12.

perspective on – on being, I think. And I'm not suggesting for one moment that's the whole of it."[117]

213. There is a nascent acceptance of the critical importance of cultural continuity and cultural healing as protective factors in the area of suicide prevention. These factors have always been understood. However, the evidence before me has shown that the centrality of these factors has not always been fully appreciated by non-Aboriginal people.

214. The Department of Premier and Cabinet through its lawyers the SSO, draws my attention to the following funded Aboriginal organisations operating in the Kimberley Region. The purpose is to show that endeavours have been, and continue to be made, to fund and advance programs that recognise and foster cultural continuity. In drawing this to my attention, they do not suggest that no further Aboriginal organisations are needed. It is however instructive to list them (below) to show in fairness that efforts have been made in this area.

215. The Nyamba Buru Yawuru Health Centre, a native title organisation, has also been referred to previously in this finding under the heading *"Community Visits"*. In addition to its activities referred to under that part, the Centre employs youth development project officers and offers services to young Yawuru people, as well as more generally to young Aboriginal people that live in the Broome area. The Centre conducts youth on country trips, administers the *"Encouraging Excellence Fund"* which provides financial support (to pay for university fees), is involved in community development and in providing the *"Transition to Work"* program and is involved with the Kimberley Aboriginal Young Leaders Committee in addition to delivering *"cultural competency"* training for new police officers coming to Broome.[118]

216. The Nindilingarri Cultural Health Service is an Aboriginal community controlled organisation which receives funds from State and Federal government and is located in Fitzroy Crossing. It partners with WACHS and Kimberley Public Health Unit and its service priority is prevention services, providing 11 prevention programs designed around the social determinants of health. This service has piloted a "*Family Approach Model*" to dealing with chronic illness in one community. Part of this program is providing cultural awareness training and local information to community based GPs. This service is part of a consortium of Aboriginal run

[117] ts 1133.
[118] ts 565, 588 to 593; ts 1854.

organisations in the Fitzroy Valley that has recently received funding from the State Government for suicide prevention. Staff of the service visit all 45 communities in the Fitzroy Valley.[119]

217. Ngnowa Aerwah, the peak Aboriginal corporation in Wyndham, provides a young girls' program, on country trip for families, men's programs, re-entry program to assist prisoners returning to the community, drug and alcohol counselling (including referrals for the courts and child protection), a parenting program for Aboriginal women that aims to equip them to deal with adolescents, alcohol and substance abuse and grief, a sobering up shelter, short stay accommodation, a rehabilitation centre, employment and psychological support services.[120]

218. The Marninwarntikura Women's Resource Centre in Fitzroy Crossing provides services to women and children. It receives State and Federal funding and provides a refuge for women escaping domestic violence. The Centre runs an early learning childhood centre that also provides therapeutic services. It has been involved in the FASD problem study with Nindilingarri Cultural Health Services. The Centre has been funded to have a social worker and counsellor for the purpose of putting *"wraparound"* supports around families. The Centre partners with a non-government organisation to deliver a program assisting families in dealing with their children as they get older.[121]

219. The Wunan Foundation in Kununurra, assists Aboriginal people to obtain drivers licences (reducing their contact with the criminal justice system and increasing their opportunities of employment). The Foundation also funds the Kimberley Excellence Education Program sending children to private schools. The Foundation runs a school attendance program in Halls Creek and has overall management of children and family centres in Kununurra and Halls Creek. The Foundation operates a workers' hostel out of Halls Creek (funded by the Department of Housing). The Foundation runs programs introducing families to the school environment, assisting people moving from communities on the outskirts of town into houses in the town as well as a program assisting people on the pathway to home ownership.[122]

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119 ts 929 to 950;
120 ts 1049 to 1052; ts 1150 to 1159; ts 1316.
121 ts 732 to 741; ts 762.
122 ts 1375 to 1377.

220. The Yiriman Project commenced in 2000 and was originally based in Jarlmadangah Burru (a remote community in west Kimberley). Its primary goal was to support young Aboriginal people (aged 15-25 years) from remote communities to connect with country, culture and family, focusing on four language groups. It is referred to in more detail in the context of my recommendations, later in this finding.[123]

221. Cultural healing programs are crucial to the maintenance of cultural continuity for Aboriginal people, which is one of the protective factors that fosters self-continuity.

222. I have taken account of the Department of Premier and Cabinet's outline of the above funding and support that is already being provided to Aboriginal organisations in formulating my recommendations, from the perspective of building upon, and expanding, existing programs (or models akin to them, having regard to the diversity of Aboriginal communities).

HEALTH SERVICES IN THE KIMBERLEY REGION

223. In order to better understand the health services that were potentially available in the Kimberley Region to the children and young persons whose deaths have been investigated, regard needs to be had to the location of those services, and any processes for outreach into the more remote communities.

224. The Western Australia Country Health Service (WACHS) comprises seven health regions across the State, one of those regions being the Kimberley. They are responsible for the development and delivery of regional, publically funded health services.

225. WACHS Kimberley consists of six acute hospitals, one Residential Aged Care Unit, an acute mental health inpatient unit, and community services and the corporate office. The organisation provides hospital, community health, public health, remote area health, residential and community aged care and mental health services across the Kimberley Region through a multidisciplinary team of medical, nursing, Aboriginal health, allied health and support staff.[124]

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[123] ts 1988 to 1989; Exhibit 1.9, Tab 63B.
[124] Ibid.

226. The six acute hospital services comprise Broome Health Campus, Derby Integrated District Hospital, Fitzroy Crossing Hospital, Halls Creek Hospital, Kununurra Integrated District Hospital and Wyndham Hospital.

227. The community services comprise:

a. Kimberley Aged and Community Services, for the frail, aged, younger disabled and their carers;

b. Kimberley Population Health Unit, supporting the delivery of primary healthcare services including:

i. Remote Area Clinics, including at One Arm Point, Lombadina/Djarindjin, Looma, Kalumburu and Warmun, where remote area nurses and Aboriginal health workers, work in partnership with Aboriginal communities; the service delivery includes care across the whole of life, acute and emergency care, including evacuations and preventative services;

ii. Community Health Services in Broome, Derby, Fitzroy Crossing, Halls Creek, Kununurra and Wyndham delivering primary health care in those centres, and regular outreach health services at Mowunjum, Wangktjunkgka, Noonkanbah, Bayulu and Yiyilli as well as a number of smaller communities; again Aboriginal health workers play a significant role;

iii. The Public Health Unit, with Kimberley wide responsibility for communicable disease control;

iv. The Allied Health Team based in Broome, Derby and Kununurra, that includes physiotherapists, occupational therapists, speech pathologists, dieticians and social workers; they are currently pursuing the expansion of a social support service.[125]

228. The Court is informed that WACHS Kimberley's resources over a ten year period have grown from an average full time equivalent (FTE) of 760 in 2007 to an FTE of 1041 in 2017. Medical resources have increased from an average of 50 FTE in 2007 to an average of 92 FTE in 2017.[126]

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[125] Exhibit 1.6, Tab 57.
[126] ts 1133.

229. It is submitted to me and I accept that of all the community services provided by WACHS in the Kimberley, the Kimberley Mental Health and Drug Service (KMHDS) is arguably the most relevant to the subject matter of this Inquest.

230. It is submitted to me and I accept that there has been an increase in the resources of the KMHDS. For example, the KMHDS budget was $7,423,168 in 2006/2007, $10,973,842 in 2011/2012 and $25,838,309 in 2016/2017. The KMHDS FTE resourcing was 55.8 in 2006/2007, 65.7 in 2011/2012 and 119.5 in 2016/2017.

231. Across Western Australia the overwhelming majority of mental health services are provided by primary care services run by private clinicians like GP's and other health professionals, including those employed in community controlled Aboriginal Medical Services. This is true in metropolitan areas and regional areas alike.[127]

232. The WACHS' mental health services in the Kimberley Region are included in the description below.

MENTAL HEALTH SERVICES IN THE KIMBERLEY REGION

233. This part outlines the mental health governance in Western Australia generally, and specifically the mental health services in the Kimberley Region. These are outlined in order to better understand the mental health services that were potentially available to the children and young persons whose deaths have been investigated. Other than in three cases, none of the other children and young persons who suicided had any substantive contact with any mental health or counselling service.

234. This begged the question of whether there was a lack of availability of mental health or counselling services, a lack of awareness of either the existence of a service, or of the need for help from such a service. It is also possible that such services, which focus on individual mental health treatment, were not considered culturally relevant by the parents and carers of the children and young persons.

235. The Chief Psychiatrist, Dr Nathan Gibson, gave evidence at the Inquest. Dr Gibson is an independent statutory officer responsible for the oversight of treatment or care by a Mental Health Service (as defined in section 4 of the *Mental Health Act* 2014

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[127] Exhibit 1.5 Tab 51A.

(WA)) including public sector services (both inpatient hospitals and community services) and private inpatient psychiatric hospitals.[128]

236. As an independent statutory officer the Chief Psychiatrist has an independent responsibility to raise matters regarding standards of care in mental health services with the Department of Health and the Mental Health Commission, as required. However, he does not operationally run the mental health services. He has no statutory remit in respect of patients in private psychiatrists or therapists rooms, or patients in primary care (for example in the care of GPs).

237. The Ministerial Council for Suicide Prevention leads the state-wide suicide prevention strategy, *Suicide prevention 2020: together we can save lives,* and oversees initiatives to:

a. improve strength and resilience;

b. expand community understanding of suicide; and

c. support capacity building in communities at risk.

238. The Mental Health Commission provides executive support to the Ministerial Council for Suicide Prevention, and the Commissioner for Mental Health is a member of the Council. The Chief Psychiatrist is not a member of the Council.

239. The Mental Health Commission is the State's mental health fund holder, funding public sector mental health services and procuring contracts for services by non-government organisations.[129]

240. The Mental Health Commission also directly provides alcohol and other drug treatment and support via the Next Step Drug and Alcohol Service, Alcohol and Drug Support Line and the Community Alcohol and Drug Services. Their strategic direction is guided by the: *"Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025: Better Choices. Better Lives."* Their focus is on prevention, early intervention and community based services and supports that keep people well and out of hospital.[130]

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[128] Ibid.
[129] Ibid.
[130] Exhibit 1.6, Tab 57.

241. Primary care services (such as GPs) provide the vast bulk of clinical mental health care in the State and thus have a direct role in clinical suicide prevention and management. These are predominantly private practitioners primarily operating through the nationally funded Medicare scheme. Community controlled Aboriginal Medical Services are typically primary health care providers.[131]

242. Three Primary Health Networks (Perth North, Perth South and Country WA) are run by the Commonwealth funded Western Australia Primary Health Alliance Commission, and seek to facilitate good practice, integration and innovation across the primary healthcare sector.[132]

243. With respect to the Kimberley Region, the WACHS' mental health services include the following:

a. The Kimberley Mental Health and Drug Service (KMHDS), providing locally based specialist mental health services with multi-disciplinary teams located in Kununurra, Halls Creek, Derby, Fitzroy Crossing and Broome, and outreach services being provided by each of those teams to surrounding and remote areas; KMHDS provides the following services:

   i. Kimberley Adult Community Mental Health Services, to provide triage, assessment and/or case management services for people with serious mental illness;

   ii. Child and Adolescent Mental Health Services to provide triage, assessment and/or case management services to children and young persons with serious mental illness; staffing consists of a Child Psychiatrist, Team Leader, eight Mental Health Professionals, and two Youth Counsellors; this is further supplemented with visiting Child Psychiatry Services through the Outreach in the Outback Program;

   iii. Kimberley Community Alcohol and Drug Services, providing general adult alcohol and drug services across the Kimberley, including counselling for individuals, families and communities;

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131 Ibid.
132 Ibid.

iv. Broome Mental Health Unit (Mabu Liyan), translated as "*a place of good spirit*" that has been able to receive involuntary mental health patients under the *Mental Health Act* 2014 (and the previous legislation) since November 2012, thereby avoiding the need for those patients to be transferred to an authorised facility in Perth;

v. The Statewide Specialist Aboriginal Mental Health Service fully established in 2012, funded by the Mental Health Commission, with the role of strengthening the cultural competence of the WACHS mental health services and facilitating access between services for Aboriginal persons and Aboriginal communities; their role includes working as secondary case managers or key workers for Aboriginal clients, and working with triage/duty officers at the first point of contact and assessment;

vi. Broome Community Recovery Centre, providing assistance and support to individuals with mental health difficulties on their recovery journeys, without stigma, and including their carers and families;

vii. The Kimberley Mental Health and Drug Service Suicide Prevention Coordinator, recruited in April 2017 and funded by the Mental Health Commission, in line with the *Suicide Prevention 2020 Strategy*;

b. The WACHS Kimberley Corporate Office provides the centralised support services to each of the above Health Service Units.[133]

244. With respect to the Child Psychiatrist referred to above, this position was filled by Dr Paul Simons, who was employed with the KMHDS of the WACHS, incorporating the specialist Child and Adolescent Mental Health Service, in January 2017. In addition to Dr Simons as clinical lead, there are eight Child and Adolescent Mental Health Practitioners working in the Kimberley Region (at Broome, Kununurra, Derby and Fitzroy Crossing).[134]

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[133] Ibid.
[134] Exhibit 1.4, Tab 40.

245. Dr Simons reports that all children under 18 years who require inpatient mental health treatment are required to be transferred to Perth. Very infrequently children close to the age of 18 years may be admitted to Mabu Liyan in Broome if there is a delay in inpatient bed availability in Perth. Where possible, they prefer to manage children and adolescents in their home environment and in their community.[135]

246. The WACHS Regional Director Ms Rebecca Smith informs me that the KMHDS has the largest proportion of Aboriginal workforce in Western Australia, at greater than 20%. The KMHDS's Aboriginal Mental Health Workers and Liaison Officers are central to the multidisciplinary team, and two-way learning is embedded within the service's practice.[136]

247. The challenges faced by the WACHS in the Kimberley Region that impact upon its ability to deliver services, include the following:

a. A high staff turnover of 25%, almost double the average turnover at WACHS at 14%, in part affected by the high number of fixed term contracts in the Kimberley Region;

b. A reliance on employer provision of housing to accommodate staff (which poses some barriers to service provision in Fitzroy Crossing, Halls Creek, Wyndham and the remote communities);

c. The tyranny of distance, travel barriers and costs particularly in the wet season.[137]

248. The emergence of Telehealth has supported the increased access to services irrespective of the consumer's geographical location. As at the time of the Inquest the *WA Telehealth Strategy and Implementation Framework 2017 – 2022* was being finalised and includes the emergency telemedicine service, for rural and remote patients. In 2016/2017 24.5% of the clinical occasions of service were delivered for the Kimberley Region.[138]

249. There are also non-government entities involved in the provision of mental health and counselling services in the Kimberley Region, and they include the following:

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135 Ibid.
136 Ibid.
137 Ibid.
138 Ibid.

a. HeadSpace provides psychological services to youth in Broome, including GP support, available as a frontline walk-in service;[139]

b. Anglicare offers counselling services (including counselling for family and domestic violence, sexual assault, relationships, mediation on separation and postvention) across the East Kimberley with men's and women's workers in Kununurra, Halls Creek, Broome and Derby;[140]

c. A number of Aboriginal organisations referred to previously, including Nyamba Buru Yawuru Health Centre (Broome area), Nindilingarri Cultural Health Service (Fitzroy Crossing), Ngnowar Aerwah (Wyndham), Marninwarntikura Women's Resource Centre (Fitzroy Crossing), the Wunan Foundation (Kununurra) and the Yiriman Project (West Kimberley, operating with the support of the Kimberley Aboriginal Law and Cultural Centre);

d. Boab Health, offering a more formal psychological intervention for mild to moderate mental health issues, Kimberley wide;[141]

e. Aboriginal Medical Services funded by the Commonwealth;

f. Save the Children in Kununurra, running preventative type programs in the East Kimberley, such as school-like programs and evening activities for Aboriginal children;[142]

g. The Black Dog Institute's *iBobbly* App with *Alive and Kicking Goals* in Broome, that is involved in supporting the suicide trial sites (a Federally funded project) where the Kimberley has been selected as one of 12 pilot sites.[143]

250. With regard to suicide, the Chief Psychiatrist receives information on suspected suicides of individuals linked to state-wide Mental Health Services. This is approximately 25 - 30% of all suspected suicides in WA. The Chief Psychiatrist through his lawyer the SSO submits to me that this figure

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[139] ts 623; Exhibit 1.5, Tab 51.
[140] ts 1169.
[141] ts 612, 894, 1051, 1312, 1329, 1466.
[142] ts 1092, 1244, 2040, 2050.
[143] ts 74 to 76; ts 2237.

means that no matter how well Mental Health Services are run, they will have no impact on the vast majority of people who suicide. Consequently, he submits that improving Mental Health Services alone is unlikely to have the most significant impact on the incidence of suicide. This State is not anomalous in this respect. The situation is similar across Australia and even the world.[144]

251. The Chief Psychiatrist submits that suicide is often the result of temporally proximal circumstances on top of pre-existing vulnerabilities. Pre-existing vulnerabilities can include mental illness but mental illness is often not the most significant immediate factor. At the Inquest he explained that there is often not a dividing line between having a mental illness and not having a mental illness. There is a spectrum. In his experience, persons who are prone to suicide often have mental health vulnerabilities, and most persons who suicide do not come through the mental health sector.[145]

252. I accept the Chief Psychiatrist's submission, insofar as it is clear that the range of factors giving rise to the pre-existing vulnerabilities cannot be addressed by mental health services alone, though such services are undeniably important.

253. The effects of intergenerational trauma on entire Aboriginal communities in the Kimberley Region, that give rise to the pre-existing vulnerabilities, are to be alleviated by community-wide and community-led responses that are supported by the Government. I have taken account of this in formulating my recommendations.

HOUSING SERVICES IN THE KIMBERLEY REGION

254. Practically all of the children and young persons whose deaths were investigated had disrupted home lives, many of them did not live with their parents, and a number of them were transient between different Aboriginal communities, living in overcrowded and/or inadequate housing arrangements.

255. Much has been written about the issues impacting upon the availability of adequate housing across the Kimberley Region. Whilst an analysis of the housing services across the region is outside the scope of the Inquest, some information has been required in order to better understand the challenges facing the

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[144] Ibid.
[145] ts 1629.

parents and carers of the children and young persons in securing and maintaining adequate housing, and to place into context the effects of the transience that they so often experienced.

256. Self-evidently, in order to thrive and gain an education, children need a safe and nurturing home environment. They need to be living in adequate housing.

257. The Housing Authority, established under the *Housing Act* 1980 (WA) is responsible for a range of measures that include the improvement of existing housing conditions, the provision of housing and land for housing, and the provision of assistance to enable persons to obtain accommodation or improve the standard of their accommodation. The Housing Authority is now part of the branch of the Department of Communities that is responsible for housing.

258. With respect to the Kimberley Region, the Housing Authority is responsible for providing and maintaining the following:

a. Public housing dwellings (also referred to as social housing) in the Kimberley to provide homes for Western Australians on very low incomes, currently 1,826 in the Kimberley Region;

b. Housing for Aboriginal communities in remote locations, currently 1742 properties in the Kimberley Region; and

c. Properties for Government Regional Officer's Housing, currently 1351 properties in the Kimberley Region.[146]

259. The Department of Communities provides employment and education facilities for Aboriginal people entering the workforce or undertaking employment training courses in Broome, Derby, Fitzroy Crossing and Halls Creek, which includes accommodation for up to three or four years to support persons undertaking that training. In partnership with the Nirrumbuk Aboriginal Corporation and Kimberley Development Commission, it provides transitional housing aimed at being stable and affordable for Aboriginal people in the Kimberley Region who meet the requirements of that program.[147]

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[146] Exhibit 1.6 Tab 54.

[147] Ibid.

260. Most of this social housing is in the major towns in the Kimberley Region on land owned by the Housing Authority. In remote Aboriginal communities in the Kimberley, the role of the Housing Authority is different because, in the majority of cases, the Housing Authority does not own the land on which it is providing and maintaining houses. This can limit the ability for the Housing Authority to build and maintain houses in these communities.[148]

261. Since 2007, a framework has been developed to enable the Housing Authority to manage non-owned houses in remote Aboriginal communities as agent for the Aboriginal entity, based upon the community entering into a voluntary Housing Management Agreement. As at the date of the Inquest, there were 55 Housing Management Agreements in the Kimberley Region.[149]

262. The Housing Management Agreements are voluntary, and only include those houses nominated by the Aboriginal community. In any given community there may be houses not subject to a Housing Management Agreement. The Housing Authority does not have the authority to do work on such properties, nor manage the letting and leasing.[150]

263. The Department of Communities acknowledges that there continues to be a shortage of social housing in the Kimberley Region, with demand being disproportionally high. Through its lawyer the SSO, it submits that simply increasing supply to meet demand is not a tenable aim. It submits that the aim should not be for more fit people of employable age to be housed in social housing, but rather, to assist people to overcome generational welfare dependency, and move into training and work, which will enable them to afford private rental or home ownership.

264. The Department of Communities through its lawyer the SSO has also drawn my attention to the Commonwealth government's funding of certain assets. In January 2017 the North West Aboriginal Housing Fund was established by the State Government, with a contribution from the Commonwealth Government, to increase housing options; the aim of this commitment of funding, was to provide targeted support for Aboriginal families, and provide incentives for them to achieve,

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[148] Ibid.

[149] Ibid

[150] Exhibit 1.6 Tab 54; ts 1810.

and improve their chances of achieving, educational and employment success.[151]

265. As at the time of writing this finding, it is clear that the decision-making regarding the funding in this area is evolving. The details of how this is developing are outside the scope of the Inquest. I note it in order to give some context to the Department of Communities' acknowledgement about the social housing shortage.

266. The Department of Communities through its lawyer the SSO points to the following efforts to address the shortage of social housing:

a. Since the former State Coroner's 2008 Inquest The Housing Authority has delivered 620 new homes and refurbished 1,058 houses in 71 remote Aboriginal communities and four regional towns in the Kimberley Region; and

b. Since 2012, the transitional housing program has operated in Kununurra; to access this housing, families must ensure that their children attend school, adults are in work or training, and that the family is engaged with wrap-around support services (including financial counselling).

267. The Department of Communities through its lawyer the SSO, draws to my attention some factors affecting its functions in delivering and maintaining social housing and essential services (including power, water and waste water facilities) in remote locations across the State, and points to the following challenges:

a. Securing funding to deliver accommodation to match the high demand in the Kimberley Region;

b. Accessing land in remote locations on which the Housing Authority can build;

c. Maintaining houses on land which is not owned by the Housing Authority;

d. Difficulties for ongoing maintenance, in particular having access to qualified tradespeople to do certain specialist tasks, whilst supporting employment opportunities for Aboriginal people who may have those

[151] Exhibit. 1.5, Tab 52; Exhibit 1.6 Tab 54.

qualifications and/or other more general labourer activities that support construction and maintenance;

e. Managing projects in partnership with remote communities and organisations, described as a "*constant*" for the Department of Communities. They have introduced a head contractor model and the Department of Communities informs me that it is now considering how to increase Aboriginal corporation participation under that model;

f. The increased cost of building in regional areas which is increased even further when constructing in remote communities. The construction of a three or four bedroom house in Perth ranges from $180,000 to $250,000, whilst the cost of a similar house in a remote community in the Fitzroy Valley increases as high as $380,000 to the low $400,000's.[152]

268. The Department of Communities also draws attention to a clearly sensible regulatory reform that has permitted local health workers in remote communities and regional towns to perform fairly basic plumbing tasks which previously have required a licensed plumber to attend to. In 2016 the *Plumbers Licensing and Plumbing Standards Regulations 2000* were amended to allow for this, thereby alleviating some of the difficulties in providing minor maintenance in remote communities.

269. I accept that the Department of Communities is making ongoing and sustained efforts to improve accessibility to housing in the Kimberley Region. Within the context of fostering stable and adequate housing for children and young persons, I have made recommendations concerning the expansion of the transitional housing program, and recommendations concerning flexibility of that program (Recommendations 14 and 15).

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[152] ts 1796, 1803 and 1820; Exhibit 1.6 Tab 54.

EDUCATION SERVICES IN THE KIMBERLEY REGION

270. Very sadly, practically all of the children and young persons whose deaths have been investigated in this Inquest had poor school attendance rates, consequential poor academic outcomes and most of them displayed behavioural problems at school. In order to better understand the accessibility of education services for the children and young persons, and to place their low attendance rates into some context, it is important to outline the education services in the Kimberley Region and the attempts made to deliver such services in a culturally competent manner.

271. The objects of the *School Education Act* 1999 (WA) (School Education Act) include to recognise the right of every child in the State to receive a school education, to provide for government schools that meet the educational needs of all children, to provide for education, training and employment alternatives at the senior secondary level, to acknowledge the importance of the involvement and participation of a child's parents in the child's education and to provide for student residential colleges that offer residential accommodation for students to attend, and participate in an educational program of, a school.[153]

272. In the Kimberley Region, the Department of Education is responsible for 23 government schools, and for providing non-government schools in the Kimberley with school psychology services.[154]

273. The CEO of the Department of Education is responsible for determining, implementing and monitoring the standard of educational instruction in government schools, and the standard of care provided to students in those schools.[155]

274. Under the School Education Act, school attendance is primarily a parental responsibility.[156]

275. The Department of Education through its lawyer the SSO, draws attention to the number of challenges it faces in delivering

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[153] Section 3, *School Education Act* 1999.

[154] Exhibit 1.5 Tab 50; ts 1387.

[155] Section 3(2), *School Education Act* 1999.

[156] ts 1616; the Act ss 9, 11AA, 23, 38.

education to Aboriginal students in the Kimberley Region, including the following:

a. The scale of the transience of Aboriginal families;

b. The educational challenges in teaching FASD and trauma affected children and children who may be developmentally vulnerable by the time they enter the education system;

c. The engagement challenges due to historical context, that causes Aboriginal communities to be wary of the education system;

d. The lack of family support for school attendances, drawing attention to the following evidence:

   i. Mr Mark Williams, Principal of Derby District High School: "*the difficulty for schools is that no matter how strong the pull from school is to get the children to school, if there is no push from home, the children will not come. And if the children do not want to come, we cannot force them.*"

   ii. Mr Greg Robson, Regional Executive Director, Kimberley Education Region, who confirmed the following: *"…attendance can also improve significantly and in a sustained way where there's support and where there's push from communities and parents."*

e. The access to specialist services in remote environments; and

f. The retention of staff.[157]

276. The Department of Education referred to the importance of the family's role in supporting a child's education and providing that child with a safe environment outside of school. As outlined by Mr Lindsay Hale, Deputy Director General, Schools, school staff understand the challenging circumstances faced by Aboriginal families, and in his experience they do step up and provide services beyond what would normally be encompassed in schooling. However, the Department of Education does not wish

[157] ts 651; Exhibit 1.4 Tab 48; Exhibit 1.5 Tab 50. Exhibit 1.3 Tab 17; Exhibit 1.5 Tab 50; ts 1594-1596 Exhibit 1.3 Tab 17; ts 676; Exhibit 1.3 Tab 19. ts 653.

to, inadvertently, replace the role of families, and thereby maintain a culture of dependence.[158]

277. The Department of Education refers to the evidence given at the Inquest to the effect that Government schools in the Kimberley Region are adequately resourced in terms of teacher to student ratios, education facilities and psychology services to meet the challenges and complexities of the Kimberley region.[159]

278. In relation to the attendance rates of Aboriginal children in the Kimberley, the Department of Education refers to the efforts undertaken by schools in this area and points to the following evidence:

a. Principals and teachers going out into the community every morning to talk to families and get the children to school;

b. Schools celebrating achievement in attendance at assemblies;

c. Schools providing breakfasts to children to attend school;

d. Schools sending minibuses around to collect children and again later in the morning for children who had slept in.[160]

279. The Department of Education recognises the importance of building genuine deep engagement with Aboriginal communities and whilst it is submitted to be a work in progress, in which the department is still finding its way, it points to the following efforts:

a. They are working to ensure schools are culturally proficient, through the implementation of the Aboriginal Cultural Standards Framework released in 2015, which sets expected standards for all staff when working with Aboriginal students, their parents, families and their communities;[161]

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[158] ts 1616 – 1617.

[159] ts 510, 530, 536; ts 681; ts 1385 - 1388; ts 1490; Exhibit 1.4 Tab 48; Exhibit 1.3 Tab 17; ts 1610.

[160] Exhibit 1.3 Tab 19; ts 520; ts 676; ts 1616; ts 995; Exhibit 1.4 Tab 48.

[161] Exhibit 1.5 Tab 50.

b. They are implementing this framework at schools across the Kimberley, and Aboriginal Islander Education Officers have been teaching "*Our People Our Story*", which is the story of Aboriginal Australia;

c. They have developed the Elders in Residence initiative in which they have engaged Elders, Professor Colleen Hayward and Mr Ian Trust, to provide advice on ways to improve how government schools work with Aboriginal children and their families;[162] and

d. They are endeavouring to work with Aboriginal families to, in the words of Mr Robson: "*....make our schools as open and appealing and as positive as we can to the families who the schools are set up to serve.*"[163]

280. The Department of Premier and Cabinet through its lawyer the SSO, points to the greater understanding of FASD within schools in the Kimberley Region and to the provision of school psychologists to assist teachers with strategies to manage affected students, information resources and training sessions.[164]

281. In terms of outcomes, despite these commendable efforts and initiatives, the Department of Education reports that there has only been marginal improvement overall for Aboriginal students in some achievement and attainment measures, while attendance data has remained largely unchanged.[165]

282. Before achievement and attainment comes into question, attendance rates must be addressed. Under the current attendance standards, from 2013, school attendance rates among Aboriginal compulsory year students in the Kimberley Region have remained stable at 67%. The gap between Aboriginal and non-Aboriginal compulsory year attendance rates over this period has also been stable at about 25%.[166]

283. The reasons as to why Aboriginal students in the Kimberley Region attend school at lower rates than non-Aboriginal students are described by Mr Hale as multiple, complex and

[162] Exhibit 1.5 Tab 50.
[163] ts 650, 676; Exhibit 1.3 Tab 19.
[164] Exhibit 1.5, Tab 50.
[165] Exhibit 1.5 Tab 50.
[166] Exhibit. 1.5, Tab 50.

contextual and many of the reasons are outside the control of the schools. Some of those factors include:

a. The Kimberley climate being extreme, at times involving cyclonic coastal conditions and heavy rains in the interior, resulting in flooding and inaccessibility;

b. Aboriginal young people having cultural commitments that are demanding on their time (caring for siblings or the elderly, attending to lore and grieving rituals);

c. Many of the remote Aboriginal communities that are *"hot spots*" for low attendances are also subject to a visible lack of quality of life, as measured by high rates of unemployment, overcrowding of housing and the prevalence of acute poverty;

d. In very remote areas, some Aboriginal families have a pattern of *"transient mobility"* in which they circulate through three or four communities/regional towns on a semi-regular basis;

e. Some children have clinically significant emotional or behavioural difficulties, making it more likely that they will be absent from school.[167]

284. In his report to the coroner Mr Hale outlines the current Department of Education policy that directs schools to develop an understanding of the localised reasons for non-attendance and to attempt to reclaim attendance by working with families and other agencies to remove barriers to attendance. This can include developing welcoming schools that are culturally relevant, planning lessons that incorporate meaningful and interesting content with appropriate challenge, and assisting as far as is reasonable to address a range of needs with which families may be battling.[168]

285. In his report to the coroner Mr Hale also provides detail of the initiatives to improve schooling and wellbeing outcomes for Aboriginal students, and he acknowledges that more could be done. He is frank in stating: "*There is no shying away from the reality that educational outcomes are unacceptably low across the Kimberley Region.*"[169]

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[167] Exhibit 1.5, Tab 50.
[168] Ibid.
[169] Ibid.

286. Importantly, Mr Hale and his Department are of the strong view that their work must continue to be locally embedded in the cultural richness, diversity and strength of each community, and be delivered in genuine partnership with community leaders and other service providers.[170]

287. At the Inquest, Mr Robson explained that the Department of Education is also addressing the need for schools within the Kimberley Region to be able to efficiently exchange critical information about students, given that transience of young people in communities such as Kununurra, Halls Creek and Fitzroy Crossing can be as high as 50%. In pursuance of this, and in recognition that effective teaching requires continuity of approach the Department of Education is developing an on-line student records sharing system (by way of a database called "*Aussie Online Student Information*").[171]

288. I have considered the Department of Education's submission to the effect that Government schools in the Kimberley Region are adequately resourced. I have also had regard to the poor attendance rates and the poor educational outcomes of the 13 children and young persons whose deaths were investigated at the Inquest, and the evidence of the departmental officers to the effect that attendance rates and educational outcomes have not improved.

289. It is to be borne in mind that a child's engagement with school and learning can operate as a significant protective factor, and mitigate some of the child's vulnerabilities. It can function as a first contact for identifying a child in need of help. An adequate education is also important for future employment prospects. To this end I have formulated a number of recommendations that aim to foster this engagement (Recommendations 35 to 40).

POLICE PRESENCE IN THE KIMBERLEY REGION

290. Practically all of the children and young persons had at some stage lived in home environments that were marred by alcohol abuse and/or domestic violence. In numerous cases, police attended, and in some of those cases, having regard to the

[170] Ibid.
[171] ts 651 to 652.

presence of children in the household, a report was made to the Department of Child Protection and Family Support.

291. Self-evidently, the scourge of domestic violence and its repercussions cannot be solved by police attendance alone, though their attendance is vital and I have formulated a recommendation to facilitate the making of reports to police, and it is hoped, the maintenance of the complaint throughout any ensuing legal proceedings (recommendation 18).

292. Aboriginal people have a history of mistrust of the police, arising from historical governmental policies that resulted in their removal from their lands, and the removal their children, with such policies often being enforced by the police. The reverberations are felt to this very day, with the result that some Aboriginal people continue to feel threatened by persons in authority, and in particular the police. These feelings of alienation can manifest in a reluctance to call for police attendance for fear of greater repercussions. They can also result in elevated levels of stress during interactions with police.

293. The police presence in the Kimberley Region is outlined below, in order to better understand the environment in which the families and carers of the children and young persons interacted with police. There is a specific focus upon the steps being taken towards cultural proficiency within the police.

294. The Western Australia Police Force maintains its police presence in remote locations through a range of measures. In the Kimberley Region police officers and staff operate from Broome, Kununurra, Derby, Fitzroy Crossing, Halls Creek and Wyndham and from the six multi-functional police facilities which are located at Balgo, Kalumburu, Bidyadanga, Dampier Peninsula, Warmun and Looma. These are designed for multi-agency use and co-location.[172]

295. The Commissioner of Police through his lawyer the SSO informs me that the Western Australia Police Force is developing a program of works to enhance Police and Aboriginal reconciliation in terms of respect, relationships and opportunities within and external to the Western Australia Police Force. To deliver these action items it is envisioned a governance framework and new structures will be required to action, monitor, measure and report back. The desired outcome is to

[172] Exhibit 1.8 Tab 59.

build trust and mutual respect and increase the employment of Aboriginal people in the Western Australia Police Force.

296. In the area of training for cultural proficiency generally, the Commissioner of Police also informs me that the Western Australia Police Force is in the process of developing a comprehensive framework of Aboriginal cultural training across the agency, which has commenced with a Western Australian University undertaking an independent audit of their existing curriculum and policies specifically relating to Aboriginal people.[173]

297. In the area of training for cultural proficiency specifically for the Kimberley Region, my attention is drawn to the following:

a. The Western Australia Police Force has engaged Nyamba Buru Yawuru, representing the Broome traditional owners, to develop a cultural induction program for police officers;

b. The development of the cultural induction program has been expanded to include other front line service workers from Government agencies to allow the training to be offered more frequently;[174]

c. The Western Australia Police Force intends to look into the broader roll out of this traditional owner led cultural induction across the six major towns in the Kimberley Region, capturing approximately 95% of the Kimberley workforce;[175]

d. The Western Australia Police Force is committed to this development, despite the anticipated difficulty of identifying the traditional owners to deliver the induction in some places, such as Fitzroy Crossing where there are multiple skin groups in the community.[176]

298. In the area of mental health and self-harm, the Commissioner of Police informs me that the Western Australia Police Force recognises the importance of addressing the devastating numbers of Aboriginal youth suicides in the Kimberley Region

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[173] Ibid.
[174] Ibid.
[175] Ibid.
[176] ts 1854 to 1855.

and they are endeavouring to do all they can in their role to contribute to a solution. Some of the measures include:

a. The development and conduct of a two day Mental Health First Aid Workshop, with the aim of training police to provide assistance to a person who is developing a mental health problem, or who is in a mental health crisis, or who is under stress, until appropriate professional treatment is received or the crisis resolves; it is an internationally recognised course, and since 2012, Western Australia Police have conducted 70 such courses and trained over 1,300 sworn and staff personnel (a number of courses have been conducted in Broome, and Kimberley District has over 40 trained officers);[177]

b. The Western Australia Police Force has taken the role of ensuring relevant government agencies and non-government organisations are notified of the details of any child related self-harm incident and, in the event of an apparent Aboriginal suicide, chair a conference call between all relevant stakeholders within 24 hours of the death. The Western Australia Police Force has also recently supported local Aboriginal social, emotional and wellbeing organisations in coordinating the response to a suicide;[178]

c. In the event of Kimberley Police coming into contact with a person indicating an intention to self-harm through word or action, Kimberley Police Officers have been given a direction that the individual is to be taken to a medical facility for assessment.[179]

299. The Western Australia Police Force draws my attention to a number of examples where Kimberley Police worked outside of their job descriptions to build trust and positive relationships with Aboriginal communities. Information was provided about police coaching football teams, coordinating activities such as community functions involving a peace march, barbeques, art projects, school holiday programs and basketball games.[180]

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[177] Ibid.
[178] Ibid.
[179] Ibid.
[180] Exhibit 1.3, Tab 23; Exhibit 1.4, Tab 28; Exhibit 1.4, Tab 46.

300. These and similar efforts are to be commended and I note that the police officers who took part did so in their own time, often on their own initiative, and with the intention of improving community relations, and promoting more positive interactions.

301. Despite all of the efforts referred to in this part, that are substantial, at a general level there is room for improvement in the area of community relations, as part of a broader response (and not only by the Western Australian Police Force). I have taken account of these matters in formulating my recommendations.

ALCOHOL RESTRICTIONS IN THE KIMBERLEY REGION

302. As outlined previously, practically all of the children and young persons had at some stage lived in home environments that were marred by alcohol abuse. This had a severe cascading effect on their lives, placing them at the risk of FASD, compromising the capacity of the mothers to nurture their infants, exposing them at a young age to dangerous and frightening incidents of alcohol-fuelled domestic violence, and robbing them of a safe and secure childhood.

303. Consequently, as a result of the alcohol abuse in the home, many of the children and young persons were frequently living in a climate of fear and uncertainty, which can become corrosive. For this reason, the Inquest examined the availability of alcohol in the Kimberley Region.

304. In general, the sale of alcohol is prohibited by the *Liquor Control Act* 1998 (WA) unless the person has a licence or permit, and the sale of alcohol without a licence or permit is an offence punishable by up to two years imprisonment.[181]

305. In relation to existing licences, the Director of Liquor Licensing (and the Liquor Commission) is empowered to impose, vary and cancel conditions. Section 64(1a) of the *Liquor Control Act* enables the Director of Liquor Licensing to impose, vary or cancel conditions of its own motion or on the application of the licensee or at the written request of the parties to a liquor accord.

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[181] *Liquor Control Act 1988* s 109(1).

306. The Governor may, on recommendation of the Minister, make regulations declaring an area of the State to be a restricted area, restricting or prohibiting the bringing of liquor into the restricted area.[182]

307. On duty members of the Police Force may require a licensee to close licensed premises if they have reasonable grounds for believing civil disorder, a breach of the peace or a threat to public disorder is occurring or is likely to occur and that it is or may be desirable to close the premises in the interests of maintaining the peace or ensuring public safety.[183]

308. The Director of Liquor Licensing, on application of the owner or occupier (or person in a prescribed class) may declare premises or part of premises (including residential premises) to be liquor restricted premises at all or specified times. This declaration can be made in the public interest despite not reflecting the wishes of the majority of the occupiers of the premises.[184]

309. With respect to the Kimberley Region, there are restrictions of various kinds, and they are not all the same across the Kimberley. Details of the restrictions are available on the Racing, Gaming and Liquor website: www.rgl.wa.gov.au. These details include a map showing the areas where restrictions apply as well as relevant decisions of the Director of Liquor Licensing.

310. There are Kimberley wide restrictions under s 64 of the Liquor Control Act that prohibit the sale and supply of packaged liquor in individual containers of more than one litre or glass containers containing more than 400ml of beer.

311. The existing conditions imposing restrictions have been introduced in response to local circumstances, and in accordance with the Director's decisions in relation to the Crossing Inn in Fitzroy Crossing (in 2008) and the Kimberley Hotel and the Halls Creek Store (in 2009).[185]

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[182] *Liquor Control Act 1988* s 175(1a).
[183] *Liquor Control Act 1988* s 114.
[184] *Liquor Control Act 1988*, Part 5B; The CEO of the Department administering the *Children and Community Services Act 2004* (WA) has been prescribed: see *Liquor Control Regulations 1989* (WA), reg 25A.
[185] Exhibit 1.3 Tab; Exhibit 1.3 Tab 16.

312. These decisions imposed conditions prohibiting the sale of packaged liquor exceeding 2.7% concentration in Fitzroy Crossing and in Halls Creek.

313. The proceedings leading to the decision in relation to the Crossing Inn were precipitated by the Marninwarntikura Fitzroy Women's Resource Centre's request for consideration of a 12 month moratorium on the sale of liquor due to their significant concerns about the extent of alcohol related harm occurring in the Fitzroy Valley Region.

314. Applications by the licensees in Fitzroy Crossing and Halls Creek to vary the conditions by permitting the sale of a higher concentration of packaged liquor have been rejected.[186]

315. On 16 November 2017 the delegate of the Director further restricted sales of packaged alcohol in Kununurra and Wyndham to a maximum cumulative quantity of 11.25 litres of liquor at 2.7-7% per customer per day (for example one carton of 30 cans, of 375mls each) and/or 3 bottles of 7-15% concentration (for example three bottles of wine, of 750mls each). This restriction was initiated following receipt of a report from the Wunan Foundation. Previous restrictions had been in place in one form or another since 2011.[187]

316. In Derby there are conditions prohibiting the sale of mainstream beer in 750ml bottles and fortified wine in two (or more) litre casks, limiting the sale of full strength packaged liquor to between 12.00 noon and 8.00 pm Monday to Sunday for hotel/tavern licences and club licences, and between 12.00 noon and 8.00 pm Monday to Saturday for liquor store licences. The sale of wine in casks or flagons is limited to one two litre cask or flagon per customer per day.[188]

317. A number of communities in the Kimberley have been declared to be restricted areas by regulations under s 175 of the Liquor Control Act. They become "*dry communities.*" These restricted areas are: Bayulu, Bungardi, Juwurlinji, Koongie Park, Kundat Djaru, Looma, Ngalingkadji, Nicholson Block, Nookenbah, Pandanus Park, Wangkatjungka, Woolah, Yakanarra. In addition, two properties in Cable Beach and one

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[186] Decision A192547 and A192549 is publically available on the Racing, Gaming and Liquor website.

[187] Decision INV 59043 is publically available on the Racing, Gaming and Liquor website.

[188] Decisions A126408 (23 February 2004) and A161211 (30 March 2005) are publically available on the Racing, Gaming and Liquor website

in Derby, being part of the Transitional Housing and Support Program are declared to be restricted areas. All of the declarations apply until a specified future date, unless repealed sooner.

318. Under s 175 of the Liquor Control Act, applications can also be made for a specific liquor restricted premises. Currently there are 232 liquor restricted premises across the Kimberley.[189]

319. The information about the destructive effects of alcohol abuse upon the lives of the children and young persons whose deaths have been investigated has led me to formulate recommendations concerning restrictions on take away alcohol, a banned drinkers' register, and alcohol and drug rehabilitation for children and young persons (Recommendations 9 and 10, and Recommendation 34).

AMALGAMATION OF GOVERNMENT DEPARTMENTS

320. In some cases, the names of the Governmental departments that interacted with the families of the children and young people whose deaths have been investigated by this Inquest are different to the names of the Governmental departments that have made submissions to the Court. The reason is outlined below.

321. As a result of the Machinery of Government changes, on 30 June 2017:

a. The Department of Aboriginal Affairs, the Department of Planning, the Department of Lands, and the Department of the State Heritage Office were amalgamated to become the Department of Planning, Lands and Heritage;

b. The Department of Corrective Services joined the Department of the Attorney General to become part of the Department of Justice;

c. The Department of Housing, the Department of Child Protection and Family Support and the Regional Services Reform Unit (together with the Disability Services Commission and components of the

[189] Exhibit 1.8, Tab 59.

Department of Local Government and Communities and the Department of Aboriginal Affairs) were amalgamated to become the Department of Communities;

d. The Department of Education now assists in the administration of all functions in relation to educating students in government and non-government schools.

322. Specifically with respect to the former Department of Aboriginal Affairs, it ceased to exist as a distinct Government department, and the Department of Premier and Cabinet assumed responsibility for Aboriginal policy.

323. The Minister for Aboriginal Affairs remains responsible for all legislation on the Aboriginal Affairs portfolio. This position is held by the Treasurer. A new Aboriginal Policy Unit has been established within the Department of Premier and Cabinet primarily to provide policy advice directly to the Premier and the Minister for Aboriginal Affairs.

324. The Deputy Premier has responsibility for the Health and Mental Health portfolios and is the lead Minister for the Government's actions to reduce the prevalence of suicide generally and specifically amongst Aboriginal youth in remote areas.

325. At the time of the deaths investigated by the Inquest, and prior to the above amalgamations, the then Department of Aboriginal Affairs was the department principally assisting the Minister for Aboriginal Affairs in the administration of the *Aboriginal Affairs Planning Authority Act* 1972 (Aboriginal Affairs Planning Authority Act), and it also administered the *Aboriginal Heritage Act* 1972.

326. For completion, both prior to and after the above amalgamations, the Minister for Aboriginal Affairs was and remains vested with responsibility for the administration of the Aboriginal Affairs Planning Authority Act. In doing so, under section 7 of that Act the Minister for Aboriginal Affairs is required to have regard to the recommendations of four statutory bodies established by that legislation, namely:

a. The Aboriginal Affairs Planning Authority, charged with the duty of promoting the wellbeing of persons of Aboriginal descent in Western Australia; part of this authority's functions include to provide for consultations with persons of Aboriginal descent, and to recognise and support traditional Aboriginal culture;

b. The Aboriginal Advisory Council, constituted by persons of Aboriginal descent, who are chosen by and from Western Australian persons of Aboriginal descent, charged with the function of advising the Aboriginal Affairs Planning Authority on matters relating to the interests and wellbeing of persons of Aboriginal descent; they make recommendations to the Minister for Aboriginal Affairs on appropriate consultations with Aboriginal people and on services that will promote the economic, social and cultural advancement of Aboriginal people;

c. The Aboriginal Affairs Coordinating Committee, charged with the function of coordinating the activities of all persons and bodies that provide or propose to provide services and assistance to persons of Aboriginal descent;

d. The Aboriginal Lands Trust, constituted by persons of Aboriginal descent appointed by the Minister for Aboriginal Affairs, charged with a number of functions that include to acquire and hold land and to use and manage that land for the benefit of persons of Aboriginal descent, and to ensure that such use and management accords with the wishes of the Aboriginal inhabitants of the area – this trust has responsibility for the management of approximately 24 million hectares (9.65%) of Western Australia's land mass.[190]

FINDINGS ON CAUSE AND MANNER OF DEATH

327. My findings on cause and manner of death in respect of each of the children and young persons appear below. Their names are suppressed from publication and the cases are numbered 1 to 13.

328. The matters outlined in the previous parts of this finding concerning *Suicide and children*, *Aboriginal suicide*, *Intergenerational trauma* and *Cultural continuity and cultural healing* are relevant to the cases referred to below and are to be read together with the cases. Those matters together with the matters outlined in the part addressing *Suicide in the Kimberley*

[190] Exhibit 1.5, Tab 49.

gave impetus to my direction that the deaths be investigated in the one Inquest.

329. In particular the matters outlined in the part concerning *Intergenerational trauma* are relevant to the origins of the circumstances surrounding the home environments in all of the cases referred to below. Tragically, this contributed to twelve of these children and young persons becoming vulnerable to suicide.

330. In most of the cases, there was a proximal event, such as a relationship breakdown, a scolding, or other disappointment shortly before the suicide. These proximal events, whilst undoubtedly upsetting, would not of themselves be expected to lead to the suicides. However, they may have acted as a precipitant in already vulnerable individuals.

331. Whilst it cannot be known precisely what was in their minds in the lead up to the suicides, I am satisfied that by reason of factors linked to the effects of intergenerational trauma, the children and young persons did have pre-existing vulnerabilities.

332. The previous parts of this finding concerning the various health, mental health, housing and education services in the Kimberley Region, the police presence, and the alcohol restrictions, set out the background in which services providers operated, and continue to operate in this region of Western Australia. The facts addressed in the individual cases below are to be read in the light of this general background.

CASE No. 1

Introduction

333. This female child was born on 9 September 1999 at Kununurra District Hospital and she died at a time between approximately 7.00pm and 10.00pm on 8 January 2013 at the age of 13 years at Kalumburu. At the time of her death she was living with her maternal aunt.[191]

334. Sadly, the child's mother was not able to look after her, because over many years her own life had been marred by longstanding alcohol abuse and incidents of domestic violence that had

[191] Exhibit 1.10, Tab 1; Exhibit. 2, Volume 1, Tab 2.

resulted in severe injuries to her person. The mother also suffered from ill health, and was in hospital at the time of her daughter's death. The tragic and repetitive cycle of life stressors endured by the mother severely compromised her ability to care for and nurture her daughter.

335. The child initially lived with her mother in Kalumburu and then in Derby. In mid-2005 she was sent back to Kalumburu to be cared for by extended family, by way of an informal family arrangement. No child protection investigation was undertaken, and there was no protection order made under the *Children and Community Services Act* 2004.

336. After mid-2005, the child was cared for by family members. She intermittently went back to live with her mother, but on each occasion she was returned to the care of her extended family.

337. Through their lawyers, the ALS (for the child's mother) in collaboration with the KCLS (for the child's aunt), the child's mother and aunt elected not to give evidence at the Inquest and having regard to the information already before me and the circumstances attending the death, no compulsions were issued.[192]

338. At my request the child's mother provided me with a letter, that I have taken into evidence.[193]

339. The details appear below.

Physical health

340. Shortly after her birth at Kununurra District Hospital on 9 September 1999, the child was transferred with her mother to Wyndham Hospital for a period of observations, and was administered antibiotics as she had a fever. The child's birth weight was normal at 3,370 grams, and after treatment, she was discharged home with her mother on 16 September 1999. There is no medical record made of her mother having consumed alcohol during the pregnancy.[194]

341. Between 2001 and 2012 the child had numerous presentations to hospital emergency departments or clinics

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[192] ts 8 to 10; ts 369; ts 803 to 807.
[193] Exhibit 2, Volume 1, Tab 30.
[194] Exhibit 1.10, Tab 1.

for a variety of complaints including asthma, ear, skin, respiratory and gastrointestinal infections and for routine immunisations. As a baby and small child her growth was recorded as adequate and testing indicated she was not anaemic. As she grew older her presentations were mainly for asthma or signs and symptoms suggestive of respiratory infections.[195]

342. Nothing in her medical records suggests any concern regarding potential sexual abuse or sexually transmitted infection.[196]

343. Despite at times living in an environment where she witnessed acts of domestic violence, nothing in her medical records suggests any concern regarding physical abuse or any acts of violence towards her.[197]

344. The child's overall physical health, namely her physical growth and development was recorded as being satisfactory.

Home environment

345. The child initially grew up in Kalumburu with her mother as the eldest of three children, the other two being her half-siblings.[198]

346. When she was about five or six years old, her mother took her to live in Derby but this arrangement, which was short-lived, had a deleterious impact upon the child because unfortunately she was exposed to adults abusing alcohol and she witnessed incidents domestic violence.[199]

347. In March 2005, when the child was six years old, a concerned individual contacted the Derby office of the Department of Child Protection and Family Support to report that the mother was drinking and unable to properly care for her daughter. Records relating to this report reflect that this person had acted protectively towards the child and had intervened to safeguard

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[195] Ibid.
[196] Ibid.
[197] Ibid.
[198] Exhibit 2, Volume 1, Tab 7.
[199] Exhibit 2, Volume 1, Tab 8.

her welfare. It was therefore considered that the child was at not at risk, nor likely to be at risk in the foreseeable future.[200]

348. On some occasions since 2004, the child had been placed in the care of a maternal aunt under an informal family arrangement. In mid-2005 the child was returned from Derby to Kalumburu where she began to reside with another maternal aunt.[201]

349. The child primarily resided with this maternal aunt in Kalumburu for approximately six or seven years until 2011, when her mother collected her and took her back to Derby. There were also occasions when she lived or stayed with her mother prior to 2011.[202]

350. On 12 April 2006 (during one of those periods when the child was in the care of her mother) the Department of Child Protection and Family Support was contacted by a concerned individual who reported that the mother had gone to see her partner at another location and that the child had been left in the care of a man who drank heavily. This individual also reported that the child was not attending school and appeared not to be adequately fed. This person requested that the Department of Child Protection and Family Support make relevant enquiries.[203]

351. There is no information in the Department of Child Protection and Family Support's records to indicate that any investigation was undertaken. The Department of Communities, through its lawyer the SSO acknowledges that the nature of the April 2006 report was such that an assessment of the child's safety should have occurred. This is addressed in more detail later in this finding in the *Adverse Comment* section.[204]

352. The next contact the Department of Child Protection and Family Support had in connection with this child was on 17 May 2006 when a departmental worker observed her and her family (comprising of her mother, her mother's partner and her ten week old half-sister) walking out from a remote community, with the apparent intention of walking over 100 kilometres, to Derby.

353. When the mother indicated that her partner was compelling them to walk to Derby, she and the children were assisted by the departmental worker, who conveyed them to a safe location

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[200] Exhibit 2, Volume 1, Tab 26.
[201] Exhibit 2, Volume 1, Tab 8.
[202] Exhibit 2, Volume 1, Tabs 8 and 26.
[203] Ibid.
[204] Exhibit 2, Volume 1, Tab 26.

nearby. Police became involved due to the partner's behaviour, and the mother and children were subsequently placed in a refuge in Derby. These dynamics were not displayed solely in this isolated instance.

354. Sadly, records reflect numerous domestic violence incidents involving the mother over almost a decade. In the year after the May 2006 incident referred to above Department of Child Protection and Family Support staff tried but could not persuade the mother to leave her partner. They also tried to reason with her partner. Ultimately the mother elected to maintain the relationship with her partner and the case was closed by that department on 4 May 2007.[205]

355. When she was living with her mother from 2011 in Derby the child unfortunately continued to be exposed to incidents of alcohol abuse and domestic violence. In about July 2012 one of her maternal aunts returned her to the Kalumburu community where she resided until her death, less than a year later.[206]

356. Given that the child's placement with this aunt was an informal family arrangement with no direct involvement from the Department of Child Protection and Family Support, the mother did not require any departmental permissions in order to take the child from her sister.[207]

357. Despite not living with her mother for extended periods of time, the child formed the belief that her mother's partner was physically violent towards her mother in her absence, a matter that was no doubt deeply distressing for her. In July 2012 when she returned to Kalumburu, she expressed her resentment over the fact that her mother would choose to live with her partner rather than her children.[208]

358. After she returned to Kalumburu in July 2012, there were unpleasant comments repeatedly made to the child by another adult regarding her parentage, specifically concerning the identity of her father. The conflict generated by such comments on occasion led to community fights. The comments were observed to make the child very upset.[209]

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[205] Exhibit 2, Volume 1, Tab 26.
[206] Exhibit 2, Volume 1, Tab 8.
[207] ts 222.
[208] Exhibit 2, Volume 1, Tab 12.
[209] Exhibit 2, Volume 1, Tab 12.

359. The child had expressed her suicidal ideations to at least two other persons shortly before her death on 8 January 2013:

a. On or about 4 January 2013, approximately four days before her death, the child was observed walking near the local airstrip by an officer of a local Aboriginal Corporation and respected community member. This officer, seeing that the child appeared sad, asked her what was wrong and the child replied that she wanted to hang herself. The officer responded by telling the child to cheer up and not do "*anything silly*." The officer told no-one else about this conversation until after the child's death, when she recounted the conversation to a local child protection worker in the employ of the Department of Child Protection and Family Support;[210]

b. The child also told a friend of hers, on a number of occasions, that she was going to hang herself. The comment was made in the context of complaining about being made to do household chores. Her friend thought that she was only "*joking*", though she did tell her own mother about it. The friend's mother did not convey that information back to the child's carers.[211]

360. The further details of the events prior to her death are addressed under *Cause and Manner of Death.*

Mental health treatment

361. There is no record of the child having any contact with any mental health or counselling services.

362. The child did inform others that she wanted to hang herself (as outlined above) but this did not generate any notification to her carers, or referral to medical or counselling services.

School attendance

363. The child's school attendance between 2008 and 2012 was good, being mostly in the mid 90% range. Her results for the National Assessment Program – Literacy and Numeracy ("NAPLAN") testing in 2008 showed she was at the minimum standard for

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[210] Exhibit 2, Volume 1, Tab 26B; ts 380 and 381.
[211] Exhibit 2, Volume 1, Tab 16.

numeracy, above the minimum standard for writing and below the standing for reading and spelling. In 2009 she was below the minimum standard across all areas. For semester one in 2012 she achieved C grades for most of her subjects. There was a single suspension in December 2012 for one and a half days for misbehaviour.[212]

364. In the child's final school report (semester 2 of 2012) her Form Teacher describes her as being capable in all areas of learning and urges her to work on her behaviour, make safe choices, slow down and show patience, and describes her in positive terms: "*[name suppressed by Court] has a happy and curious nature and generally is fun to have in class.*"[213]

Cause and manner of death

365. At the time of her death the child was residing with her aunt, great aunt and other children at a house in Kalumburu.

366. On the afternoon of 8 January 2013, the date of her death, the child was scolded and struck twice on the arm with a bamboo stick by a family member following an altercation about her hitting another child that she had been babysitting. This striking, done with the intention of chastising the child, was performed in the presence of other people, the child was visibly upset, reported feeling "*shamed*" and she walked away in tears, accompanied by some other persons. This was the last occasion upon which that family member saw her alive. The child was observed to have returned home at approximately 7.00 pm on 8 January 2013, she appears to have gone to her bedroom, and no person saw her alive after this time.[214]

367. At approximately 10.00 pm on 8 January 2013, as the child's aunt prepared for bed, she sought to open the door to the child's bedroom but found it locked. The aunt was able to gain entry and to her immense shock saw the child hanging from a ligature tied to an article in in her bedroom, with her feet dangling off the ground. The aunt ran out screaming for help.[215]

368. All of the adults in the house sought to call for help, and two male neighbours alerted to the sounds of crying and shouting, immediately attended. Together the two neighbours released the

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[212] Exhibit 2, Volume 1, Tab 27.
[213] Ibid.
[214] Exhibit 2, Volume 1, Tab 8.
[215] Exhibit 2, Volume 1, Tabs 2, 7 and 8.

child from the ligature, lifting her and then laying her on the ground. I have taken account of the description of the child's body by the male person who was involved in removing the ligature and am satisfied that by this stage, the child was tragically deceased.[216]

369. One of the male neighbours went to the house of the local Remote Area Nurse to seek her help, informing her that the child was not breathing, and describing the location. The Remote Area Nurse recalled this happening at approximately 10.45 pm on 8 January 2013. This male neighbour also informed police.[217]

370. The Remote Area Nurse, being a registered nurse, was promptly conveyed to the child's house, arriving at approximately 10.52 pm, having also arranged for another nurse to meet her at the location. Upon arrival she immediately attended to the child, who had been placed on the bedroom floor, and checked for signs of life, finding none. She heard sounds that appeared to her to come from an angry crowd gathering outside, and she commenced to perform cardiac compressions on the child.[218]

371. Shortly afterwards a resident brought the Remote Area Nurse a torch, and she was able to establish that the child's pupils were fixed and dilated. The child's body was already cool to the touch. She ceased compressions, and later assisted with conveying the child's body to the local clinic and completing the certification, declaring the child as being deceased after she assessed her at 10.52 pm on 8 January 2013.[219]

372. On 16 January 2013 the forensic pathologist made a post-mortem examination at the State Mortuary on the child's body and on that date formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging). The forensic pathologist noted extensive decomposition change and a probable ligature mark to the neck that would be in keeping with the ligature provide to him. The forensic pathologist noted that there was no other evidence of significant injury or significant natural disease.[220]

373. Subsequent toxicological analysis showed a bile alcohol level of 0.173%, but given that this was not a blood alcohol level, and considering the extensive decomposition changes, this alcohol

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[216] Exhibit 2, Volume 1, Tabs 2 and 11.
[217] Exhibit 2, Volume 1, Tabs 2, 11 and 13.
[218] Ibid.
[219] Exhibit 2, Volume 1, Tabs 4 and 11.
[220] Exhibit 2, Volume 1, Tab 5.

level is difficult to interpret, and must be read with caution. It does not establish that the child consumed any alcohol. Toxicological analysis of the liver showed no evidence of common drugs. The forensic pathologist's opinion on cause of death remained unchanged.[221]

374. I have taken account of the forensic pathologist's report and his opinion on the cause of death, the toxicological analysis, and the evidence concerning the circumstances whereby the child was found hanging in her bedroom, and specifically the evidence concerning the actual ligature and its placement.

375. **I find that the cause of the child's death in Case No. 1 was ligature compression of the neck (hanging).**

376. As described above, the child had previously expressed an intention to self-harm by hanging, as recently as four days before her death. I am satisfied that she knew the foreseeable consequence of hanging herself was death, and that she intended that consequence. I take into account a handwritten note that she left on a religious altar in her bedroom, expressing her love for her family and specifically naming persons that included her small half-siblings, and her behaviour in locking her bedroom door.[222]

377. On the night of 8 January 2013 between approximately 7.00 pm and 10.00pm the child affixed a household item, that was used by her as a ligature, to an article in her bedroom and hanged herself, and she undertook those acts with the intention of taking her life. I am satisfied that the child acted alone to use the item as a ligature in a manner that resulted in her death.

378. **I find that the manner of the child's death in Case No. 1 was Suicide.**

CASE No. 2

Introduction

379. This male child was born on 7 July 1997 at Royal Darwin Hospital and he died at a time between night-time on 4 April 2015 and the early hours on 5 April 2015 at Broome. At the

[221] Exhibit 2, Volume 1, Tabs 5 and 6.
[222] Exhibit 2, Volume 1, Tabs 2 and 12A.

time of his death he was 17 years old and living with members of his extended family in Broome.[223]

380. Sadly the child's mother was not able to look after him for most of his childhood due to her frequent and extensive alcohol consumption. The level of dysfunction in her life led to grave concerns being expressed about this child's wellbeing at an early stage in his life.

381. After birth the child initially resided with his mother, but shortly before he attained the age of two years, he was placed into the care of his relatives. Initially, he was placed in the care of an aunt at the Bayulu community, but this was short-lived. He was then placed with his paternal great aunt initially residing with her in the Balgo community, and then also the Yagga Yagga and Wangkatjungka communities, in the Kimberley Region. The living arrangement with his great aunt continued until he was approximately eight years old.

382. Afterwards, the child began to reside with another aunt and uncle primarily in the Wangkatjungka community and this arrangement continued until he was approximately 14 years of age. During this time he intermittently saw his mother and other members of his extended family.

383. The child, being an older teenager at that stage, ceased residing with his aunt and uncle, but remained in the Wangkatjungka community for a time, and then he relocated to Broome, where other members of his extended family also lived.

384. All of the child's placements with his extended family were by way of informal family arrangements. There was no protection order made under the *Children and Community Services Act* 2004. There were a number of investigations carried out by officers of the Department of Child Protection and Family Support under s 32(1)(d) of the *Children and Community Services Act* 2004 for the purpose of ascertaining whether the child may be in need of protection, but on each occasion the case was closed. On one occasion, neglect was substantiated and efforts were made to assist the mother in caring for him.

385. Through her lawyers the ALS in collaboration with the KCLS, the child's mother elected not to give evidence at the Inquest and having regard to the information already before me and the

[223] Exhibit 4, Volume 1, Tab 2.

circumstances attending the death, no compulsion was issued.[224]

386. At my request the child's mother provided me with a letter, and I have taken that into evidence.[225]

387. The details appear below.

Physical health

388. The child was born prematurely at 33 weeks gestation at Royal Darwin Hospital under emergency circumstances on 7 July 1997. His mother had just been involved in a serious motor vehicle accident in which, alarmingly, she was badly injured, and this caused or contributed to the premature birth. His father tragically died in the same accident.

389. The child's birth weight was only 1,713 grams and he required ventilation in the neo-natal intensive care unit. In his first few days of life he developed signs of sepsis and respiratory syncytial virus. He was treated with antibiotics and once his condition improved, he was transferred to Derby Hospital for assistance with feeding, then to Fitzroy Crossing Hospital and then back to Derby Hospital for further assistance in that regard. He was eventually discharged into the care of his mother on 3 September 1997.

390. There is no medical record made of his mother having consumed alcohol during the pregnancy.[226]

391. The child had regular hospital and or clinic treatments throughout his childhood for failure to thrive (which is now more commonly referred to as poor growth), speech delay, chronic perforated ear drums and other various childhood illnesses. His health during his early years was unfortunately very poor.[227]

Home environment

392. This child was the fourth of six children born to his mother. The mother's extensive alcohol consumption impacted on her ability to care for her children, and there were early concerns expressed for his welfare. The child and his other siblings initially went to

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[224] ts 8 to 10; ts 369; ts 803 to 807.
[225] Exhibit 1.4, Volume 1, Tab 41.
[226] ts 786.
[227] Exhibit 1.10, Tab 2.

live with a relative, in Bayulu, a non-drinking "*dry*" community. This occurred even though it was known by the Department of Child Protection and Family Support that this relative had encountered difficulties caring for her own children.[228]

393. At age 11 months and in the care of this relative, the child was presented to Halls Creek Hospital in June 1998 in what was recorded as a *"deplorable condition"*. Medical records show a range of conditions that taken together, substantiated neglect, and he was returned to his mother.[229]

394. A report written on 14 July 1998 (one week after his first birthday) by a doctor from the Halls Creek Hospital reported that he was *"seriously failing to thrive"* and that he had anaemia, parasitic infections of the gut, recurrent skin and respiratory infections and developmental delay.[230]

395. In July 1998 the Fitzroy Valley Health Service also raised concerns about the child not having received any follow up. A doctor with the Fitzroy Valley Health Service recorded that this child was the worst case of failure to thrive that he had encountered, and he strongly recommended referral to the placement support unit (which was not a recommendation that the child be removed from the mother's care, but was a safety measure).[231]

396. The medical records reflect the doctors' ongoing concerns about this child's state of ill-health, and their frustrations with the circumstances giving rise to his appalling condition.

397. As a consequence, neglect was again substantiated and on this occasion, in July 1998, the Department of Child Protection and Family Support assisted with accommodating the child with his mother and another sibling in the placement support unit in Halls Creek. The aim was to educate the mother rather than removing her children from her care, and to encourage her to maintain a support network. The plan was to assist the mother in administering the child's daily medication and in carrying out the daily activities required to care for her child.[232]

398. Unfortunately however, tensions escalated and in August 1998 the mother was involved in a fight whilst accommodated at the placement support unit. The circumstances resulted in the

[228] Exhibit 4, Volume 1, Tab 15.
[229] Exhibit 1.10, Tab 2; Exhibit 4, Volume 1, Tab 15.
[230] Ibid.
[231] Ibid.
[232] Ibid.

mother being evicted from the placement support unit after comments she made in connection with her children.[233]

399. Throughout 1998 and while the child was still under the age of two years, he was subjected to continued neglect as outlined in the two instances below.

400. On 7 October 1998 the child was located in an area of long grass by adults unaware of his identity. They took the child to the placement support unit where he was admitted overnight, and released to his mother at 5.30 am the following morning (contrary to Department of Child Protection and Family Support policy).[234]

401. On 20 November 1998, at age 19 months, the child was found in the care of a seven year old child in a park in Halls Creek whilst his mother was intoxicated and apparently asleep nearby. Local police took the child to the placement support unit and neglect was again substantiated.[235]

402. By June 1999 following further medical reviews reflecting the child's ongoing ill health, and with the mother's agreement, the child was placed in the care of his paternal great aunt in Balgo Community by the Department of Child Protection and Family Support, and they paid the great aunt a subsidy. It was by way of an agreed family placement, and not pursuant to a court order.[236]

403. The Department of Communities through its lawyer the SSO acknowledges that reports that it received in connection with the child in 1998 and 1999 warranted an assessment that, on the department's records, appears not to have occurred. This is addressed in more detail later in the finding under the *Adverse Comment* section.

404. In the care of his great aunt, the child moved between the Balgo and Yagga Yagga communities, and by 2002, they relocated to the Wangkatjunka community. The child remained in the care of his great aunt until May 2005. Some records from this time reflect that his great aunt and her partner provided a high level of care, and there are also records that reflect concerns about the care. Upon inquiry, no concerns were substantiated and on

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233 Exhibit 4, Volume 1, Tab 15.
234 Exhibit 4, Volume 1, Tab 15.
235 Ibid.
236 Ibid.

each occasion the Department of Child Protection and Family Support closed their files.[237]

405. In January 2005 the child disclosed to members of the Wangkatjungka Community that boys within the community had been touching him inappropriately. He was seven years old at the time. He was interviewed in connection with this disclosure on the same day.[238]

406. An assessment by the Department of Child Protection and Family Support noted that he was intimidated by the community he was living in and that adults were aware of what had happened to him but were reluctant to name those responsible due to the dynamics of the community.[239]

407. On 28 April 2005 staff from the Department of Child Protection and Family Support visited the Wangkatjunka community and spoke to the child who disclosed facts that indicated he had been the victim of sexual abuse by two juveniles (extra-familial) in that community.[240]

408. As a consequence, on 30 April 2005 the child was taken to the Derby Hospital for a paediatric examination with respect to allegations that he had been sexually abused by juvenile perpetrators. Although the history given was suggestive of sexual penetration, the paediatrician could find no evidence consistent with abuse.[241]

409. The child had apparently informed his great aunt of this abuse but she did not report it to the Department of Child Protection and Family Support or the police because she did not believe it to be true. Later she became aware that it was "*not gossip or rumour*" and she took part in discussions with departmental officers regarding a safety plan for the child, which included increased supervision, vigilance and separation from the alleged perpetrators. After Department of Child Protection and Family Support received assurances from the great aunt that she could provide a safe environment for the child, he remained living with her. However, shortly afterwards, as described below, the child began to reside with other relatives.[242]

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[237] Ibid.
[238] Ibid.
[239] Exhibit 4, Volume 1, Tab 15.
[240] Ibid.
[241] Exhibit 1.10, Tab 2.
[242] Exhibit 4, Volume 1, Tab 22.

410. Following his medical examination on 30 April 2005, the child was interviewed by police (accompanied by an Aboriginal Police Liaison Officer) on 6 May 2005 but he did not disclose the allegations to them. Having regard to the change in his demeanour, the concern was expressed to the effect that the child may have been threatened in connection with speaking to police. This was not however substantiated.[243]

411. From May 2005 to August 2011 the child began to reside with his maternal aunt and her partner, two respected members of the Wangkatjungka Community. He was eight years old when he started to reside with them, and remained consistently in their care until he was 14 years old. The six years that he lived with his aunt and her partner were the most settled in his life.[244]

412. The child's aunt described him as a happy and willing child who was keen to go to school, but she also noted that he had a lot of learning difficulties and that he was prone to sudden outbursts of anger. Having undertaken her own studies regarding foetal alcohol spectrum disorder (FASD), she formed the view that her nephew's symptoms were attributable to FASD.[245]

413. The child was not formally diagnosed with FASD. It is to be borne in mind that diagnosis is a complex and multidisciplinary undertaking. I am satisfied that the aunt had a reasonable basis for coming to her own view that the child had FASD. However, on the information before me I cannot be satisfied that he did have FASD.

414. When he became a teenager, the child began associating with what relatives described as the "*wrong crowd*", some of these friends were older than him, and unfortunately he commenced using cannabis, though he was not known to use other types of drugs.[246]

415. When the child decided to leave the care of his aunt in August 2011, he was 14 years old, and he continued to reside in the Wangkatjungka Community. Not long afterwards, his aunt expressed concerns about the welfare of her nephew to the Department of Child Protection and Family Support and she suggested that he be removed from the Wangkatjungka Community for his own safety. At the Inquest she indicated that

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[243] Exhibit 4, Volume 1, Tab 22.
[244] ts 786; Exhibit 4, Volume 1, Tab 15.
[245] ts 788.
[246] ts 789.

she said words to the effect of: "*Please rescue the child. He's – he's getting himself into trouble.*"[247]

416. The Department of Child Protection and Family Support did not take any action to remove the child from the environment that he was in. Through its lawyer the SSO, the Department of Communities acknowledges that the report made by the aunt in 2011 warranted an assessment that appears not to have been made. This is addressed in more detail later in this finding in the *Adverse Comment* section.[248]

417. In January 2013 when the child was 15 years old, he was admitted to Broome Hospital after a traditional circumcision that appeared to have been carried out on him became infected. A mandatory report of sexual abuse was completed by the treating doctor who formed the view that the procedure had been done against the child's will, though he felt he had no proof. On 7 February 2013 the child was interviewed (by telephone) by the Department of Child Protection and Family Support, and he said that he consented to the procedure for cultural reasons and did not wish to complain about it, nor discuss it.[249]

418. By this stage, at the instigation of his aunt the child was residing at a regional college (hence the telephone interview). For part of 2013 he also attended a college in Melbourne.[250]

419. By August 2013, at the age of 16 years, the child had returned to the Wangkatjungka Community, and was residing in the "*single men's house*" two doors away from his aunt, who still considered herself to be his guardian. The information provided was that the community considered him to have reached a level of maturity having undergone practices associated with traditional Aboriginal lore.[251]

420. By mid-2013 and again in early 2014, the child's statements and behaviour began to alert others to the possibility that he may be at risk of self-harm and he was assessed at the Fitzroy Crossing Hospital (this is addressed in more detail under the *Mental Health* heading below).[252]

421. When the child was 17 years old, he moved to Broome, where he stayed with other members of his extended family. By this stage

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[247] Exhibit 4, Volume 1, Tab 15; ts 791.
[248] Exhibit 4, Volume 1, Tab 15.
[249] Exhibit 1.10, Tab 2; ts 789.
[250] Exhibit 4, Volume 1, Tab 15; ts 791-792.
[251] Exhibit 4, Volume 1, Tab 15.
[252] Exhibit 4, Volume 1, Tabs 2 and 15.

he was no longer at school. Alarmingly, his self-harming behaviour began to escalate.

422. On 31 March 2015 Broome police responded to a report of this child jumping in front of traffic, with vehicles needing to take evasive action. When police attended, he refused to move off the road and he told them he wanted to take his life. He appeared to be intoxicated and said he had taken "*speed.*" Police conveyed the child to Broome Hospital for treatment, where he was reviewed by the mental health team and then discharged and referred for assessment by the Kimberley Mental Health and Drug Service. Unfortunately this assessment did not occur and he died five days later. This is addressed in more detail under the *Mental health treatment* heading immediately below.[253]

423. The further details of the events prior to his death are addressed under *Cause and Manner of Death.*

Mental health treatment

424. On 11 June 2013, this child had been taken to the Fitzroy Crossing Hospital by police for assessment after he stated that he wanted to hang himself. He was assessed by the hospital's mental health team. He claimed to them that life in Fitzroy Crossing was stressful (citing his increased drinking and people being bad influences on him). He said that he felt less stressed in the Wangkatjungka Community. No mental health issues were identified and a plan was made to transfer him back to the Wangkatjungka Community. During the assessment he also disclosed that he had been using "*gunja*" (cannabis) regularly.[254]

425. In a report dated 11 October 2013 following another assessment of this child, the Child and Adolescent psychiatrist with the Kimberley Mental Health and Drug Service recorded that the child was feeling sad at times and having thoughts about harming himself, but denied future plans to harm himself. The child was moving between various communities and living with people known to be cannabis users. The psychiatrist's impression was that the child was not currently suffering from a psychotic illness, but he noted the child was in an *"at risk"* mental state category for developing a psychotic illness. The doctor's recommendations were that there be :

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[253] Exhibit 4, Tabs 2 and 19D.
[254] Exhibit 1.10, Tab 2; Exhibit 4, Volume 1, Tab 19F.

a. close monitoring of his mental state;

b. a low threshold for seeking further psychiatric review;

c. continuing discussion concerning his cannabis use;

d. work to be undertaken with the extended family to try to reduce some of his current high expressed emotions;

e. liaison with Kununurra Child and Adolescent Mental Health Service in case the child and his mother move.[255]

426. At around this time the child moved to Melbourne to attend a college, and his case file was closed. However, he later returned to Fitzroy Crossing because the college placement did not work out.

427. On 22 April 2014, the child was admitted to Fitzroy Crossing Hospital again after threatening to hang himself. At this stage, he was living with his sister. At hospital he described feeling sad and angry since the death of his brother/cousin two weeks previously. He was unable to name one person or thing that made him happy or that would stop him from harming himself. He had been asked to leave the college's boarding school in Melbourne. He did not want to remain in hospital and on 23 April 2014 he became angry, damaged equipment, and had to be restrained and sedated. Arrangements were made to transfer him by Royal Flying Doctor Service to the Bentley Adolescent Unit, and he was admitted to that unit as an involuntary patient on that date.[256]

428. During the child's detention at the Bentley Adolescent Unit, a history was taken and he was initially diagnosed with adjustment disorder secondary to the recent apparent suicide of his cousin and it was recorded that he had a lack of coping strategies due to learning difficulties. It was noted he had a conflictual relationship with a family member that he had been staying with (not his aunt).[257]

429. In reviews by psychiatrists at the Bentley Adolescent Unit on 27 and 28 April 2014, he denied suicidal thoughts and stated he was happy to return to school in Fitzroy Crossing (working on a station) or to live with his aunt and uncle. A representative from the State Aboriginal Mental Health Services was involved in the review. After review he was made a voluntary patient. He

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[255] Exhibit 1.10, Tab 2.
[256] Ibid.
[257] Ibid.

was observed to be making regular telephone contact with his girlfriend, and to express eagerness about returning home.[258]

430. On 4 May 2014 he was discharged from the Bentley Adolescent Unit and nursing staff escorted him to Broome Hospital, where he was collected by his aunt and taken back to Fitzroy Crossing.[259]

431. On 26 November 2014, the child was again seen at the Fitzroy Crossing Hospital after he had an argument with a family member and threatened to hang himself. He was on a curfew at the time. He was admitted to a ward for observation but absconded the following day before he could be reviewed by the Kimberley Mental Health and Drug Services clinicians.[260]

432. The child was then referred to the Fitzroy Crossing Child and Adolescent Mental Health Service and he was reviewed at his home on 8 December 2014. He denied psychosis or thoughts of self-harm, indicating that such thoughts were due to an argument, and that he had no actual intent to do so. He was offered support in seeking employment (he again said he would like to work at a station) and agreed to seek mental health services if he was to struggle in the future. However there is no record of him seeking such treatment from that date to the time of his death between 4 and 5 April 2015.[261]

433. On the night of 31 March 2015 the child was taken to Broome Hospital by police after he was reported to be jumping in front of cars, as outlined earlier in this finding. Records reflect that he stated that his family "*hates*" him and that he had taken "*speed*." He also stated that he would hang himself. He was found to have a blood alcohol level of 0.176% and amphetamines in his system.[262]

434. Due to his level of intoxication he was admitted to the short stay ward overnight and reviewed by the Broome Hospital mental health team the following day. He reported that no one cared about him. He also stated he had no Centrelink income. He denied wanting to take his life and maintained that he did not want to stay in hospital. He was discharged and a plan was made for the Kimberley Mental Health and Drug Services to

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[258] Ibid.
[259] Ibid.
[260] Ibid.
[261] Ibid.
[262] Exhibit 4, Volume 1, Tab 19B.

assess him again. That assessment had not occurred by the time he died four days later.[263]

School attendance

435. The child attended the Wangkatjungka Remote Community School between January 2005 and May 2012. He also attended a college in Melbourne in 2013 though that placement was terminated due to his behaviour keeping other boarders awake during the night.

436. The child consistently performed below average at school with his grades averaging "E". Sadly his attendance rate in 2012, by the time he was 14 or 15 years old, was 44%.

437. From age seven he was reported to be regularly hitting other students, swearing, and displaying difficulties with anger control and with regulating his emotions. He was seen by school psychologists on several occasions, including on 23 August 2005 when he was seen regarding his alleged sexual abuse. In communications between the school psychologist and the child protection worker, it is recorded that they had no doubt that this child had been subjected to some type of inappropriate sexual behaviour, but the extent was unknown and that there was: *"no-one here equipped to deal with the specialised needs that a sexually abused child requires."*[264]

438. It was suspected that this child had FASD and he had been placed on a behaviour management policy in 2005 (the year he turned eight). He had also been referred for level 3 services to the Disability Services Commission regarding his significant intellectual and academic difficulties.[265]

Cause and manner of death

439. On the night of 4 April 2015 (the approximate date of his death) the child was approached by Broome police in their vehicle when he was observed walking by the side of the unlit Old Broome

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[263] Exhibit 1, Tab 2.
[264] Exhibit 4, Volume 1, Tab 13
[265] Ibid

Road. Their initial intent was to speak to him about the risks to his safety in walking along the unlit road at night.[266]

440. As they came closer, police saw he had a large fish filleting knife that he held level with his chest. The child appeared to move towards opening the police vehicle door, and police initially accelerated away.[267]

441. Police then executed a U-turn and upon returning to speak with the child, they observed that he no longer had possession of the large fish filleting knife. He told police that he had thrown the knife away (police were not able to later locate it in the nearby bushland). Police did locate a smaller pocket knife on his person. When questioned by police he stated the knives were for protection against the *"Broome murderers."* The child was carrying a small puppy under his shirt and he also told police he intended to walk to Fitzroy Crossing (several hundred kilometres away).[268]

442. Police informed the child that he would be summonsed for possessing an article with intent to cause fear and then they drove him back towards the house where he said he was living. There was an alert on the police computer system regarding the child's prior self-harm attempts, with the most recent one being some four days previously. In the usual course this would have been relayed over the police radio to the attending officers, but for reasons that cannot now be known, it was either not relayed or not acted upon.[269]

443. Police then drove the child back to the area near his nominated home in Broome at approximately 8.30 pm (4 April 2015), and they observed him to walk in the direction of his home. He was residing there with a number of other young people. He did not appear to the police to be under the influence of drugs or alcohol. From their perspective they held no concerns for his welfare.[270]

444. After returning to the Broome Police Station to complete their paperwork the police officers discovered he was only 17 years old. At the Inquest one of the attending police officers stated that on that night, he had estimated the child's age to be at least

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266 Exhibit 4, Tab 2.
267 Exhibit 4, Tab 10.
268 Exhibit 4, Tabs 2, 9 and 10.
269 Exhibit 4, Volume 1, Tab 19B; Exhibit 4, Volume 1, Tabs 9 and10; ts 491; ts 503 to 504.
270 Ibid.

25 years, based upon his behaviour and his facial appearance (as he had a full grown beard).[271]

445. Tragically, this child's body was found by some young passers-by shortly before 3.00 am the next morning, 5 April 2015, at an oval in Broome. Records reflect that police were contacted by telephone at 2.58 am on 5 April 2015, with a person reporting the presence of the child on the oval with no apparent signs of life. This oval was approximately one kilometre away from his home.[272]

446. Police attended at 3.10 am and upon searching the area they located the deceased, and saw that he appeared to have affixed a pre-existing item on the oval, that he used as ligature, to a fixture on the oval, and that he had died by apparent hanging. They released him from the ligature and checked, but did not find any signs of life. An examination of his body did not reveal any injuries, defensive wounds or other indications of a struggle occurring. An ambulance was called for at 3.14 am and arrived at the scene by 3.22 am. Paramedics commenced CPR and conveyed the child to Broome Hospital, arriving by 3.38 am with CPR in progress.[273]

447. Further attempts to resuscitate the child in the Emergency Department at Broome Hospital proved unsuccessful, and he was tragically pronounced dead by the doctor at 3.55 am on 5 April 2015.[274]

448. On 13 April 2015 the forensic pathologist made a post mortem examination on the child's body and on that date formed the opinion that the cause of death was ligature compression of the neck (hanging). The forensic pathologist noted that the post mortem examination showed a ligature mark around the neck. The ligature was made available to her and it appeared to be in keeping with her observations of items found around the neck area. There were no injuries recorded by her in her report that might be suggestive of a struggle.[275]

449. Subsequent toxicological analysis of blood showed an alcohol level of 0.153%. Analysis of the bile sample showed an alcohol level of 0.167%. No common basic drugs were detected. The

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[271] Exhibit 4, Volume 1, Tab 19B; ts 491.
[272] Exhibit 4, Tabs 2, 7 and 8.
[273] Exhibit 4, Volume 1, Tabs 2, 7, 8 and 11.
[274] Exhibit 4, Volume 1, Tabs 4 and 13.
[275] Exhibit 4, Tab 5.

forensic pathologist's opinion on cause of death remained unchanged.[276]

450. I have taken account of the forensic pathologist's report and her opinion on the cause of death, the toxicological analysis and the evidence concerning the circumstances whereby the child was found hanged at the oval in Broome, including the placement of the ligature.

451. **I find that the cause of the child's death in Case No. 2 was ligature compression of the neck (hanging).**

452. This child was subjected to sustained periods of neglect and abuse throughout his short and tragic life. His mother did love him, but she was sadly in no condition to care for him. His father died in a car accident as he was coming into the world. Over different periods of his life he resided with extended family, and he did enjoy a period of stability for some years when he was cared for by his aunt and uncle. This came to an end at his election as he grew older, and the downward spiral of his life took hold and continued, with no apparent respite. It is possible that he had some features of FASD, but no diagnosis was ever made and I do not find that he had FASD. It is likely that he was sexually abused as a young boy in his community, and that this had a lasting and traumatic effect upon him.

453. The cumulative effect of unrelenting hurt and pain became too much for him to bear. The sustained neglect that he was subjected to in his early years severely compromised his ability to manage his emotions and deprived him of any meaningful coping strategies.

454. The child had expressed an intention to take his life on a number of previous occasions. On the night of 4 April 2015, or in the early hours of 5 April 2015, he affixed a pre-existing item on the oval that he used as a ligature, to a fixture on the oval and hanged himself, and he undertook those acts with the intention of taking his life. I am satisfied that the child acted alone to use the item as a ligature in a manner that resulted in his death.

455. It is likely that his level of intoxication contributed to disinhibiting him. I am satisfied that he knew the foreseeable consequence of hanging himself was death, and that he was able to form the requisite intention for this finding.

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[276] Exhibit 4, Tabs 5 and 6.

456. **I find that the manner of the child's death in Case No. 2 was Suicide.**

CASE No. 3

Introduction

457. This young man was born on 10 April 1991 at Derby Hospital and he died in the early hours of 7 May 2015 at the age of 24 years at Broome. At the time of his death he was living with members of his immediate and extended family.[277]

458. He was the oldest of the children and young persons whose deaths are investigated by this Inquest, but still very young, with very many years ahead of him, had he lived.

459. The young man had been involved in a complicated relationship of approximately four years' duration with his partner, that was often conflictual, and on occasion, seriously so. From time to time they separated, and then reunited. They were not living together at the time of his death, but they were in communication with each other, and his partner was one of the last persons that he endeavoured to contact. They had a child together, who was two years old at the time of his death.[278]

460. The young man had expressed the intention to take his life by hanging on a number of occasions throughout his life, and most recently he expressed that to his partner a few days before his death. Save for one presentation in 2011, there are no records of mental health treatment for this young man.[279]

461. The young man had presented for medical treatment for a range of ailments on numerous occasions particularly as a young child. There were concerns about his failure to thrive. In his early years he lived with his mother. Later and for a period of time he was cared for by his aunt and uncle on the Gibb River Station.

462. As a child he was not at any stage the subject of a protection order under the *Children and Community Services Act* 2004, nor was there any investigation conducted under that legislation for

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[277] Exhibit 5, Volume 1, Tabs 2 and 7.
[278] Exhibit 5, Volume 1, Tabs 2 and 9.
[279] Exhibit 1.10, Tab 3; Exhibit 5, Volume 1, Tabs 2 and 9.

the purpose of ascertaining whether he may be in need of protection.

463. Through her lawyers, the ALS in collaboration with the KCLS, the young man's mother elected not to give evidence at the Inquest, and having regard to the information already before me and the circumstances attending the death, no compulsion was issued.[280]

464. At my request the young man's mother provided me with a letter, that I have taken into evidence.[281]

465. The details appear below.

Physical health

466. The deceased young man's birth weight was normal at 3,120 grams. He was born at 37 weeks' gestation. Antibiotics were administered for a brief period. Shortly after his birth on 10 April 1991, he was discharged into the care of his mother.[282]

467. There is no medical record made of his mother having consumed alcohol during the pregnancy. Medical records for later in his life (also referred to below under the heading *Home Environment*) reflect that he was cared for by his aunt and uncle on the Gibb River Station due to his mother's excessive alcohol consumption.[283]

468. Between 1992 and 1994, when he was between the ages of one and three years, he had regular admissions at Derby Hospital for severe and persistent failure to thrive, gastroenteritis (including repeated bouts of vomiting and diarrhoea), bronchiolitis, pneumonia, ear infections, parasitic infections and a range of other conditions, including anaemia and moderate asthma.[284]

469. On occasion he was referred to the Derby Hospital by the community health nurses, who endeavoured to monitor his progress, with the comment being made that his mother was unable to look after him. The concerns about his failure to

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[280] ts 8 to 10; ts 369; ts 803 to 807.
[281] Exhibit 5, Volume 1, Tab 24.
[282] Exhibit 1.10, Tab 3.
[283] Ibid.
[284] Ibid.

thrive, and the difficulties with the provision of care for him, were an ongoing feature of his early medical records.[285]

470. On two occasions in 2008 when he was 16 and then 17 years old, he presented to the Derby Hospital Emergency Department for treatment in respect of injuries occasioned by alcohol related violence (the first occasion involving lacerations that were sutured and the second occasion, a fractured jaw). Records reflect that on the first occasion he was very intoxicated, that he was treated and reassessed when sober, and then discharged. On the second occasion, he presented after being assaulted the previous night, and he was treated and then discharged.[286]

Home environment

471. During this young man's childhood, medical records reflect that his mother drank alcohol to excess and that she became unable to care for him. He initially lived in Derby with his mother, and then moved to the Gibb River Station, where he grew up primarily in the care of his aunt and uncle, who are non-drinkers.[287]

472. He enjoyed working on stations, he was a very good horseman and he liked his cattle mustering work.[288]

473. A review of records from the Department of Child Protection and Family Support reflects that they had limited contact regarding this young man, and that there were no periods of case management where ongoing departmental assessment or services were provided.[289]

474. As a young man he was involved in a troubled relationship with his partner for approximately four years before his death. Occasionally they separated, and then reunited. They had a two year old daughter, and at the time of his death he and his partner were not living together.[290]

475. In the past he had often said to his partner that he wanted to hang himself because he felt *"lost"*; however he had not to her

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285 Ibid.
286 Exhibit 1.10, Tab 3; Exhibit 5, Volume 1, Tabs 2 and 24.
287 Ibid.
288 Exhibit 5, Volume 1, Tab 24.
289 Exhibit 5, Volume 1, Tab 12.
290 Exhibit 5, Volume 1, Tab 9.

knowledge made any attempt to do so, and she would endeavour to help him through these periods of felt hopelessness.[291]

476. On 25 February 2015 (just over two months before his death) he was placed on a six month intensive supervision order by the Broome Magistrates Court following convictions for assaulting a public officer, obstructing a public officer and breach of a police order under the *Restraining Orders Act* 1997.[292]

477. The above convictions arose out of a domestic violence incident involving this young man and his partner in November 2014 that police were called to attend. There was a report of people fighting at the front of a property. When police arrived and commenced inquiries, they found the young man to be intoxicated and aggressive, and their attempts to defuse the situation were unsuccessful. He was restrained and conveyed to the Derby Police Station and issued with a 24 hour police order for his partner's protection, due to information provided to police. His partner had no apparent injuries and wanted no further involvement in the matter.[293]

478. The young man subsequently breached the 24 hour police order, resulting in him being remanded in Casuarina Prison. After the charges were dealt with, on 26 February 2015, he was released on the intensive supervision order and he moved to Broome, where he subsequently re-established contact with his partner.[294]

479. The observations made by his partner and family members in the period leading to his death are outlined under the heading *Cause and manner of death*.

Mental health treatment

480. This young man was reviewed at the Derby Hospital by a community mental health nurse at approximately 9.30 pm on 28 April 2011, when he was 20 years old. He was brought in by police, who were concerned for his welfare after it was reported to them that he threated to hang himself, while he was intoxicated, in the course of an argument with a family member.

[291] Exhibit 5, Volume 1, Tab 9.
[292] Exhibit 5, Volume 1, Tab 13.
[293] Exhibit 5, Volume 1, Tab 12.
[294] Ibid.

There was a suggestion that he might have been in possession of an item that could have been used as a ligature.[295]

481. In this presentation the young man told the clinician that he first had thoughts of harming himself when he was 15 years old, and he reported an incident in 2010 where he punched a car window in anger, resulting in a laceration that required suturing. It was noted that this was his first presentation for mental health issues, and that he had never previously been seen by a mental health clinician. Upon assessment it was determined that he did not have a definite plan to suicide, and he was kept for observation overnight at Derby Hospital.[296]

482. He was reviewed the next day, 29 April 2011 and he told a mental health nurse at Derby Hospital that his thoughts of self-harm were anger driven, and there was discussion about avoiding anger provoking situations. Records reflect that it was intended that he have follow up with the Kimberley Mental Health and Drug Service the next week, and that he was agreeable to this. He was then discharged.[297]

483. The Derby Adult Community Mental Health notes reflect that the matter was referred to them and that they attempted follow up with this young man on 24 May 2011 (approximately one month after his discharge). However, it appeared he had by that stage returned to the Gibb River Station and the mental health services were unable to make contact with him.[298]

484. On 16 September 2014, the young man was held in custody for two days. Questions from the Department of Corrective Services staff regarding suicidal thoughts, impulsive behaviour and self-harming were all recorded as having been answered in the negative by him. There is also a medical entry in the Department of Corrective Services records dated 2 December 2014 where, upon being questioned he again denied any history of mental health or self-harm to a clinical nurse manager.[299]

485. On 5 December 2014, after a transfer from one prison to another, the young man was again directly questioned about thoughts of self-harm or suicide and again he denied having any.[300]

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[295] Exhibit 1.10, Tab 3.
[296] Ibid.
[297] Ibid.
[298] Ibid.
[299] Ibid.
[300] Ibid.

486. In contrast to the above records, in the police file for the young man under the heading *"Intelligence"* the following appears:

> *"Talk of Self-Harm, May inflict Self-Injury, Known Prohibited Drug User and Suffers from Depression."*

487. These warnings were placed under the young man's name on the Incident Management System (the police computer system) which is generated after a person has answered custody assessment questions. These warnings had been entered in November 2014.[301]

488. There is no information before me to indicate that the Department of Corrective Services had any awareness of these warnings when the young man was incarcerated in December 2014. It is clear that he was assessed upon admission to custody on both occasions, and that he denied suicidal thoughts.

489. Despite the above entries in the police computer system and the statements he had made to his partner regarding wanting to hang himself, there are no records of this young man having contact with any mental health or counselling services save for his review at the Derby District Hospital on 28 and 29 April 2011 referred to above. Unfortunately the Derby Adult Community Mental Health service was unable to make contact with him when they attempted follow up on 24 May 2011, as outlined above.

School attendance

490. There is limited information concerning this young man's education. As a child he attended a remote community school and later the Derby District High School. There are no records in connection with him in the school psychology file. The assessments at Derby District High School for year 10 in 2006 have not been completed due to poor school attendance.[302]

491. It is clear that he was more adept at, and far more interested in, station work, such as cattle mustering.

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[301] Exhibit 5, Volume 1, Tab 2.
[302] Exhibit 5, Volume 1, Tab 11.

492. In early May 2015 the young man made contact with his partner expressing a desire to see her, following his release from Casuarina Prison, and she travelled to Broome for that purpose. On 4 May 2015 they met up, and she observed that he was in a depressed state. He spoke to her about his family, and said that he was feeling lost again. He also said that he wanted to hang himself. She noted that he was sober and she endeavoured to support him, before returning to stay at her aunt's home.[303]

493. On the following day 5 May 2015, in the morning the young man spent some time with his daughter at a park and he appeared to be happy. His partner invited him to return with her and their daughter to the community where she was living (that was not in Broome) but he declined. He then left to meet another family member. During that interaction his partner did not consider that he appeared depressed. Later that evening, he telephoned her and asked her to come drinking with him but she declined. By this stage he sounded intoxicated to her.[304]

494. The young man telephoned his partner again later that same night and by this stage he sounded both angry and intoxicated. His partner turned off her phone and the following morning, 6 May 2016, she saw that she had nine missed telephone calls and one voice message from the young man. That voice message falsely accused her of being with another man. She then made a telephone call to him at 8.50 am on 6 May 2015 and he still sounded intoxicated to her. She told him she would come over to visit but she did not do so as her daughter subsequently fell asleep.[305]

495. This was the last occasion upon which his partner was able to make contact with him. In the early evening of 6 May 2016, his partner made repeated but unsuccessful attempts to contact him by telephone.[306]

496. In the meantime the young man had begun drinking alcohol early on the morning of 6 May 2015 at his home with his nephew and some friends, which would be the reason for his partner to discern that he sounded intoxicated when she spoke with him on the telephone that morning.[307]

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[303] Exhibit 5, Volume 1, Tab 9.
[304] Ibid.
[305] Ibid.
[306] Exhibit 5, Volume 1, Tab 9.
[307] Exhibit 5, Volume 1, Tabs 2, 7, 8 and 9.

497. His older brother was present at the home but not drinking. In the late morning on 6 May 2015 they left the house and the young man continued drinking at various locations throughout the day and evening, in company, and returning home in the mid to late afternoon.[308]

498. When they returned home the young man informed his older brother at one point that he had been having "*problems with his missus*" the night before, but the conversation did not develop from there. His brother noted that he appeared a bit upset at that point. Generally, however, the young man had appeared happy during the day and night of 6 May 2015, and he did not indicate to anyone that he was going to self-harm.[309]

499. Later that night of 6 May 2015, the young man and some others were watching television at the home. He appeared to be in good spirits. At around midnight, the young man got up suddenly, leaving his companions in the lounge room, and he went outside. When he had not returned for approximately 15 minutes his brother and nephew went outside to look for him and alarmingly, they found him hanging from a tree in the backyard. A household item had been used by the young man as a ligature, that he had affixed to a branch of that tree.[310]

500. In what must have been a moment both horrifying and heartbreaking, his older brother released the young man from the ligature, and yelled out for an ambulance. Neighbours were alerted and the emergency services were called.[311]

501. Records reflect that the St John Ambulance service was called at 12.31 am and that the paramedics arrived at the house at 12.38 am on 7 May 2015. Police had arrived before the paramedics and they commenced performing CPR, with the paramedics taking over upon their arrival. The paramedics continued the CPR, a laryngeal mask airway was inserted, and adrenaline was administered. The young man remained in asystole with no signs of life. The resuscitation was terminated after 21 minutes, and a paramedic pronounced the young man dead at the scene at 1.13 am on 7 May 2015.[312]

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[308] Ibid.
[309] Exhibit 5, Volume 1, Tabs 2, 7 and 8.
[310] Exhibit 5, Volume 1, Tab 8.
[311] Exhibit 5, Volume 1, Tab 7.
[312] Exhibit 5, Volume 1, Tabs 2, 4, 7, 9 and 10.

502. Police assessed the body and noted no recent injuries, save for the ligature marks on the young man's neck.[313]

503. On 11 May 2015 the forensic pathologist made a post mortem examination at the State Mortuary on the body of the young man and on that date formed the opinion that the cause of death was ligature compression of the neck (hanging). The forensic pathologist noted a faint ligature mark to the neck and pinpoint haemorrhages (petechiae) to the eyes. The ligature was made available to him. There was no other evidence of significant injury and no evidence of significant natural disease.[314]

504. Subsequent toxicological analysis showed a blood alcohol level of 0.314%. The urinary alcohol level was 0.400%. Tetrahydrocannabinol (the principal active constituent of cannabis) was identified in the blood at a level of 6.5 micrograms per litre.[315]

505. I have taken account of the forensic pathologist's report and his opinion on the cause of death, the toxicological analysis, and the evidence concerning the circumstances whereby the young man was found hanging in the backyard of his home, and specifically the evidence concerning the ligature and its placement.

506. **I find that the cause of the young man's death in Case No. 3 was ligature compression of the neck (hanging).**

507. This young man died at the age of 24 years. He had previously stated to his partner that he wanted to hang himself. On most of these earlier occasions, he was intoxicated. However on the most recent occasion when he told his partner that he wanted to hang himself, being approximately three days before his death, he was sober.

508. Toxicology results indicate that he was heavily intoxicated at the time of his death and affected by cannabis. I am satisfied that shortly after midnight, in the very early hours of 7 May 2015 the young man affixed a ligature to a tree in the backyard of his home and hanged himself, with the intention of taking his life. I am satisfied that the young man acted alone to use the item as a ligature in a manner that resulted in his death.

509. It is likely that his level of intoxication contributed to disinhibiting him. I am satisfied that he knew the foreseeable

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[313] Exhibit 5, Volume 1, Tab 2.
[314] Exhibit 5, Volume 1, Tab 5.
[315] Exhibit 5, Volume 1, Tab 6.

consequence of hanging himself was death, and that he was able to form the requisite intention for this finding.

510. **I find that the manner of the young man's death in Case No. 3 was Suicide.**

CASE No. 4

Introduction

511. This female child was born on 9 February 2006 at Royal Darwin Hospital and she died at approximately 7.40 pm on 6 March 2016 at the age of ten years at Looma Aboriginal Community. At the time of her death she was living with her carers, who also cared for a number of other young children, including her younger brother.[316]

512. Sadly the child's mother was not able to look after her, due to her own dysfunctional living circumstances, which were marred by longstanding alcohol abuse and unabated and increasingly serious incidents of domestic violence that had resulted in severe injuries to her person. The mother also suffered from ill health, and from the trauma occasioned by the death in 2013 of her older daughter, who was still a child herself. The tragic and repetitive cycle of life stressors endured by the mother severely compromised her ability to care for and nurture her younger daughter.[317]

513. This child initially lived with her mother in Derby, and they also travelled between Looma and Kalumburu. Attempts by the Department of Child Protection and Family Support to encourage and support the mother in separating from her partner in light of the domestic violence incidents were met with resistance, and were unsuccessful.[318]

514. In 2012, when this child was five or six years old she came into the care of her paternal aunt in Looma, by way of an informal family arrangement, with the mother and aunt signing a Safety

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[316] Exhibit 1.10, Tab 4; Exhibit 3, Tabs 4 and 42.
[317] Exhibit 3, Tabs 4 and 42.
[318] Exhibit 3, Tab 42.

Plan in respect of the child in consultation with the Department of Child Protection and Family Support.[319]

515. In 2013 the paternal aunt took this child and a sibling with her to live in Perth for a period. The Department of Child Protection and Family Support continued to monitor the child's circumstances, and another Safety Plan was signed.[320]

516. In the earlier part of 2014 the child's living arrangements changed again, and she was placed into the care of another paternal aunt and uncle, who had a history as carers who were previously approved for such a role by the Department of Child Protection and Family Support. This was also by way of an informal family arrangement. The child initially lived with them in Derby. In January 2016 (approximately one month before her death), the child moved with them to Looma. There were a number of children in this household, including her younger brother.[321]

517. In 2013 when this child was seven years old, her older half-sister, then 13 years old, and living with another relative, had died by suicide. By the time she was ten years old, this child knew of her half-sister's death, and she had some awareness of the manner of that death.[322]

518. This child was not the subject of a protection order under the *Children and Community Services Act* 2004. Nor was any investigation conducted under s 32(1)(d) for the purpose of ascertaining whether the child may be in need of protection.

519. Through their lawyers the ALS in collaboration with the KCLS, the child's mother and her carer elected not to give evidence at the Inquest, and having regard to the information already before me and the circumstances attending the death, no compulsions were issued.[323]

520. At my request the child's mother provided me with a letter, that I have taken into evidence.[324]

521. The details appear below.

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[319] Ibid.
[320] Ibid.
[321] Ibid.
[322] Exhibit 3, Volume 1, Tabs 4 and 42.
[323] ts 8 to 10; ts 369; ts 803 to 807.
[324] Exhibit 3, Volume 1, Tab 41.

Physical health

522. This young child's birth weight was normal at 3,045 grams and there were no maternal complications recorded in connection with the birth. Shortly after her birth at Royal Darwin Hospital on 9 February 2006 she was discharged into the care of her mother. There is no medical record made of her mother having consumed alcohol during the pregnancy.[325]

523. During her childhood she was treated for chronic ear infections with perforations, boils, bouts of gastroenteritis, iron deficiency, anaemia and skin infections.[326]

Home environment

524. The child's parents' relationship was unfortunately characterised by alcohol abuse and domestic violence, some of which very sadly, was witnessed by her. The first involvement by the Department of Child Protection and Family Support with this young child was on 28 April 2006 when it received a domestic violence incident report involving her parents. At the time, the child was just ten weeks old. Police attended but the mother did not wish to seek refuge.[327]

525. The next contact the Department of Child Protection and Family Support had in connection with this child was on 17 May 2006 when a departmental worker observed her and her family (comprising of her mother, her mother's partner and her older half-sister) walking out from a remote community, with the apparent intention of walking over 100 kilometres, to Derby.[328]

526. When the mother indicated that her partner was compelling them to walk to Derby, she and the children were assisted by the departmental worker, who conveyed them to a safe location nearby. Police became involved due to the partner's behaviour, and the mother and children were subsequently placed in a refuge in Derby.[329]

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[325] Exhibit 1.10, Tab 4.
[326] Ibid.
[327] Exhibit 3, Volume 1, Tab 42.
[328] Ibid.
[329] Ibid.

527. In the year that followed Department of Child Protection and Community Support staff endeavoured, but could not persuade the mother to leave her partner, and return to her family at Kalumburu, for safety. The mother moved between Derby, Looma and Broome with her child. The case was eventually closed by the departmental officer on 4 May 2007. No formal investigation was conducted.[330]

528. The mother, partner and child are recorded as residing at various times in Looma, Derby, Kununurra and Kalumburu. Department of Child Protection and Family Support records indicate that the family was the subject of numerous contacts for domestic violence incidents, financial matters and family support. There were no reports of violence or abuse directed towards the child. Some incidents are described below.[331]

529. A domestic violence report was received by the Department of Child Protection and Family Support on 4 August 2010 concerning the child's parents, and on this occasion a 24 hour police order was made. On 17 August 2010, following a further domestic violence incident that the child had witnessed, which must have been harrowing, the mother attended hospital for medical treatment. Legal proceedings ensued. The child was four and a half years old at the time.[332]

530. On 14 September 2010 the child was again present when another incident requiring police intervention between the mother, who was pregnant, and her partner occurred, which included breach of protective bail conditions. Further discussions were held between the Department of Child Protection and Family Support and the mother in 2012, with a view to ascertaining whether there were ongoing risks to her safety and that of her children.[333]

531. In periods throughout 2012, the child was in Looma and enrolled in school there, and she moved with her mother between Looma and Kalumburu. On occasion the child was also cared for by her paternal aunt in Looma. Members of the extended family were supportive of the child remaining in Looma.[334]

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[330] Ibid.
[331] Exhibit 3, Volume 1, Tab 4.
[332] Exhibit 3, Volume 1, Tab 32.
[333] Ibid.
[334] Exhibit 3, Volume 1, Tab 42.

532. On 22 October 2012 a family meeting involving the Department of Child Protection and Family Support, the mother, and extended family members was held for the purpose of giving the family an opportunity to create safety for the child. Following the meeting a Safety Plan was signed by the child's mother and her paternal aunt with the result that the child would remain in the care of that aunt in the Looma Community. It was by way of an informal family arrangement.[335]

533. On 7 December 2012 the paternal aunt and carer sought financial assistance from the Department of Child Protection and Family Support to move to Midland with the child and a sibling. The aunt agreed to continue to care for the child as part of the informal family arrangement. The case was then closed by the department's West Kimberley District and opened as Family Support by the department's Midland Office.[336]

534. They duly moved to Midland and the child was enrolled in school for the 2013 school year. Records reflect that the child was observed to be talkative and happy and enjoying school. Her school attendance rate ranged from 80% to 66%, with numerous attempts made to engage with her carer for the purposes of improving attendance. Mid-way through that year, the Department of Child Protection and Family Support closed the case.[337]

535. Within approximately a month however there was cause to reopen the case and the Department of Child Protection and Family Support resumed contact with the family. On 17 October 2013 a social worker at the child's school contacted the Department of Child Protection and Family Support expressing concern for the child's safety and wellbeing on the basis of a comment that the child had made to her about her home environment, to the effect that she had been hit at home.[338]

536. Upon further inquiry by a departmental staff member with the social worker on 25 October 2013, additional information came to light, namely that the child had also disclosed to that same social worker that her older half-sister had suicided. The child was just seven years old at the time. The social worker advised the departmental staff member that she had spoken with the child's aunt (carer), that she planned to see the child weekly and that she held no current concerns for the child. The Department

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[335] Ibid.
[336] Ibid.
[337] Ibid.
[338] Ibid.

of Child Protection and Family Support advised the social worker they would be closing their case (which they did in January 2014) and requested that she contact them should she have a future child protection concern.[339]

537. It transpired that in the latter part of 2013, the child had stopped attending school, and the school was unable to contact from the aunt either. Upon further inquiry it appeared that the child had been relocated from the Perth metropolitan area back to the Kimberley Region.[340]

538. In the earlier part of 2014, it was noted that the child was living in Derby again, and had that she had been placed in the care of another paternal aunt and uncle, again by way of an informal family arrangement. This aunt and uncle also cared for her a number of other children they are together referred to below as the "nominated aunt and uncle." They had previously been assessed as suitable foster carers and the Department of Child Protection and Family Support regarded them as being able to provide a high standard of care and safety to children who lived with them.[341]

539. In August 2015, the Department of Child Protection and Family Support became aware that that the care arrangements for this child were being shared amongst her nominated aunt and uncle, her parents, and the paternal aunt who initially cared for her. A family meeting with a departmental officer was held that addressed a number of matters related to another child. The outcome in connection with this child was that she remained primarily in the care of the nominated aunt and uncle, by way of an informal family arrangement. Departmental officers remained in contact with the family throughout the remainder of 2015 and offered support.[342]

540. In January 2016 the nominated aunt and uncle and the children they were caring for (including this child) moved from Derby to the Looma Community. Approximately two months later this young child tragically died.[343]

541. The child had been cared for by the nominated aunt and uncle for approximately two and a half years. They describe her in loving terms as a happy and healthy child, very mature and level

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[339] Ibid.
[340] Ibid.
[341] Ibid.
[342] Ibid.
[343] Exhibit 3, Volume 1, Tabs 4, 10 and 11.

headed for her years, helpful around the house, and amenable to taking instruction. She had a group of friends and relatives of her own age with whom she regularly played.[344]

542. It is also clear that the child had endured cumulative harm from the exposure to incidents of domestic violence and alcohol fuelled violence in her early years, before she was taken into the care of her various relatives. That care was itself fragmented because those relatives were not always in a position to provide continuity of care for her. The two and a half years that she spent with her nominated aunt and uncle in Derby and then Looma would appear to be the most stable of her home environments in her very short life.

543. Through its lawyer the SSO, the Department of Communities accepts that the Department of Child Protection and Family Support ought to have undertaken assessments of the child's wellbeing after certain reports in October 2013, February 2014 and between April and October 2015 (by reason of outcomes of departmental inquiries in respect of another child of the household). This is addressed later in this finding under the heading *Adverse Comment.*

Mental health treatment

544. There was no record of this child participating in any mental health or counselling services save for the contact with the social worker in October 2013 referred to previously. No person referred her to any such services.

545. This is despite the child having disclosed, at the age of seven years, that her older half-sister had suicided.

School attendance

546. For the most part, this young child had a poor attendance rate throughout her school years and consequently, a below average performance in her school work. Records reflect that her school in Perth made frequent attempts to inform her carer that the child was at risk due to her low attendance rate,

[344] Exhibit 3, Volume 1, Tabs 10 and 11.

and to encourage her carer to work together and to attend meetings with them to discuss her absence from school.[345]

547. The staff members at her school in Derby did not know that the child's older sister had died in 2013. The child was only enrolled in the school in Looma for four weeks, and her teacher there did not know of the death of the child's older sister in 2013 either.[346]

548. The child's school in Derby reported that she did not display at-risk behaviours, and they based this view upon the number of suicide risk assessments that take place at that school. She was described as a quiet student in class, who did not speak up unless prompted by the teacher. The teachers considered they had a good relationship with the child, and with her carers, who they described as "*very approachable.*"[347]

549. By 2016, when she had moved to Looma, she was attending school on average only two days out of each week before her death. Her primary school teacher could not recall any areas of concern regarding the child, and it is to be borne in mind that she was only enrolled there for four weeks. Her teacher recalled that she was a very quiet girl who rarely spoke in class, that she usually appeared quite happy and that she was becoming more comfortable in the classroom environment, and interacting with other students. The Aboriginal Islander Education Officer attached to her class also recalled her to usually be quiet and happy.[348]

550. In the week prior to her death, the child was seen to be crying at school. Her teacher consulted with the Aboriginal Islander Education Officer, who in turn suggested that it may be helpful for one of the other Aboriginal Islander Education Officers to seek to engage with the child about this due to it being more culturally appropriate. The view was subsequently formed that the child was unhappy because she was being made to attend school.[349]

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[345] Exhibit 3, Volume 1, Tab 39.
[346] Exhibit 3, Volume 1, Tabs 20, 38 and 39; ts 434 to 436.
[347] Exhibit 3, Volume 1, Tab 38.
[348] Exhibit 3, Volume 1, Tabs 13 and 20; ts 434 to 435.
[349] Exhibit 3, Volume 1, Tabs 13 and 20; ts 435 to 438.

551. On the date of her death, 6 March 2016, the child spent the afternoon playing with friends and relatives of her own age in and around her home and nearby homes of friends and relatives. She appeared happy and was observed to be laughing and joking. Various adults who knew her well had sighted her throughout the day, and no one held any concerns for her safety.[350]

552. During the late afternoon, after a days' play, the child returned to her home. Her carers did not note anything untoward in her behaviour. She settled into her usual activities around the house, and interacted with her carers in her usual manner. Shortly after 5.00 pm her carer requested that she locate a missing item of her footwear, and the child left her home in order to go to one of her nearby friends' houses, to find her footwear. The child had sought permission for a sleepover there, and it appeared to have been granted, on condition of her locating her missing footwear.[351]

553. Her carers then left their home to go to church, and this is the last occasion upon which they saw the child alive. Shortly afterwards, another adult saw some young children at the friend's house, who told her that the child had found her footwear. They also said that the child would be returning to her own home.[352]

554. Shortly before 6.40 pm on 6 March 2016, one of the occupants of the child's friend's house, an adult, went into the rear yard to retrieve a household article. To his horror he saw the child hanging from a ligature affixed to an item in the rear yard. He screamed for help and a number of persons immediately attended. Those persons released the child from her ligature and laid her on the ground. Numerous other persons arrived, and they were all greatly distressed.[353]

555. At approximately 6.40 pm the police officer in charge of the Looma Multifunctional Police Station, who happened to be nearby, heard a commotion which he described as yelling, loud screaming and crying. He decided to investigate and attended at the house. Upon arrival, he saw the child's body laid on the ground, with numerous persons around the child in an obvious

[350] Exhibit 3, Volume 1, Tabs 4 and 10 to 12.
[351] Ibid.
[352] Exhibit 3, Volume 1, Tabs 4, 12 and 13.
[353] Exhibit 3, Volume 1, Tabs 12 to 16.

state of shock and grief. He immediately checked the child for signs of life, but could not find any.[354]

556. The police officer commenced performing CPR on the child, and was subsequently assisted by two of the other persons present. The emergency services were called, resulting in the attendance of two remote area nurses at approximately 7.00 pm and two additional police officers, to assist with the resuscitation efforts.[355]

557. Upon arrival, the remote area nurses took over the resuscitation. With the assistance of police, the child was conveyed to the Looma Medical Clinic by ambulance, and CPR was continued in the ambulance and at the clinic. There was no spontaneous breathing, no spontaneous circulation, and her pupils were fixed and dilated. After approximately one hour of attempted resuscitation, tragically at 7.46 pm on 6 March 2016 the child was pronounced dead by a clinician at the Looma Medical Clinic.[356]

558. On 15 March 2016 the forensic pathologist made a post mortem examination at the State Mortuary on the child's body and on that date formed the opinion that the cause of death was ligature compression of the neck (hanging). The forensic pathologist noted that there was a ligature mark to the neck, consistent with the presumed ligature provided to him. I am satisfied that the correct ligature was provided by police.[357]

559. The forensic pathologist recorded that there was no other evidence of significant injury and no evidence of natural disease. Further examinations were conducted. Toxicology showed no evidence of alcohol or common drugs. Microscopic examination of tissues showed no evidence of significant abnormality. A detailed examination conducted in accordance with all proper procedures was able to establish that there was no other evidence of any form of physical assault upon the child.[358]

560. I have taken account of the forensic pathologist's report and his opinion on the cause of death, the additional examinations, and the evidence of the circumstances whereby the child was found hanging in the rear of the yard, and specifically the evidence concerning the actual ligature and its placement.

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[354] Exhibit 3, Volume 1, Tabs 4 and 21.
[355] Exhibit 3, Volume 1, Tabs 4, 21
[356] Exhibit 3, Volume 1, Tabs 2 to 5, and Tabs 21 to 25.
[357] Exhibit 3, Volume 1, Tab 6.
[358] Exhibit 3, Volume 1, Tabs 6 and 7.

561. **I find that the cause of the child's death in Case No. 4 was ligature compression of the neck (hanging).**

562. Given the child's very young age and the means by which the ligature had been affixed a question arose as to whether a child of her age would have the capacity and/or dexterity to do that without any assistance from a third party, and further evidence was gathered on this point.[359]

563. I have taken account of the evidence of the child's height, the height of the suspension point, the observed position of the child when found hanging, and the subsequent police investigation. I have also taken account of the Chief Psychiatrist's evidence. At the Inquest Dr Gibson was shown photographs of the suspension point that were taken as part of the subsequent investigation. Whilst Dr Gibson cannot comment on how this child used the ligature, his evidence about the behaviour of young children who self-harm persuades me that it is not beyond the capacity of a ten year old child to utilise that particular item as a ligature and to affix it to the suspension point, in the way that she did.[360]

564. It is not known how the item that was used as a ligature came to be at that house. The more likely explanation is that the item was already affixed to the anchor point on that article in the rear yard, with parts of it hanging down. The less plausible explanation is that the child herself found and then affixed the item to the anchor point which she then utilised as the suspension point. In either case I am satisfied that the child acted alone to use the item as a ligature in a manner that resulted in her death.[361]

565. If the item that was used as a ligature was already affixed to the anchor point by another person, it had not been affixed with the intention that any person would subsequently utilise it as a suspension point for hanging.

566. There have been accounts of the child appearing to be sad in the last week of her life, with an observable change in her mood. Further inquiries undertaken by the police and separately, by the Department of Child Protection and Family Support after her death, and evidential matters before me, do not support the claim, that was made by some persons, to the effect that she

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[359] Exhibit 3, Volume 1, Tab 4A.
[360] ts 1641 to 1643.
[361] Exhibit 3, Volume 1, Tabs 4 and 4A; ts 1641 to 1643.

was not well cared for by the nominated aunt and uncle. Nor is there any information before me to support the claim, again made by some persons, that the child had argued with her carers, or been inappropriately disciplined by them, shortly before her death.[362]

567. It is to be borne in mind that this young child was exposed to witnessing unabated and disturbing incidents of domestic violence and alcohol abuse from a very young age, and long before she came into the care of the nominated aunt and uncle. The cumulative harm of this earlier exposure will have been traumatising and most likely, relentlessly so, persisting long after she was removed from that environment.

568. There is no evidence of this child stating that she was thinking of or intending to self-harm. She may have been too young to articulate such feelings in a manner that could be understood as such by those around her. I am satisfied that she was aware of the fact of her older half-sister's death, and this tragic event impacted on her already fragile and vulnerable mental state, at such a tender age. She may have been aware that her half-sister died by suicide, though I cannot be satisfied, to the requisite standard, that she did have a complete understanding.

569. The child was known to have regularly viewed or read her deceased half-sister's diary. The diary contained numerous family photographs, religious depictions, a vale notice regarding her half-sister's funeral, and poignant notes pertaining to the death of her half-sister, and how much she was missed. This very young child had experienced recurrent and traumatising losses during her tragically short life, and at the time of her death it is likely that she was overwhelmed by her sadness.[363]

570. I am satisfied that this child knew that the foreseeable consequence of hanging herself was death, and that she intended that consequence. I have outlined the expert evidence and expert opinions concerning the ages at which children have the capacity to understand the concept of death, and its permanency, under the heading *Suicide in Children*, earlier in this finding.

571. The intention of taking her life may have been experienced as an intention to go to an after-life, a life after death where she would again see her half-sister. Her actions appear to have been impulsive. Those matters do not negate a suicide. I am satisfied

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[362] Exhibit 3, Volume 1, Tabs 4 and 42.
[363] Exhibit 3, Volume 1, Tab 37.

that this child's intention, in the words of one of the experts, was to no longer be in this life:

> *It's just, 'Right at this point in time my distress is so overwhelming I can't tolerate it. I need to do something and all I can think to do is not to be alive'*[364]

572. Whilst this expert also suggested that a child in such turmoil might not mean to die, I am satisfied that in the case of this child, she did mean to die at that point.

573. On 6 March 2016, between approximately 5.00 pm and 6.40 pm, the child used an item as a ligature (that she affixed, or that was already affixed to an article in the rear yard of a house) and she hanged herself, with the intention of taking her life. I am satisfied that the child acted alone to use the item as a ligature in a manner that resulted in her death.

574. **I find that the manner of the child's death in Case No. 4 was Suicide.**

CASE No. 5

Introduction

575. This female child was born on 5 March 2000 at Kununurra District Hospital and she died at a time between 6.00 pm on 14 February 2013 and 1.00 pm on 15 February 2013 at the age of 12 years at Wyndham. At the time of her death she was living with her parents.[365]

576. The child was the youngest of six children. In her early years she lived with her family in Oombulgurri Community. When the child was approximately ten years old the Oombulgurri Community was closed and she relocated permanently to Wyndham with her family.[366]

577. The child's home life was marred by the effects of her parents' excessive alcohol consumption, instances of domestic violence and disruption to her routine occasioned by overcrowding. Her parents felt overwhelmed by the

[364] ts 1309.
[365] Exhibit 1.10, Tab 5.
[366] Exhibit 14, Volume 2, Tab 1.

unexpected closure of Oombulgurri Community, which was their home, during a period when they had temporarily relocated to Wyndham to support an adult daughter.

578. As this child became older, she began to experiment with alcohol and cannabis, she avoided going to school, and she was also found to be walking around the streets of Wyndham unsupervised, with other children late at night.[367]

579. The child and her parents unfortunately developed a conflictual relationship that involved escalating arguments. Approximately one month prior to her death she had expressed an intention to self-harm by hanging. She was referred to the mental health services, but she had not been seen by a clinician prior to her death.[368]

580. The child had been identified as a child at risk by the inter-agency Wyndham Children at Risk Group. She was not the subject of a protection order under the *Children and Community Services Act* 2004. There were investigations conducted under s 32(1)(d) of this legislation for the purpose of ascertaining whether the child may be in need of protection. On each occasion, no harm was substantiated.

581. Through their lawyers the KCLS, the child's parents elected not to give evidence at the Inquest, and having regard to the information already before me and the circumstances attending the death, no compulsions were issued. That information included statements made by both parents at the time of the child's death in 2013. The child's parents also provided the court with a joint statement dated 3 October 2017, outlining some of their family history and pointing to the importance, to them, of the Oombulgurri Community, and the difficulties they experienced in relocating to Wyndham when that community was closed.[369]

582. The details appear below.

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[367] Ibid.
[368] Exhibit 14.1, Tabs 2, 7 and 8; Exhibit 14.2, Tab 1.
[369] ts 8 to 10; ts 369; ts 803 to 807; Exhibit 14.1, Tabs 7, 8 and 8A.

Physical health

583. The child's birth weight was normal at 3,850 grams. Shortly after her birth on 5 March 2000 she was discharged into the care of her mother. There is no medical record made of her mother having consumed alcohol during the pregnancy.[370]

584. During the child's early years she presented to the Oombulgurri Community Clinic for treatment for various ailments. Throughout 2007 and 2012 she presented regularly at Wyndham Hospital for a range of ailments that included numerous instances of skin infections and bouts of diarrhoea.[371]

585. The child also had two presentations at Wyndham Hospital in September 2010 and January 2011 following collapsing episodes. On the first such presentation, she was transferred to Kununurra District Hospital for overnight admission. It was noted she had an ongoing chest infection. She was referred back to Wyndham Hospital for further investigations and paediatric review. No conclusive diagnosis was made as to the cause of these collapses and psychological reasons were not ruled out.[372]

Home environment

586. This child was the youngest of six children and up until 2011 she lived with her family in the Oombulgurri Community which was located 45 kilometres northwest of Wyndham. This was a dysfunctional community which was eventually closed in 2011, and this child's family, along with numerous others, were relocated to Wyndham.[373]

587. There had been reported incidents of domestic violence within the child's home in 2003, 2007 and 2010, none of them involving children:

a. In the case of the 2003 report, the Department of Child Protection and Family Support offered financial assistance for the mother to go and stay with her family in Wyndham;

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[370] Exhibit 1.10, Tab 5.
[371] Ibid.
[372] Ibid.
[373] Exhibit 14, Volume 2, Tab 1.

b. In the case of reports in 2007, the police attended and undertook some protective steps;

c. In the case of the 2010 report, the police attended and it was recorded that there were some injuries sustained, but no further steps were taken due to the parties involved being intoxicated.[374]

588. In June 2005 and again in February 2009, the Department of Child Protection and Family Support became aware of certain relevant allegations made against a member of this child's household. The 2009 allegations did not relate to the children of the household, but they would ordinarily precipitate an inquiry concerning the safety of the children of the household.[375]

589. Records reflect that in July 2009, some months after the February 2009 notification of the allegations, staff from this department undertook an assessment to determine the safety of the children in the household, including this child. Investigating staff determined there to be no direct risk to the children, no harm was substantiated, and a Safety Plan was developed. None of the allegations subsequently resulted in convictions. My comments in connection with the quality of the Department of Child Protection and Family Support's assessment are addressed later in this finding under the heading *Adverse Comment.*[376]

590. Between March 2012 and January 2013 the child was frequently found wandering the streets of Wyndham unsupervised at night time (after 10.00 pm). Police routinely returned her to her home. Ten of these instances prompted a report by police to the Department of Child Protection and Family Support, but there are no file records of contact being made by this department with the family. My comments in connection with the lack of contact by the Department of Child Protection and Family Support appear later in this finding under the heading *Adverse "Comment.*[377]

591. The child's behaviour was very disturbing. She risked becoming vulnerable to exploitation and abuse by older men, in addition to getting into trouble as might be expected when young children are out together unsupervised late at night. During this period

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[374] Exhibit 14, Volume 2, Tabs 1, 2 and 2A.
[375] Ibid.
[376] Ibid.
[377] Ibid.

the child began consuming alcohol and cannabis, and ceased attending school.[378]

592. Multi-agency strategies in relation to reports of children being out late at night and unsupervised included: Kids at Risk Group (involving Police, Departments of Child Protection and Family Support, Education, Health and Justice), joint night patrols, income management in identified circumstances, meetings with parents, and alcohol restrictions in respect of some premises.[379]

593. In 2012 this child came to the attention of the East Kimberly Regional Youth Justice Services. Wyndham Police had referred her to them in May 2012. Family meetings and assessments began in July 2012, with the initial recommendation being for medium level intervention. However, a risk assessment on 13 August 2012 indicated that the child was at serious risk given her age, transience, school disengagement, school suspensions and use of cannabis and alcohol.[380]

594. Following their risk assessment of 13 August 2012, Youth Justice Services determined that a high level of intervention was required, and plans were developed to increase the weekly contact with the child. With the consent of her parents, the Youth Justice Services continued their engagement with her for a period of approximately nine months, from the perspective of prevention and diversion from the criminal justice system.[381]

595. On 25 September 2012 the Department of Child Protection and Family Support received a referral regarding this child from a doctor at Wyndham Hospital. The child and her older sister had an altercation, resulting in an injury to the older sister. In the course of treating the older sister's injury, and taking a history, the doctor expressed concerns about this child's behaviour, and suggested that the Department of Child Protection and Family Support could help. There is no record of the referral being acknowledged or followed up by the Department of Child Protection and Family Support.[382]

596. On 23 November 2012 police contacted the Youth Justice Services expressing concern about the child's wellbeing following a callout to her home. It had been reported that the child appeared to be: "*under the influence and on the street after*

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[378] Ibid.
[379] Ibid.
[380] Ibid.
[381] Ibid.
[382] Exhibit 14, Volume 2, Tab 18.

a disturbance at about 3.00 am." Staff from the Department of Child Protection and Family Support became involved and together with an Aboriginal Support Worker from Youth Justice Services, on 27 November 2012 they visited the child at her home.[383]

597. During this visit the child told them that due to the noise and consumption of alcohol at her house, she walked around the streets with other children late at night. She also acknowledged her non-attendance at school. There were no adults present on the occasion of that visit. Her home address was known to regularly have intoxicated occupants present late at night.[384]

598. This team put an action plan together with a view to visiting the child's home again to engage with her parents or a responsible adult, explore options to assist the child with re-engaging at school, and consider the option of liquor restrictions on the child's premises.[385]

599. On 30 November 2012 the child was referred to the Wyndham Children at Risk register, with concern raised by Wyndham Police regarding her welfare. The Children at Risk register is utilised by an inter-government agency group that discusses and devises strategies to address young persons' needs, where they have been identified as being at risk by one or more government agencies.[386]

600. On 16 January 2013, the child ran away from home threatening to hang herself. She was chased by her mother who persuaded her to return home. A child protection worker was contacted by the child's mother as she feared her daughter might be at risk of self-harm.[387]

601. This alarming incident was discussed at the Wyndham Children at Risk meeting later that same day and it was determined that a referral to the Child and Adolescent Mental Health Service be completed for this child. This task was assigned to the Department of Corrective Services Youth Justice representative at the meeting, but for reasons that are outlined later in this finding, it was not commenced for approximately two weeks. My

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[383] Exhibit 14, Volume 2, Tab 2.
[384] Ibid.
[385] Ibid.
[386] Ibid.
[387] Exhibit 14, Volume 2, Tab 1.

comments in connection with the quality of this follow up appear under the heading *Adverse Comment.*[388]

602. On 30 January 2013 police attended at the child's home in respect of an incident between the child and her father. The father had reported to police that she was arguing and demanding money to buy drugs. He requested the assistance of the Department of Child Protection and Family Support. At this stage the child was just 12 years old. Police who visited the premises made some inquiries. The child appeared to be depressed and volatile. Police notified the Department of Child Protection and Family Support. There is no record of departmental contact with the child or her family in connection with this incident.[389]

603. On the same day as this incident, 30 January 2013, the child was again the subject of discussion at the Wyndham Children at Risk meeting. It was agreed that she appeared to be at significant risk. It was hardly possible to have come to any other conclusion. The referral to the Child and Adolescent Mental Health Service that had been agreed to at the meeting on 16 January 2013 had yet not been done, and that task was again assigned to Department of Corrective Services Youth Justice representative, for completion.[390]

604. The referral to the Child and Adolescent Mental Health Service for this child was finally completed by Department of Corrective Services Youth Justice representative and sent by facsimile to them on Saturday 2 February 2013, approximately two weeks after the task has originally been assigned. It was noted that the child had repeatedly expressed the desire to take her life. A staff member from the Child and Adolescent Mental Health Service followed up the referral on Monday, 4 February 2013.[391]

605. The Child and Adolescent Mental Health Service staff member consulted with the nominated Department of Corrective Services Youth Justice representative and the Department of Child Protection and Community Support Senior Aboriginal Community Child Protection Worker, and another staff member of that department. The question of whether hospitalisation could be utilised was explored. There was also discussion of a welfare check. The impression gained by the Child and Adolescent Mental Health Service staff member from the

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[388] Exhibit 14, Volume 2, Tabs 2 and 2A.
[389] Exhibit 14, Volume 1, Tab 29; Exhibit 14, Volume 2, Tab 1.
[390] Exhibit 14, Volume 2, Tab 2A.
[391] Ibid.

consultations was that the matter was not urgent, but that the child may be vulnerable.[392]

606. As a result, the Child and Adolescent Mental Health Service staff member decided that a clinician would attempt to contact the child's family on their next planned visit to Wyndham, that was scheduled for 11 February 2013. However, that planned visit was subsequently postponed due to other clinical priorities in Kununurra. Very tragically, the child died a few days later, and before any visit by the clinician was arranged.[393]

607. The further details of the events prior to the child's death appear under the heading *Cause and manner of death*.

Mental health treatment

608. Despite the child being identified as at high risk of self-harm in the weeks leading to her death, she had no contact with any mental health or counselling services during that period, nor at any other stage in her life.

609. There were no school psychology notes, nor any indication of a referral to her school psychologist.

610. The referral to the Child and Adolescent Mental Health Service was actioned two weeks after the assignment of the task, and it was treated by the Child and Adolescent Mental Health Service as being non-urgent, based upon the content of the referral itself, and the consultations with the nominated Department of Corrective Services Youth Justice representative and the Department of Child Protection and Community Support Senior Aboriginal Community Child Protection Worker, and another staff member of that department.

School attendance

611. The Wyndham District High School's report reflects that this child moved across to Wyndham from Oombulgurri when it closed in mid-2011 and that like a number of the Oombulgurri children she had been transient between there and Wyndham prior to the closure of that remote community. The house in which the child resided was also home to a number of other

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[392] Exhibit 14, Volume 1, Tab 29.
[393] Ibid.

families, mainly from Oombulgurri. It was overcrowded and the school noted there was a shortage of housing in the community.[394]

612. The Department of Education records reflect that in her early years of primary school this child's attendances were good but they dropped off by Year 5. In 2011, her school attendance rate was 49%. In 2012 it plummeted to 25%. By February 2013, records reflect a school attendance rate of 50%, which was still very poor, and in no way sufficient for any meaningful learning for this child. Her school attendance was in fact so poor that she was not able to be assessed in most subjects in her later years of schooling.[395]

613. Unsurprisingly, given her unsettling home environment and her disengagement from school, the child became disruptive and her school records reflect numerous instances of negative behaviour on her part. These include threats of violence towards other students, refusal to follow teachers' instructions, verbal abuse directed at staff, and truancy.[396]

614. Late in 2012, the child's mother had approached the Wyndham District High School's Aboriginal Islander Education Officer to request assistance with getting her daughter to school. In response the officer was released from her usual school duties in order to better assist the child's family through the implementation of a Parenting Program, to act as a liaison between the school and the parents, and to participate in workshops with the family. The child's mother was actively engaged with the Wyndham District High School and made sustained efforts with the aim of improving her daughter's school attendance.[397]

615. Efforts on the part of Wyndham District High School itself to encourage the child to return to school and generally improve her attendance rate also continued at various levels. They included home visits by the School Based Attendance Officer, the offer of a structured re-entry back to school, a modified timetable and offers of practical assistance, such as with uniforms. The school also issued positive behaviour reports, praising the child for working hard and attending. Unfortunately

[394] Exhibit 14, Volume 1, Tab 31B.
[395] Ibid.
[396] Exhibit 14, Volume 1, Tabs 31B and 31C.
[397] Exhibit 14, Volume 1, Tab 31C.

despite these efforts the child would briefly return to school, and then truant again.[398]

Cause and manner of death

616. On 14 February 2013, after being told by her parents that they would not give her money to buy what they believed would be cannabis and then throwing rocks at her house, the child ran away. A family member followed her in an effort to persuade her to return home, but the child refused to do so and remained sitting opposite a park. Very soon afterwards, the child was no longer seen. The mother contacted the senior community child protection worker, and expressed serious concerns about her daughter harming herself. There was cause for alarm because approximately one month previously, the child had expressed an intention to take her life, as outlined previously in this finding.[399]

617. A Department of Child Protection and Community Support officer and a Department of Corrective Services Youth Justice Services officer attended the child's home on that day, and spoke with the mother, who gave an account of what had happened. During that visit, the two officers observed a number of very intoxicated adults at the premises.[400]

618. These two officers attempted to locate the child at a number of homes and venues on 14 February 2013, without success. The parents formed the view that the child had likely gone to stay with her aunt, as had occurred on previous occasions, but they were not able to make contact with that aunt in order to verify their belief.[401]

619. At approximately 10.00 pm on 14 February 2013 two police officers attended at the child's home to conduct a curfew check in respect of the child, who was not present at her home. The child's parents informed the police about the altercation, and told them that they believed the child had gone to her aunt's home. The police left with the intention of going to the aunt's home to verify that, but were deployed to another task, and did not attend at the aunt's home that night. The child's

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[398] Exhibit 14.1, Volume 1, Tab 31B.
[399] Exhibit 14, Volume 1, Tabs 2, 7, 8 and 9; Exhibit 14 Volume 2, Tabs 1, 2 & 2A.
[400] Ibid.
[401] Exhibit 14, Volume 1, Tabs 7 and 8; Exhibit 14, Volume 2, Tab 1.

whereabouts on the night of 14 February 2013 remain unknown.[402]

620. At approximately 1.00 pm on 15 February 2013 a Community Work Officer from the Department of Corrective Services, together with an individual who was performing his Community Hours work, were cutting grass at a park in Wyndham. As they drove through the park in order to continue that work, they observed what appeared to them to be a person hiding in the bushes. Upon closer inspection, they saw, alarmingly, that this child was lying on the ground, unresponsive, with a ligature around her neck. Records reflect that shortly after 1.00 pm, they contacted police, who attended the scene, and formed the view that the child was obviously deceased, and they secured the scene.[403]

621. Records also reflect that police contacted the St John Ambulance volunteer service at 1.40 pm on 15 February 2013 and that they arrived at the scene at 2.06 pm. The attending volunteer ambulance officer checked and found no signs of life. I am satisfied that the child had tragically died before she was found lying on the ground by the Community Work Officer. She was pronounced dead by the volunteer ambulance officer at the scene at 2.00 pm on 15 February 2013.[404]

622. The subsequent police investigation and the evidence at the Inquest from the Chief Psychiatrist has established to the requisite standard that the child affixed a household item, that she used as a ligature, to a tree in the park that was a short distance away from her home, and she hanged herself, at a time after 6.00 pm on 14 February 2013, and before 1.00 pm on 15 February 2013. By the time the Community Work Officer found her, the ligature itself had broken off from the tree, resulting in the child being observed to be lying on the ground.[405]

623. On 21 February 2013 the forensic pathologist made a post mortem examination at the State Mortuary on the child's body and on that date formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging). The forensic pathologist was able to observe the ligature, and whilst he did not have information at that time regarding a discernible

[402] Exhibit 14, Volume 1, Tabs 2, 7 to 10, 23 and 24.
[403] Exhibit 14, Volume 1, Tabs 11 to 12 and 17 to 22.
[404] Exhibit 14, Volume 1, Tabs 4, 25 and 30.
[405] Exhibit 14, Volume 1, Tab 2A, Tabs 19 and 19.1; ts 1642.

suspension point, that has since been established to be the tree under which the child was found.[406]

624. Subsequent toxicological analysis showed a small amount of alcohol in the blood sample (0.014%) and in the bile sample (0.034%). The forensic pathologist noted that decomposition changes to the body would potentially have accounted for these readings. It does not establish that the child consumed alcohol before her death. No common drugs were detected in the blood or the liver. The forensic pathologist's opinion on cause of death remained unchanged.[407]

625. I have taken account of the forensic pathologist's report and his opinion on cause of death, the toxicological analysis, and the evidence concerning the circumstances whereby the child was found, and specifically, the evidence concerning the actual ligature, the subsequent police investigation concerning the likely suspension point, and the evidence of the Chief Psychiatrist regarding the relevance of the suspension point.

626. **I find that the cause of the child's death in Case No. 5 was ligature compression of the neck (hanging).**

627. The child was less than three weeks away from her 13th birthday when she died. Though she was known to already be consuming alcohol and cannabis, the toxicology findings were inconclusive as to whether she had consumed alcohol immediately prior to her death. The levels detected were small, and they are more likely to be related to decomposition changes.

628. As described above, approximately one month prior to her death, the child had expressed an intention to self-harm by hanging. I am satisfied that she knew the foreseeable consequence of hanging herself was death, and that she was able to form the requisite intention for this finding.

629. The Child and Adolescent Mental Health Service staff considered the child to be at risk of self-harm due substantially to the information about her prior expressed intentions, and they had commenced the process of making an appointment for her to see a clinician.

630. At the time of her death, the child had an increased need for support and intervention for her substance use, personal welfare and mental wellbeing issues. Her home life was

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[406] Exhibit 14, Volume 1, Tab 5.
[407] Exhibit 14.1, Volume 1, Tab 16.

unsettled, and she was largely unsupervised. She had been wandering the streets at night and later become subject to a curfew. She was displaying disruptive behaviours, with little ability to regulate her emotions. She had a substantial and volatile altercation as she was leaving her home on the evening of 14 February 2013, and shortly afterwards, was no longer seen by her family.

631. At a time between 6.00 pm on 14 February 2013 and 1.00 pm on 15 February 2013, the child affixed a ligature to a tree in a park that was close to her home, and hanged herself with the intention of taking her life. I am satisfied that the child acted alone to use the item as a ligature in a manner that resulted in her death.

632. **I find that the manner of the child's death in Case No. 5 was Suicide.**

CASE No. 6

Introduction

633. This male child was born on 6 July 1997 at the Derby Regional Hospital and he died at a time between approximately 9.00 pm on 7 January 2014 and 4.30 am on 8 January 2014 at the age of 16 years at Mud Springs Community, near Kununurra. At the time of his death he was in the care of his maternal aunt and her partner.[408]

634. In the years before his death the child had at different stages lived with his mother, his aunt and his father. He had moved between a number of small Aboriginal communities located proximate to Kununurra, living in those communities and also in Kununurra, including in the care of individuals at the Aboriginal Hostel in Kununurra.[409]

635. Sadly the child's parents were not able to look after him on an ongoing basis, due to the severe dysfunction in their own relationship, that was marred by continuing alcohol abuse and domestic violence.[410]

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[408] Exhibit 1.10, Tab 6; Exhibit 10, Tab 9.
[409] Exhibit 10, Volume 1, Tab 14.
[410] Ibid.

636. By reason of separate events that had affected this child, his sibling and half-sibling, the family had come to the attention of the Department of Child Protection and Family Support. Steps had been taken to endeavour to assist the mother with her rehabilitation, and to place this child into the care of his aunt, by informal family arrangement. These steps were accelerated after it became apparent that the child may have been subjected to sexual harm (extra-familial).[411]

637. It appears that the ultimate aim was, with the assistance of his aunt, to move the child to a boarding school, in order to remove him from an environment where he remained at risk of extra-familial sexual harm. Shortly before his death, arrangements had been made for the child to attend a school in Esperance for the 2014 academic year.[412]

638. No child protection order was made under the *Children and Community Services Act* 2014. An investigation under s 32(1)(d) of this legislation conducted for the purpose of ascertaining whether the child may be in need of protection resulted in sexual harm being substantiated.[413]

639. Through the KCLS the court was informed that child's mother did not request that they continue to act for her. The mother remained traumatised by all of the circumstances, and did not wish to participate in the Inquest. Having regard to the information already before me and the circumstances attending the death, no compulsions were issued, and separately, the offer of care was extended through Anglicare's Standby programme at the behest of the Coronial Counselling Service.[414]

640. The details appear below.

Physical health

641. The child's birth weight was low at 1,840 grams. Post-delivery on 6 July 1997 at Derby Hospital there were episodes of bradycardia (slow pulse) and thrombocytopenia (low platelets) and he received intravenous antibiotics and frequent monitoring and paediatric review. He was discharged to Kununurra Hospital 10 days after his birth, though there is no evidence of

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[411] Ibid.
[412] Ibid.
[413] Ibid.
[414] ts 5 to 6; ts 1506.

a corresponding admission to Kununurra Hospital at the material time.[415]

642. There is no medical record made of his mother having consumed alcohol during the pregnancy.[416]

643. Records reflect that between 2010 and 2013 the child had infrequent presentations at Kununurra District Hospital for minor ailments that included chest infections, ear infections and infection of his left lower leg, from a wound.[417]

644. The child was also treated at the Ord Valley Aboriginal Health Service and records between 2010 and 2013 reflect a number of presentations again for minor ailments including conjunctivitis, skin and chest infections.[418]

645. On 27 March 2012 when the child was 14 years old, the Ord Valley Aboriginal Health Service ordered a urine test for sexually transmitted infections, which was returned negative. Medical notes reflect that this testing was arranged after an education session, and there is nothing to show that it related to a specific concern or event.[419]

646. However on 4 July 2013, shortly before the child attained 16 years of age, the Ord Valley Aboriginal Health Service had cause to order tests for the sexually transmitted infections chlamydia, gonorrhoea and syphilis. They were also returned negative. Related notes reflect that the child had seen a counsellor earlier in the year for an incident that he described as "*resolved.*" I am satisfied that this incident was in fact the allegation of sexual assault upon the child, referred to below, where harm was substantiated in the course of a departmental inquiry.[420]

647. On 24 August 2013 when the child was 16 years old, he presented to the Emergency Department of the Kununurra District Hospital and he was treated for a laceration and tendon damage to the back of his hand sustained after punching a glass window when intoxicated.[421]

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[415] Exhibit 1.10, Tab 6.
[416] Ibid.
[417] Ibid.
[418] Ibid.
[419] Ibid.
[420] Ibid.
[421] Ibid.

Home environment

648. This child was one of two children from the relationship between his mother and father. His mother also had one child from a previous relationship who was ten years older than him.[422]

649. Sadly there was a significant history of domestic violence between this child's parents. As of February 2012, police had recorded ten reported incidents. Alcohol had featured in these reports with either one or both parties intoxicated.[423]

650. The Department of Child Protection and Family Support first had contact with this child on 25 May 2010 when he was 12 years old. He was one of a group of ten children who had been making a commotion and were found with petrol, either setting light to it, or possibly sniffing it. Though police referred them to the Department of Child Protection and Family Support there is no record of any departmental follow up in response to this referral.[424]

651. On 21 February 2013 a mandatory report alleging sexual abuse of this child by an extra-familial person was reported to the Department of Child Protection and Family Support. He was 15 years old at the time. A child assessment interview was conducted on 8 March 2013 by the Department of Child Protection and Family Support. The child disclosed a harrowing incident of sexual assault involving multiple perpetrators that allegedly occurred after Christmas 2012.[425]

652. In interview the child also disclosed that he had informed his parents of this incident, but that they were intoxicated at the time, and he formed the view that they did not comprehend what he was saying. Sexual harm was substantiated by the Department of Child Protection and Family Support. However, the child maintained that he did not want to make a complaint to the police as he feared reprisals upon himself and his family should he do so.[426]

653. It was considered that the child's maternal aunt would be in a position to care for him. To this end, the Department of Child Protection and Family Support conducted a Signs of Safety mapping on 26 March 2013 with a view to assisting the child's maternal aunt in supporting him. A Safety and Wellbeing

[422] Exhibit 10, Volume 1, Tab 14.
[423] Ibid.
[424] Ibid.
[425] Ibid.
[426] Ibid.

Assessment was completed on 5 April 2013 which included a plan to organise a meeting with the maternal aunt to:

a. persuade her to have the child accept counselling and to discuss how the family can keep him safe from persons of interest;

b. explore the use of restraining orders; and

c. assist the child to disclose the incident to police, so that charges could be considered.[427]

654. However, these actions were not progressed by staff until August 2013, and the plan was not able to be implemented for a variety of reasons.

655. After August 2013 the efforts of the Department of Child Protection and Family Support staff were primarily focussed on securing a boarding school option for this child, with a view to providing him with an opportunity to experience a safe and stable living situation. Shortly before his death, he was due to attend a boarding school in Esperance for the 2104 academic year, and his maternal aunt was named as his guardian.[428]

656. Before that, the option of a boarding school in Queensland had also been considered. The aim was to work towards removing the child from an environment where he may be unsafe, including by reason of the risk of further sexual harm.[429]

657. In the year before his death, the child's living arrangements continued to be shared between different family members at various Aboriginal communities in close proximity to Kununurra (including Mud Springs, Bell Springs and Emu Creek).[430]

658. Over this period the child unfortunately became a regular user of alcohol and prohibited drugs, and his school attendance dropped markedly. Combined with the lack of consistent adult supervision, these factors made him vulnerable to the ongoing risk of abuse.

659. The further details of the events leading up to the child's death appear under the heading *Cause and manner of death.*

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[427] Ibid.
[428] Ibid.
[429] Ibid.
[430] Exhibit 10, Volume 1, Tab 14.

Mental health treatment

660. The Ord Valley Aboriginal Health Service notes for 4 July 2013 reflect that the child had seen a counsellor earlier in the year in connection with an "*incident which he says has resolved.*" He was advised on that date to seek further help if needed. I am satisfied that this review on 4 July 2013 and the related testing (on that same date) for the sexually transmitted infections, arose as a result of the child's disclosure of the incident of sexual harm referred to above in this finding.[431]

661. Through his behaviour, this child had come to the attention of the Youth Justice Services. On 20 September 2013 the East Kimberley Youth Justice Services referred this child to the Kimberley Mental Health and Drug Service in Kununurra, noting that alcohol and drug counselling had been requested by the child himself, as he had accepted that he had an issue with substances. It was also noted that the child was hoping to go to boarding school in the not too distant future, and that he believed this would also assist his attempts to move away from substance use.[432]

662. As a result of this referral to the Kimberley Mental Health and Drug Service, attempts were made to have the child participate in a youth program, namely the "*What Now*" program. Although there were five scheduled program appointments with the Kimberly Community Drug Service team, the child did not attend any of those appointments.[433]

663. There are no records of contact with school psychologists in his education records, referred to immediately below.

School attendance

664. Department of Education records for this child reflect a fragmented school history with generally poor attendance rates, and consequently, poor academic outcomes.[434]

665. The child's early years at Kununurra Primary School show problems with attendance, attention, behaviour and

[431] Exhibit 1.10, Tab 6.
[432] Ibid.
[433] Ibid.
[434] Exhibit 10, Volume 1, Tab 13.

concentration. He was described as a very likeable student, but it was noted that he had limited progress in many areas due to his frequent absences, and his very short attention span.[435]

666. The child was enrolled at Kununurra District High School from 2009 (Year 7) through to 2013 (Year 11). He was also enrolled at Wyndham District High School for one semester in 2011 (Year 8). Overall attendance at high school was generally very poor. His attendance rates ranged from between approximately 35% to 57%, and they were in no way sufficient for any meaningful learning. His school grades were consequently very poor. There are frequent reports detailing disruptive and difficult behaviours.[436]

667. For the one semester at Wyndham District High School, he did achieve an attendance rate of approximately 95%, and it is unfortunate that he did not maintain it. However, his school records over this relatively short period also show frequent Individual Behaviour Reports for disruptive behaviour.[437]

668. Between 2010 and 2012 the child was suspended four times, which included suspensions for physical assault or intimidation of other students. It was noted that he tended to lose his temper quite quickly. There are no notes within the child's school records which suggest he had engaged with a school psychologist.[438]

669. School records between 2009 and 2012 reflect that the child was being cared for by a number of different relatives at various locations in and near Kununurra. This fragmented approach to his care did not assist with his poor attendance rates. In August 2011, when the child was 14 years old, the Deputy Principal of Kununurra District High School recorded that he was operating at around a Year 5 (10 year old) level in all areas.[439]

Family suicides

670. Records reflect that a relative of this child, a young man, was found to have died by suicide in July 2012, approximately one and a half years prior to this child's death.

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[435] Exhibit 10, Volume 1, Tab 13A.
[436] Ibid.
[437] Exhibit 10, Volume 1, Tab 13C.
[438] Exhibit 10, Volume 1, Tab 13A.
[439] Ibid.

671. Another relative of this child died by suicide in August 2015, just over one and a half years after this child's death.

672. This child's cousin, who was with him the night before he died, died by suicide in March 2016, just over two years after this child's death. He was 23 years old at the time of his death and the circumstances were investigated at the Inquest (Case No. 9).

673. The effects of the cumulative trauma occasioned by these deaths, together with the intergenerational trauma borne by the child's community, would be beyond comprehension to many people.

Cause and manner of death

674. In early January 2014, this child was in the care of his maternal aunt and residing with her and her partner at the Mud Springs Community. Within that community he had numerous friends. His mother and members of his extended family also resided in that community, and he had frequent contact with his mother.[440]

675. During the afternoon and night of 7 January 2014, the child was socialising and consuming alcohol with friends and relatives at the Mud Springs Community. In the days prior, he had been observed by his aunt's partner to appear happy.[441]

676. One of the young friends who was drinking with the child on the afternoon of 7 January 2014 also observed him to appear happy and normal. However, a relative of his (who is subsequently the subject of Case 9) reported that on the night of 7 January 2014, the child had spoken of "*doing something silly*".[442]

677. The child's adult next door neighbour had been socialising nearby with his mother, and early that evening she had observed the group of boys putting music on and having some fun. Shortly before retiring for the night, at 8.00 pm on 7January 2014, she heard, but did not observe, the sounds of some boys fighting.[443]

678. The child's mother saw him at approximately 9.00 pm on 7 January 2014. She reported that he was in a good frame of mind, that he was looking forward to moving to Esperance for

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440 Exhibit 10, Volume 1, Tabs 2, 7, 9 and 13.
441 Exhibit 10, Volume 1, Tabs 2 and 9.
442 Exhibit 10, Volume 1, Tab 2.
443 Exhibit 10, Volume 1, Tab 7.

the 2014 academic year, and that he was talking about the future.[444]

679. That is the last sighting of this child. It appears that after this time, the people with whom he had been socialising retired for the night.

680. At approximately 4.30 am on the morning of 8 January 2014, the child's next door neighbour was awoken by the sounds of dogs barking. Upon going outside, alarmingly she saw the child hanging by a ligature that had been affixed to the branch of a tree. She called for assistance and the child's maternal aunt, her partner and her grandson came outside. Together they endeavoured to hold up the child, and they released him from the ligature. They laid him on the ground. He was not breathing and cold to the touch. They checked but could not find a pulse.[445]

681. Records reflect that a member of the Mud Springs community contacted the St John Ambulance service at 4.37 am on 8 January 2014 and that they arrived at the scene at 5.09 am. Kununurra Police were contacted at 4.39 am and they arrived at 4.59 am. The police and the paramedic checked and found no signs of life. The paramedic ascertained that the child remained in asystole and no CPR was conducted. Tragically, the paramedic pronounced the child dead at 5.12 am on 8 January 2014.[446]

682. On 20 January 2014 the forensic pathologist made a post mortem examination at the State Mortuary on the child's body and on that date formed the opinion that the cause of death was ligature compression of the neck (hanging). The forensic pathologist noted the ligature-type marking to the skin of the neck, and he noted some changes which may be seen with asphyxiation due to neck compression. There were no further significant changes, and no evident natural disease.[447]

683. Subsequent toxicological analysis detected alcohol in the blood sample at 0.129% and in the urine sample at 0.201%. Tetrahydrocannabinol was detected in the sample of blood at less than 0.5 ug/L and carboxytetrahydrocannabinol was

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[444] Ibid.
[445] Exhibit 10, Volume 1, Tabs 2, and Tabs 7 to 9.
[446] Exhibit 10, Volume 1, Tabs 2, 4, 11 and 12.
[447] Exhibit 10, Volume 1, Tab 5.

detected in the blood at less than 15ug/L. The forensic pathologist's opinion on cause of death remained unchanged.[448]

684. I have taken account of the forensic pathologist's report and his opinion on the cause of death, the toxicological analysis, and the evidence concerning the circumstances whereby the child was found hanging in the front yard, and specifically the evidence concerning the actual ligature and its placement.

685. **I find that the cause of the child's death in Case No. 6 was ligature compression of the neck (hanging).**

686. As described above, the child was a regular user of alcohol and prohibited drugs prior to his death. He had cannabis in his system and a blood alcohol reading of 0.129% at the time of death. Sexual harm upon him was substantiated in the course of a departmental inquiry a year earlier, when he was 15 years old. The night before his death he had spoken about *"doing something silly"*, which in some Aboriginal communities, correlates with carrying out an act of self-harm. He also had an older half-sibling who died by suicide 18 months earlier, and it is likely that he had some knowledge of some of the circumstances surrounding that death.

687. Between approximately 9.00 pm on 7 January 2014 and 4.30 am on 8 January 2014 the child affixed a ligature to a tree near the front of his home and hanged himself, with the intention of taking his life. It is likely that his level of intoxication contributed to disinhibiting him. I am satisfied that he knew the foreseeable consequence of hanging himself was death, and that he was able to form the requisite intention for this finding. I am satisfied that he acted alone to use the item as a ligature in a manner that resulted in his death.

688. **I find that the manner of the child's death in Case No. 6 was Suicide.**

CASE No. 7

Introduction

689. This male child was born on 18 October 2000 at Kununurra District Hospital and he died at approximately 1.00 pm on 26 September 2014 at the age of 13 years, at Kununurra. At

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[448] Exhibit 10, Volume 1, Tab 6.

the time of his death he was living with his mother and her partner.[449]

690. Unfortunately over numerous periods this child's home life had been disrupted by domestic violence incidents, exacerbated by alcohol abuse. In respect of one such incident, the perpetrator served a prison sentence. Over time, there was consideration given to seeking refuge for the mother and her children, and the Department of Child Protection and Family Support offered financial and practical assistance in this regard.[450]

691. On occasions this child had lived with his maternal grandmother and, when his mother and siblings accessed the refuge, this child remained living with his maternal great aunt. Intermittently, he had a troubled relationship with his mother's partner. He also expressed concerns about the abuse of alcohol by others in his home environment, and its impact upon him.[451]

692. The child had shown a good academic aptitude during his early primary school years, but later his school attendance rate dropped, his grades consequently fell, and he showed signs of aggression, becoming disruptive and threatening in the school environment.[452]

693. Through their lawyers the KCLS, this child's mother and grandmother elected to meet with me in a less formal setting to provide me with their views about the circumstances surrounding their child's death. Counsel were invited to attend. A record of that meeting was made.[453]

694. There was no protection order made in respect of this child under the *Children and Community Services Act* 2004, nor was there any investigation under s 32(1)(d) of that legislation, for the purpose of ascertaining whether the child may be in need of protection.

695. The details appear below.

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[449] Exhibit 1.10, Tab 7.
[450] Exhibit 12, Volume 1, Tab 23.
[451] Exhibit 12, Volume 1, Tabs 9 and 23.
[452] Exhibit 12, Volume 1, Tabs 22 and 23.
[453] Exhibit 12, Volume 1, Tab 31.

Physical health

696. This child's birth weight was normal at 3,520 grams, and shortly after his birth on 18 October 2000 at Kununurra District Hospital he was discharged into the care of his mother. There is no medical record made of his mother having consumed alcohol during the pregnancy.[454]

697. At four months of age the child was admitted overnight to Kununurra District Hospital with gastroenteritis. At the age of 17 months he was admitted for two days to Kununurra District Hospital with respect to an ear infection, and it was recorded that he presented with a failure to thrive. Medical records reflect a poor weight gain over the preceding nine months with his weight below the second percentile. It was also noted that he made good weight gain in hospital.[455]

698. Between 2000 and 2014 the child was seen at the Ord Valley Aboriginal Health Service with conditions including recurrent infected skin sores, anaemia, poor growth, ear infections, respiratory infections and gastroenteritis. The child also required admissions at Kununurra District Hospital for treatment of skin infections and pneumonia. Some instances of treatment at the Ord Valley Aboriginal Health Service appear below.[456]

699. On 3 December 2009, when the child was nine years old, a concerned relative took him for review at the Ord Valley Aboriginal Health Service. A yearly ATSI child health check was performed. The child reported being physically disciplined, and of feeling unsafe in the home when others were intoxicated. The response to the question of whether the child can always get plenty to eat was in the negative. The clinician recorded identified concerns, being "*child neglect*", "*physical abuse*" and "*hearing.*"[457]

700. The clinician performing the yearly ATSI child health check on 3 December 2009 recorded follow up issues through communication with *"school, DCP and visits to mother…."* There are no further notes on the Ord Valley Aboriginal Health Service file that refer to the planned follow up, and there is no evidence

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[454] Exhibit 1.10, Tab 7.
[455] Ibid.
[456] Ibid.
[457] Ibid.

of a referral to the Department of Child Protection and Family Services in relation to the identified concerns.[458]

701. There is no record of child neglect or physical abuse in respect of this child being substantiated by departmental inquiry at the material time. I am however satisfied that the child experienced his home environment as being volatile and it was unsettling for him.

702. A second ATSI child health check was performed at the Ord Valley Aboriginal Health Service approximately one year later, on 8 October 2010. The child was still nine years old, and on this occasion, he was accompanied by his mother. Records reflect that the clinician made a note regarding an audiology review, but there were no social concerns recorded.[459]

703. On 13 August 2014 (six weeks before this child's death) another ATSI child health check was performed at the Ord Valley Aboriginal Health Service. There is no record of an adult carer being present during the check. The clinician recorded that the child was anaemic and underweight (requiring monitoring) but no additional problems were noted. The child was prescribed medication to treat infections and there was a plan to review his anaemia in three months' time. It was noted that monitoring was required in regard to the child's weight. The child denied drug or alcohol use and reported that he was going to school regularly.[460]

704. The responses to questions in a screening tool designed for measuring distress (known as the "Distress Thermometer") were recorded during the ATSI child health check of 13 August 2014. Whilst the child appears to have rated his distress level as *"0"* in the previous week, and answered *"no"* to questions regarding depression, fear, nervousness, sadness, worry and any loss of interest in his usual activities, I am not satisfied that this particular questionnaire is pertinent for an Aboriginal child.[461]

705. Sixteen days before his death, the child presented to the Emergency Department of Kununurra District Hospital with an injury to his leg after it had been crushed between a bull and some railing. No fracture was noted and the wound was cleaned and dressed before he was sent home.[462]

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[458] Ibid.
[459] Ibid.
[460] Exhibit 1.10, Tab 7; Exhibit 12, Volume 1, Tab 21.
[461] Ibid.
[462] Exhibit 1.10, Tab 7.

Home environment

706. The child lived primarily in his mother's household, and had one sibling and three half-siblings.[463]

707. In the early years of his life, his home environment was marred by numerous incidents of domestic violence, though these did not involve the children. Legal proceedings ensued after one such incident. The family had come to the attention of the Department of Child Protection and Family Support over a number of years. Records reflect requests for financial assistance and/or family support between 1996 and 1999, and 2003, 2013 and 2014.[464]

708. The child's mother separated from the father and commenced a de facto relationship. Department of Child Protection and Family Support records reflect a significant history of domestic violence in this subsequent relationship, between 2007 and 2013. The child was aged between seven and 13 years over this period.[465]

709. On 9 March 2011 the Kununurra Womens' Refuge Centre co-ordinator advised Department of Child Protection and Family Support that the child's mother and her three children to her de facto partner had been in the refuge since 28 February 2011. At the mother's request, the Department of Child Protection and Family Support provided approval for flights for her and her children, to leave Kununurra for a refuge in another location. This child was residing with his maternal great aunt in Kununurra, and it was not proposed that he be relocated along with his mother and half-siblings. He was then 10 years old.[466]

710. There is no record of this relocation occurring. It is not known whether the mother and her children from her de facto partner relocated to the other location as planned, because further incidents placed them back in Kununurra by 14 September 2011.[467]

711. Though the Department of Child Protection and Family Support had significant involvement with the child's mother and her two partners, it was primarily within the context of domestic

[463] Exhibit 12, Volume 1, Tab 2.
[464] Exhibit 12, Volume 1, Tab 23.
[465] Ibid.
[466] Ibid.
[467] Ibid.

violence. There was a minimal reference to the child in this department's records. The child is mentioned in five domestic violence incidents, and records indicate that he was in attendance at two of these incidents.[468]

712. The records of the Department of Child Protection and Family Support also reflect that this child was not known to frequent the streets unsupervised or engage in risk taking behaviour.[469]

Mental health treatment

713. There is no evidence that this child had expressed an intention to self-harm or suicide. Nor is there any evidence of him attempting to do so. There was no record of him accessing any mental health or counselling services. Following his disengagement from school during the first year of his high school, in 2014 he was encouraged to see the school psychologist but the records reflect that he did not do so.[470]

School attendance

714. This child's school attendance during his early primary school years was variable, at between 70% and 80%. The attendance rate for semester 1 of 2011 (Year 5) was better, at approximately 90%, but this was followed by a marked decline from semester 2 of the 2011 year. Afterwards it is variable, showing a marked downward trend in attendance rates from the semester 2 of 2013 (Year 7).[471]

715. The child's Year 5 teacher reported that he was "….*a very, very capable student*…." and noted his potential in the academic area. NAPLAN results for Year 7 showed that he achieved the national minimum standard for numeracy, reading, writing, punctuation and grammar and above the minimum standard for spelling. However, by his final year of primary school in 2013 there was a dramatic decline in his school results consistent with his poor attendance record.[472]

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[468] Ibid.
[469] Ibid.
[470] Exhibit 12, Volume 1, Tab 22B.
[471] Ibid.
[472] Ibid.

716. In 2014, the child's first year of high school (Year 8), his attendance rate was so poor that he was *"not assessed"* in most subjects due to non-attendance and/or failure to participate in class. During this time, his behaviour at school worsened and he became disruptive. By semester 2 of 2014, his attendance rate had fallen to approximately 38%.[473]

717. Between 2010 and 2014 the child was suspended from school on ten occasions. The bulk of those suspensions were for physical assaults or intimidation of other students or teaching staff. The school became aware that on a number of such occasions, the child did not wish to return to his home.[474]

718. Following disengagement in his first year of high school in 2014, attempts were made by the school to have the child see the school psychologist and engage with the Clontarf Academy program (namely the KELS program designed for students with low attendance). School teachers held a meeting with his mother, grandmother with the aim of addressing the child's non-attendance. His mother did not wish him to attend Clontarf. It was ascertained that the child was not prepared to engage with psychological services or Clontarf. The mother elected not to accept an offer of parent support.[475]

719. At this meeting, discussion was had about the child remaining out at night and his association with the *"wrong crowd"*, which was unusual for him. It was arranged that the child would live with his uncles on a remote station at another location. However, this arrangement did not last long, because he absconded from their care when he returned to Kununurra for an agricultural show. Records reflect ongoing efforts by the school to offer parent support.[476]

Cause and manner of death

720. On the evening of 25 September 2014, with his mother's permission, this child had intended to stay at a friend's house. However, at approximately 10.00 pm that night, he changed his mind and decided to return home. He went to his grandmother's house and from there arrangements were made for his mother's

[473] Ibid.
[474] Exhibit 12, Volume 1, Tabs 22A, 22B and 22C; ts 981 to 982.
[475] Exhibit 12, Volume 1, Tab 22B and Tab 31; ts 977 to 980.
[476] Exhibit 12, Volume 1, Tab 23.

partner to collect him. His mother's partner observed him to appear happy and untroubled.[477]

721. The next morning, 26 September 2014, together with his mother, her partner and their children, this child went to the local school to see a student performance. He was described as being his normal self and that he was not upset or angry. Whilst at the school, he approached a relative (who was employed as a school based attendance officer). He asked her for permission to come along for a ride if she was going to collect other children for school. Being the last day of term, this relative did not need to collect any children and she informed him of this. He sat in the staff office and did some colouring in.[478]

722. Just after 10.00 am on 26 September 2014, the family were leaving the school. As the child walked with his family back to their car the Deputy Principal greeted him and asked if he was returning back to school next term, telling him it would be great to see him. The Deputy Principal recalled that the child's demeanour was that of a typical teenager, that he appeared normal, a little shy, but that he did not seem solemn or depressed.[479]

723. Initially, the child did not get into the car with his family, but simply kept walking away. He eventually got into the car when it stopped next to him. His mother noted that he seemed grumpy and when he was asked what he wanted to do he stated that he wanted to go home. He was then dropped off at his home and he was left there by himself. It was normal for him to stay at home alone and play on his X-box computer game.[480]

724. The family went into town to conduct various activities. When they returned home at approximately midday, his mother looked for him. Horrifyingly, she found him hanging in an area of one of the bedrooms. He had used an item of clothing as a ligature and affixed it to a structure in the bedroom, that he used as a suspension point. The mother raised the alarm and together with her partner, who came running in response to her screams, they released the child from the ligature.[481]

725. Contractors working nearby responded to the cries for help, called the emergency services and came into the home to assist

[477] Exhibit 12, Volume 1, Tabs 2, 7 and 8.
[478] Ibid.
[479] ts 985.
[480] Exhibit 12, Volume 1, Tabs 7 and 8.
[481] ts 985 to 985.

with the resuscitation. One of the contractors checked and could not feel a pulse and commenced to perform CPR on the child, pending the arrival of the ambulance.[482]

726. Records reflect that the St John Ambulance Service received a call at 12.16 pm on 26 September 2014 and that the paramedics arrived at the scene at 12.25 pm, followed directly by the police. Upon arrival the paramedics took over the CPR and conveyed the child to hospital, where resuscitation attempts continued.[483]

727. The District Medical Officer reported that there were no signs of life detected in the child's body, the pupils were dilated and not reacting, there was no heart sound and no carotid pulse. Due to these findings, resuscitation attempts were ceased and the child was tragically pronounced dead at 1.00 pm on 26 September 2014.[484]

728. On 7 October 2014 the forensic pathologist made a post-mortem examination at the State Mortuary on the child's body and on that date formed the opinion that the cause of death was ligature compression of the neck (hanging). The forensic pathologist noted a ligature mark to the neck that was felt to be consistent with the presumed ligature provided. He noted a small area of abrasion to the right side of the chest, but no other evidence of significant recent injury. There was no evidence of natural disease.[485]

729. Subsequent toxicological analysis showed a low level of alcohol within urine (0.014%), but no alcohol in the blood. It does not establish that he consumed alcohol before his death. There was a low level of paracetamol within the blood (less than 1 mg/L). Other common drugs were not detected. The forensic pathologist's opinion on cause of death remained unchanged.[486]

730. I have taken account of the forensic pathologist's report and his opinion on the cause of death, the toxicological analysis, and the evidence of the circumstances whereby the child was found hanging in the bedroom, and evidence concerning the ligature and its actual placement.

731. **I find that the cause of the child's death in Case No. 7 was ligature compression of the neck (hanging).**

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[482] Exhibit 12, Volume 1, Tabs 11 and 11A.
[483] Exhibit 12, Volume 1, Tabs 12 to 15 and Tab 18.
[484] Exhibit 12, Volume 1, Tabs 4 and 20.
[485] Exhibit 12, Volume 1, Tab 5.
[486] Exhibit 12, Volume 1, Tabs 5 and 6.

732. This child died just under one month before his 14th birthday. There is no evidence that he ever expressed an intention to self-harm. He did not have a history of consuming alcohol or taking drugs. He lived in his mother's household, and he had a close relationship with his grandmother, which are to be regarded as protective factors.

733. Evidence at the Inquest from the Deputy Principal of the child's high school at the material time raised a question as to whether this child intended to take his life.

734. In 2014, the school became aware, through the local community, that a student within this child's peer group was engaging in highly dangerous behaviour that was, alarmingly, considered by the children to be a game. It was during a period prior to this child's death. The Deputy Principal's evidence was that the school was concerned that other students within his peer group may also be trialling and attempting the same thing. He had no direct knowledge of this child engaging in this behaviour. The school made a critical incident report to the district office and took some other measures. The Chief Psychiatrist gave evidence about the dangers of this behaviour, and the unintended risk of death.[487]

735. I have made a non-publication order under s 49(1)(b) of the Coroners Act of the evidence concerning the practicing by children of this dangerous behaviour which is under no circumstances to be considered to be a "*game*" (nor did the Deputy Principal refer to it as such, though that reference was made). It will be referred to in the below analysis as the "*dangerous behaviour.*"[488]

736. On 26 September 2014 shortly before midday, the child affixed an item of clothing, that he used as a ligature, to a structure in a bedroom of his home and hanged himself. I am satisfied that he acted on his own.

737. In terms of the manner of death, two possible verdicts are equally open:

a. If, immediately before death, it is likely that the child had engaged in the dangerous behaviour referred to above, it would be open for me to find that his death was by way of misadventure, because he would not have had an intention to take his life, and he may not

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[487] ts 988 to 990.

[488] ts 988 to 990, ts 1644; Exhibit 12, Volume 1, Tab 31.

have foreseen that the consequence of his actions was likely to be his death. Evidence that supports this includes the suspected activities of his peer group, and the fact that he had not evinced a prior intention to self-harm either by word or action;

b. If, immediately before death, it is likely that the child had not engaged in this dangerous behaviour, then taking account of all of the surrounding circumstances, the only reasonable inference would be that he acted with an intention to take his life, and it would be open for me to find that his death was by way of suicide.

738. The evidence does not adequately disclose the means by which the death occurred. There is not enough evidence to satisfy either verdict on the balance of probabilities. In the circumstances, **I make an Open Finding as to the manner of the child's death in Case No. 7.**

739. Through their lawyers the KCLS, this child's mother and carer submitted to me that I make an adverse finding against the child's high school, for not speaking to the child and his mother about the risks of the suspected dangerous behaviour, with a view to possibly averting the death.

740. At the Inquest, the Chief Psychiatrist, who had consulted with child and adolescent psychiatrists regarding this dangerous behaviour, spoke of the importance of engaging with children at their level and identifying the things that are likely to influence their views, to mitigate the risks. The Chief Psychiatrist opined that such an approach is preferable to avoiding the issue for fear that discussion itself may introduce the concept of the dangerous behaviour.[489]

741. With the benefit of hindsight, and having regard to the expertise of the Chief Psychiatrist, a more proactive approach on the part of the school could have been justified, but any suggestion that it would have averted this tragic death is speculation. On all of the evidence and in light of my finding on the manner of death, I do not make any adverse comment concerning the child's high school.

[489] ts 1644 to 1648.

CASE No. 8

Introduction

742. This male child was born on 18 September 1997 at Kununurra District Hospital and he died at approximately 11.40 pm on 12 December 2014 at the age of 17 years at Kununurra. At the time of his death he was living with his aunt and other members of his extended family. His girlfriend often stayed at the same address.[490]

743. Sadly, the child's mother had not been able to look after him for many years due to her longstanding and severe alcohol abuse. His first informal placement into the care of a community member occurred when he was just five months old.[491]

744. Over the years the child lived intermittently with his mother, his father, his paternal grandmother, community caregivers, and other members of his extended family. Numerous child protection concerns were raised with the Department of Child Protection and Family Support.[492]

745. By reason of these informal care arrangements, he moved between Kununurra, Halls Creek and Broome.

746. Through her lawyers the KCLS, the child's aunt (with whom he was residing at the time of his death) elected not to give evidence at the Inquest and having regard to the information already before me and the circumstances attending the death, no compulsions were issued.[493]

747. There was no protection order made under the *Children and Community Services Act* 2004. Investigations under s 32(1)(d) of this legislation conducted for the purpose of ascertaining whether the child may be in need of protection resulted in neglect being substantiated on one occasion, and on the other occasion, the alleged physical harm was not substantiated.

748. The details appear below.

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[490] Exhibit 1.10, Tab 8; Exhibit 13, Tab 2.
[491] Exhibit 13, Volume 1, Tab 14.
[492] Ibid.
[493] ts 8 to 10; ts 369; ts 803 to 807.

Physical health

749. This child was born prematurely at 34 weeks with a low birth weight of 2,345 grams, on 18 September 1997 at Kununurra District Hospital. There were no maternal concerns noted and he was discharged into the care of his mother after seven days, after gaining some weight in hospital. There is no record made of his mother having consumed alcohol during her pregnancy.[494]

750. Unfortunately, the child's health remained poor and when he was reviewed as a toddler, clinicians expressed their concerns that he was grossly underweight. Between 17 and 26 February 1999 when the child was approximately 17 months old, he was admitted to Kununurra District Hospital, with a diagnosis of gross failure to thrive with gastroenteritis and vomiting. The child was found to have not put on any weight for seven months. Concern was also raised (sadly not for the first time) about the mother's alcohol intake.[495]

751. Subsequent hospital attendances as a child included treatment for a number of respiratory infections, and alcohol intoxication at age 14 and again at age 16 (on this latter occasion with a very high blood alcohol level of 0.236%). Medical records dated 4 October 2012 reflect that the Department of Child Protection and Family Support was notified in connection with the child's "*underage drinking/dangerous drinking*" behaviour. The department's response is addressed in the below section.[496]

752. Other medical treatments indicate that the child was sexually active by the age of 16 years.[497]

Home environment

753. This child was the oldest of three children born to his mother.[498]

754. The Department of Child Protection and Family Support had involvement with this family in connection with child protection concerns from 1998 to 2008. These concerns related to the child

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494 Exhibit 1.10, Tab 8.
495 Ibid.
496 Ibid
497 Ibid.
498 Exhibit 13, Volume 1, Tab 14.

being unattended to by his caregivers, primarily his mother, during the early years of his life.[499]

755. When aged just five months in February 1998, the Department of Child Protection and Family Support Crisis Care unit was contacted by Kununurra Police at 10.30 pm one night requesting that a placement be found for him as his parents were inebriated and he had apparently been left in his pram at a park. By informal arrangement, he was placed with a community caregiver. This was one of many occasions in which he had apparently been left unattended.[500]

756. Following the child's admission to Kununurra District Hospital in February 1999, at the age of 17 months and weighing just seven kilograms, a clinician from a medical service reported a child protection concern. In discussion with the clinician, the Department of Child Protection and Family Support decided not to undertake further investigation, pending other medical diagnoses being ruled out for the lack of weight gain.[501]

757. A joint home visit in Kununurra by the Department of Child Protection and Family Support and a staff member of a clinical service was undertaken on 28 April 1999 and the child was sighted and recorded to be a slim baby, but looking healthy. However, by 14 May 1999 the Department of Child Protection and Family Support received a referral from a clinician at another medical service advising that the child showed clinical signs of malnutrition, which unchecked can lead to cognitive impairment.[502]

758. A later home visit by the Department of Child Protection and Family Support on 24 May 1999 recorded that the child was sighted and reported to be healthy, lively and responsive to his mother. The department continued to be involved in monitoring the child's growth and development throughout 1999. Whilst his weight gradually increased, the community health worker reported that the mother was not at home on the occasions that she visited.[503]

759. In December 1999, the child's mother reported that he had gone to stay with his paternal grandmother in Halls Creek in early November 1999. He continued to reside with his paternal

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[499] Ibid.
[500] Ibid.
[501] Ibid.
[502] Ibid.
[503] Ibid.

grandmother throughout 2000 and 2001, and intermittently with his mother.[504]

760. There are records of financial support from the Department of Child Protection and Family Support to the child's mother between 1998 and 2011.[505]

761. Between 2000 and 2011, there were no reported child protection concerns involving this child, save for an instance in October 2000. On this occasion, the Department of Child Protection and Family Support substantiated neglect in respect of this child after he and a sibling were placed in the department's care for one evening in Broome following a report from police related to the child's mother. As a consequence, by informal family arrangement, the child was again placed into the care of his paternal grandmother, in Halls Creek.[506]

762. From 2010 to 2015 the Department of Child Protection and Family Support had sporadic contact with the child's mother in relation to other matters concerning the family. Sadly the mother's household environment was marred by family and domestic violence incidents. This child was not sighted at his mother's household during these contacts. It is known that, in addition to living for periods with his mother in various locations, and his paternal grandmother in Halls Creek, he also lived with a community caregiver in Broome.[507]

763. On 4 November 2011, when the child was 14 years old, police conveyed him to the Department of Child Protection and Family Support's Broome Office because he disclosed to them that his community caregiver had hit him on numerous occasions. By this stage he had been in the care of this community care giver for the previous four years. He stated he wanted to return to Kununurra to live with his parents.[508]

764. A Safety and Wellbeing Assessment Report was completed as a result of this disclosure. Physical abuse was not substantiated. However, after the Department of Child Protection and Family Support consulted with his father, the child was returned to Kununurra on 11 November 2011 to reside with his uncles. It was

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[504] Ibid.
[505] Ibid.
[506] Ibid.
[507] Ibid.
[508] Ibid.

later ascertained that he was also residing with his paternal grandmother, and the arrangement appeared satisfactory.[509]

765. On 4 August 2012 the Department of Child Protection and Family Support Crisis Care unit was contacted by the Kununurra District Hospital advising that the child was brought into the hospital by an aunt the previous night intoxicated with alcohol and marijuana. He was 14 years and 11 months old at the time. He had then left the hospital without being formally discharged, and could not be located.[510]

766. In response, the Department of Child Protection and Family Support suggested that the hospital contact police and/or family members, and the hospital was advised to recontact the department if further assistance was required.[511]

767. It is clear that by this time the child's life was spiralling out of control. Given the many placements during his growing years, he had no consistent guidance from a parental figure. He was lacking in boundaries and vulnerable to risk-taking behaviours.

Mental health treatment

768. There is no record of this child participating in any mental health or counselling services.

769. Notwithstanding the child's expressed intention to hang himself on the two days before his death (described in more detail under the heading *Cause and manner of death* below) the child did not seek, nor did anyone else refer him to, any mental health or counselling services.[512]

School attendance

770. The child was enrolled at five different schools between 2005 and 2013, moving between Kununurra, Halls Creek, Broome and then back to Halls Creek, with the last recorded enrolment being in May 2013. There are no records of the child having attended school after May 2013. The Department of Education records reflect

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509 Ibid.
510 Ibid.
511 Ibid.
512 Exhibit 1.10, Tab 8; Exhibit 13, Volume 1, Tab 10.

significant gaps in his enrolments. When the child was enrolled, his attendance rates averaged between 61% and 81%.[513]

771. His poor attendance rates were reflected in his academic outcomes. Results of his 2010 NAPLAN (Year 7) showed he was below the minimum standard in all subjects. His school reports between 2008 and 2011 show similar educational outcomes.[514]

772. The child was suspended on seven occasions between Years 5 and 8 for incidents including physical assault and intimidation of other students and violation of the school's code of conduct.[515]

Cause and manner of death

773. In the week before his death, the child appeared intermittently unhappy and he told his partner and, separately, a family member that he wanted to take his life. They both tried to comfort him as best they could. Two days prior to his death, and again one day prior to his death, he was observed by his partner to have taken a rope and stated that he wanted to hang himself. On both occasions the rope was taken from him before he could act on his stated intention. On the first occasion that the rope was taken from him, he was especially upset and he spoke of being distressed about some family members, but he did not elaborate.[516]

774. The child's behaviours referred to above were not brought to the attention of medical personnel or the police at the time that they happened. Unfortunately, it is unlikely that the persons involved would have known who to turn to for help, when the child expressed his intention to take his life.[517]

775. On the day of his death, 12 December 2014, the child again appeared intermittently upset for reasons that remain unknown. He was observed to have been drinking alcohol during the day, in company. In the afternoon, he returned to the home that he shared with members of his extended family, accompanied by his partner. He interacted with the occupants, on a convivial basis, and he slept for a period of time.[518]

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[513] Exhibit 13, Volume 1, Tab 13.
[514] Ibid.
[515] Ibid.
[516] Exhibit 13, Volume 1, Tabs 2, 7 and 8.
[517] Ibid.
[518] Ibid.

776. The child and his partner left the house at approximately 8.00 pm or 9.00 pm, on an errand. The child later returned home on his own, with his partner following later that night. There is no reason to suspect that they argued.[519]

777. At approximately 10.15 pm one of the occupants of the house, a member of the deceased's family, awoke, intending to go out. As he was preparing to do so, alarmingly he saw the child hanging by a ligature from an outside structure at the rear of the house. He yelled for help and ran to the child. Another family member responded to the calls for help and together they released the child from the ligature. The occupants contacted the emergency services.[520]

778. Police arrived and found the child to be unresponsive and they commenced performing CPR. Records reflect that at 10.45 pm the St John Ambulance Service was called and that they arrived at the scene within 10 minutes. Upon arrival they took over the resuscitation. Paramedics observed that the child had no signs of life, no breathing and no pulse. They continued CPR and conveyed the child to Kununurra District Hospital, where attempts to resuscitate him continued. Tragically the resuscitation attempts were unsuccessful and the child was pronounced dead at the hospital at 11.40 pm on 12 December 2014.[521]

779. On 18 December 2014 the forensic pathologists made a post-mortem examination at the State Mortuary on the child's body and on that date formed the opinion that the cause of death was ligature compression of the neck (hanging). The forensic pathologists noted that the examination showed a ligature mark around the neck consistent with the ligature provided. They found no evidence of internal injury or natural disease.[522]

780. Subsequent toxicological analysis showed the presence of alcohol in a blood sample (0.044%) and in the urine (0.067%). Tetrahydrocannabinol in the blood was detected at a level of 5.8 ug/L, indicating the presence of cannabis at a potentially intoxicating level. The forensic pathologists' opinion on cause of death remained unchanged.[523]

781. I have taken account of the forensic pathologists' report and their opinion on cause of death, the toxicological analysis, and the

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[519] Exhibit 13, Volume 1, Tabs 2 and 7.
[520] Exhibit 13, Volume 1, Tabs 8 and 9.
[521] Exhibit 13, Volume 1, Tabs 2, 4, 11 and 12.
[522] Exhibit 13, Volume 1, Tab 5.
[523] Exhibit 13, Volume 1, Tabs 5 and 6.

evidence concerning the circumstances whereby the child was found hanging at the rear of the house, and specifically the evidence concerning the actual ligature and its placement.

782. **I find that the cause of the child's death in Case No. 8 was ligature compression of the neck (hanging).**

783. As described above the child had previously expressed an intention to die by hanging, in the days before his death. I am satisfied that he knew the foreseeable consequence of hanging himself to be death.

784. On the night of 12 December 2014 between approximately 9.00 pm and 10.15 pm, this child affixed a ligature to a structure at the rear of his home, and hanged himself, with the intention of taking his life. It is likely that his level of intoxication contributed to disinhibiting him, and I am satisfied that he was able to form the requisite intention for this finding. I am satisfied that he acted on his own.

785. **I find that the manner of the child's death in Case No. 8 was Suicide.**

CASE No. 9

Introduction

786. This young man was born on 11 March 1993 at Kununurra District Hospital and he died at approximately 1.00 am on 24 March 2016 at the age of 23 years at Mud Springs Aboriginal Community, near Kununurra. At the time of his death he was residing with his paternal aunt at Bell Springs Aboriginal Community, near Kununurra.[524]

787. The young man came into the care of his paternal aunt after his father died in 1997, when he was three or four years old, and she continued to care for him throughout his life.[525]

788. Tragically, this young man had endured the trauma occasioned by the deaths of a number of persons within his family.

789. The circumstances of those deaths (referred to in more detail under the heading *Family suicides* below) caused this young man

[524] Exhibit 1.10, Tab 9.
[525] Exhibit 11, Tab 7.

to experience ongoing and unresolved grief and distress, elevating his own risk of self-harm.

790. Through her lawyers the KCLS, the child's carer (and paternal aunt) elected not to give evidence at the Inquest and having regard to the information already before me (including a statement made by her close to the time of the young man's death) and the circumstance attending the death, no compulsions were issued.[526]

791. The details appear below.

Physical health

792. The young man was born on 11 March 1993 at Kununurra District Hospital. His birth weight was normal at 2,925 grams. There is no medical record made of his mother having consumed alcohol during the pregnancy, and there were no concerns noted.[527]

793. As a child, he was treated at Kununurra District Hospital for chest infections, bronchitis and pneumonia. At the age of 12 years (in March 2005) he had surgery at Kununurra District Hospital for a bone infection in his right knee joint. At the age of 20 years (in June 2013) he had surgery at the Royal Darwin Hospital after badly lacerating his left thumb with a knife, accidentally, when he was cutting meat.[528]

794. Hospital admission notes in 2014 and 2015 indicate that this young man was drinking alcohol to excess over these periods, and that it was impacting on his health and wellbeing.[529]

Home environment

795. Initially, as a child he lived with his mother at Emu Creek Aboriginal Community. His father sadly died in 1997. After that, from when he was about four years old, he was primarily looked after by his paternal aunt, who lived at Bell Springs Aboriginal Community.[530]

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[526] ts 8 to 10; ts 369; ts 803 to 807; Exhibit 11, Volume 1, Tab 7.
[527] Exhibit 1.10, Tab 9.
[528] Ibid.
[529] Ibid.
[530] Exhibit 11, Volume 1, Tab 7.

796. His paternal aunt informed the Court that for about 10 years, there had been a number of deaths in the family, and that this had always played on the young man's mind. She observed that it was his nature to keep quiet and hold everything in. As a young man he was known to stay in the Bell Springs Aboriginal community most of the time and he did not leave very often.[531]

797. The young man had intermittently expressed his sadness to his paternal aunt and, disturbingly, he used to tell her that he was going to hang himself one day. She had formed the view that he suffered from depression.[532]

798. His paternal aunt also informed the Court that the young man was especially troubled by the loss of five of his family members in the previous five years. A number of these tragic deaths that occurred by way of suicide are referenced below under the headings *Mental health treatment* and *Family suicides.*[533]

Mental health treatment

799. In July 2012 a relative of this young man had died by suicide (hanging) at the age of 28 years, and he was greatly upset by it. Approximately one month after his relative's death, when he was 19 years old, the young man presented to the Emergency Department of the Kununurra District Hospital in a state of distress and underwent the Kimberley Mental Health and Drug Service's full mental health assessment.

800. Later that same year (on 29 August 2012), the young man again presented to the Emergency Department of the Kununurra District Hospital displaying characteristics of body dysmorphic syndrome. During his presentation it was also noted that the young man had delusions that his family was against him, and it was recorded that his cousin had recently died by suicide, but that the young man himself denied suicidal thoughts. He was referred to the North West Mental Health Service. The young man was promptly seen by the Kimberley Mental Health and Drug Service triage officer that same day (29 August 2012).[534]

801. The next day (30 August 2012) the Kimberley Mental Health and Drug Service triage officer and a senior Aboriginal Mental Health Worker visited the young man at his home in Bells Springs

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[531] Exhibit 11, Volume 1, Tabs 6 and 7.
[532] Exhibit 11, Volume 1, Tabs 6 and 7.
[533] Exhibit 11, Volume 1, Tab 6.
[534] Exhibit 1.10, Tab 9.

Aboriginal Community and performed a full mental health assessment. Their preliminary formulation indicated that the young man presented with features of an anxiety disorder characterised by preoccupation with physical abnormality and illness. He had a history of cannabis and alcohol use, but no history of psychiatric disorder or self-harming behaviour.[535]

802. In their assessment the clinicians noted that there was a family history of suicide, and that the young man expressed high levels of distress. It was also noted that he did not express suicidal ideas and had no plan or intent in that regard. It was seen that he had strong family support. The initial management plan was to encourage the young man to engage with the Kimberley Mental Health and Drug Service, to arrange a review with the visiting psychiatrist and to monitor risks. He was also encouraged to engage in employment training opportunities. Ultimately no risk factors were identified by the Kimberley Mental Health and Drug Service.[536]

803. After a number of further unsuccessful attempts to contact the young man, and several missed appointments with the psychiatrist, on 11 October 2012 the Kimberley Mental Health and Drug Service triage officer collected him from his home and conveyed him to his re-scheduled appointment with the psychiatrist. Following review, the Consultant Psychiatrist noted that a relative of the young man had recently died by suicide, but that the young man did not display any clear psychotic symptoms and denied thoughts of suicide. The young man was a "*worrier*" but there were no obvious features of generalised anxiety disorder.[537]

804. As part of that review on 11 October 2012, the Consultant Psychiatrist felt that the young man's most likely diagnosis was of an anxiety spectrum disorder, or alternatively an adjustment disorder with anxiety symptoms. The Consultant Psychiatrist considered that a latent psychotic disorder was unlikely, and that the young man's risk to self and others appeared low.[538]

805. As part of the Consultant Psychiatrist's management plan for the young man, he was to be followed up in the community by the Kimberley Mental Health and Drug Service clinician, and

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535 Ibid.
536 Ibid.
537 Ibid.
538 Ibid.

encouraged to avoid cannabis exposure as he was likely to have a "*vulnerable brain.*"[539]

806. After a number of unsuccessful attempts to follow up the young man, the Kimberley Mental Health and Drug Service clinician was able to visit him at his home on 2 November 2012, and it appeared he had improved. The Kimberley Mental Health and Drug Service made further contact with the young man on occasions between November 2012 and January 2013, with offers of counselling for his anxiety and drug and alcohol issues, and for support in his dealings with Centrelink and employment options. The young man chose not to engage with these offers, and felt that he no longer needed to have support from mental health clinicians. After checking on the young man's state with a relative, the Kimberley Mental Health and Drug Service discharged the young man from their service on 14 January 2013.[540]

807. In January 2014, another relative of this young man tragically died by suicide (hanging) at the age of 16 years (this child is the subject of Case No. 6 referred to above). Later that year, in October 2014, a concerned relative referred this young man to the Ord Valley Aboriginal Health Service, because it was felt that he was a "*suicidal risk.*"[541]

808. Records reflect that the young man was located and seen by a mental health team member from the Ord Valley Aboriginal Health Service on 8 October 2014. The notes from that consultation record that the young man was feeling very low the week his relative died by suicide and that the thought of suicide did enter his mind. However, it is also recorded that he denied any suicide plans or thoughts at that consult. There were no symptoms of depression observed during that consult, though the young man did say he was feeling sad.[542]

809. The Ord Valley Aboriginal Health Service clinician noted that there were elements of guilt apparent as the young man had mentioned several times he had tried to take care of his relative. It is known that the young man was with this relative, who was just 16 years old (and who is the subject of Case No. 6) the night before he died.[543]

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[539] Ibid.
[540] Ibid.
[541] Exhibit 11, Volume 1, Tab 16.
[542] Ibid.
[543] Ibid.

810. The Ord Valley Aboriginal Health Service records reflect that grief counselling commenced on that day together with some motivational counselling. They discussed how regular meetings with him and other young males would help. The young man volunteered to attend for counselling the next week when he was to be in town. It was noted that the young man appeared to be motivated to address his personal issues and the clinician felt there was no reason to be concerned at the time of the meeting. It was noted that *"a regular contact will be maintained."* However, there are no notes from the Ord Valley Aboriginal Health Service relating to any further contact occurring.[544]

811. The Ord Valley Aboriginal Health Service also informed the Court that on 8 October 2014, the young man was urgently referred to that service's Social Support Unit. A primary (though not exclusive) focus of the Social Support Unit is in supporting people with issues related to alcohol and/or other drugs. The clinician's notes recorded the fact of the young man's alcohol consumption and cannabis use, and noted that he was "*happy for referral to quit smoking team.*" There are no records of further treatment or engagement with the young man and this service.[545]

School attendance

812. As a child, he was enrolled at Kununurra District High School, with some time also spent at Fitzroy Valley District High School. His school attendance rate as a youngster averaged 76% (Year 4, in 2003) but thereafter it declined markedly and by upper high school (after Year 9, in 2008) it often fell below 50%. Towards the end of his schooling, it averaged around 13% (Year 10 in 2009).[546]

813. As a consequence of his poor attendance rate, his academic performance throughout his schooling was also poor, with many subjects not being assessed due to school absences.[547]

814. Behavioural reports reflect that he frequently displayed physical aggression towards students, and his negative behaviours included abuse, threats, harassment or intimidation of teaching staff. He was suspended on numerous occasions. There had been attempts to re-engage him by acknowledging good behaviours and endeavours, and individual behaviour management plans

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[544] Ibid.
[545] Ibid.
[546] Exhibit 1.10, Tab 9.
[547] Ibid.

designed to be supportive. Sadly he remained substantially disengaged from school, thereby missing out on an early protective factor.[548]

Family suicides

815. As outlined above this young man was socialising with the child referred to in Case No. 6, who died by suicide at the age of 16 years, on the night before his death. He had heard that child talking about "*doing something silly*" which, as I have said previously, has come to be associated with carrying out an act of self-harm in some Aboriginal communities. He was undoubtedly grief-stricken to have learnt that that child had died so shortly afterwards (on 8 January 2014).[549]

816. Another relative had died by suicide just under four years prior to this young man's death (in July 2012), and another relative died by suicide in the year prior to his death (in August 2015). The young man was close to his relatives and greatly disturbed by their deaths.[550]

817. As I have already indicated (in respect of the child in Case No. 6) the effects of the cumulative trauma occasioned by these deaths, together with the intergenerational trauma borne by the young man's community, would be beyond comprehension to many people.

Cause and manner of death

818. On 23 March 2016, being the day before his death, the young man was listening to music and consuming alcohol with some of his family members in the outside area of a relative's house at the Mud Springs Aboriginal Community. He was observed to appear happy and not to be acting out of the ordinary.[551]

819. Towards midnight, most of his relatives had retired for the night. The last person to see him alive was one of his cousins who had been socialising with him. She went inside for the night at approximately 11.50 pm on 23 March 2016, and at this point, the

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[548] Ibid.
[549] Exhibit 10, Volume 1, Tab 2.
[550] Exhibit 11, Volume 1, Tab 7.
[551] Exhibit 11, Volume 1, Tab 6.

young man was the only person left outside, listening to the music.[552]

820. Ten minutes later at approximately midnight his cousin came back outside and shockingly, she saw the young man hanging by a ligature that had been affixed to an outside structure at the front of the house.[553]

821. She raised the alarm and proceeded to release the young man from the ligature. It appears that relatives commenced to perform CPR on the young man, but were unable to continue.[554]

822. Records reflect that at 12.21 am on 24 March 2016, the St John Ambulance Service received a call, and that they arrived at the scene at 12.52 am. Whilst the paramedics were on their way, at 12.45 am on 24 March 2016 police arrived at the scene and they commenced to perform CPR on the young man. Paramedics took over the resuscitation efforts when they arrived.[555]

823. The paramedics observed that the young man's pupils were dilated and non-reactive, and that he was in asystole during the resuscitation. There were no signs of life and the young man was tragically pronounced dead by the paramedic at the scene at 1.02 am on 24 March 2016.[556]

824. On 5 April 2016 the forensic pathologist made a post-mortem examination at the State Mortuary on the young man's body and on that date formed the opinion that the cause of death was ligature compression of the neck (hanging). The forensic pathologist noted the ligature mark to the neck, and the ligature was provided to him. The forensic pathologist noted that there was no other evidence of significant injury or significant natural disease.[557]

825. Subsequent toxicological analysis showed a blood alcohol level of 0.280% and a urine alcohol level of 0.40%. Other common drugs were not detected. The forensic pathologist's opinion on cause of death remained unchanged.[558]

826. I have taken account of the forensic pathologist's report and his opinion on the cause of death, the toxicological analysis, and the

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[552] Ibid.
[553] Ibid.
[554] Ibid.
[555] Exhibit 11, Volume 1, Tabs 6 and 14.
[556] Exhibit 11, Volume 1, Tabs 3, 6 and 14.
[557] Exhibit 11, Volume 1, Tab 4.
[558] Exhibit 11, Volume 5, Tab 5.

evidence concerning the circumstances whereby the young man was found hanging outside the front of the house, and specifically the evidence concerning the actual ligature and its placement.

827. **I find that the cause of the young man's death in Case No. 9 was ligature compression of the neck (hanging).**

828. As described above, the young man had previously spoken to his aunt (with whom he resided) about self-harm, referring to the loss of five family members in five years. He had told his aunt that he would hang himself one day and she had formed the view that he was suffering from depression.

829. Through her lawyers, his aunt raises her concern that she could not watch him all of the time. It is clear that watching him all of the time would have been impossible for her, or anyone. His aunt loved and supported him throughout his life.

830. The young man was in need of professional mental health treatment and counselling support. That support was offered to him. However, on a number of occasions, he elected not to engage with that support.

831. He had sadly endured the ongoing grief and trauma occasioned by the deaths of a number of close relatives, and the tragedies overwhelmed him.

832. At a point between approximately 11.50 pm and midnight on 23 March 2016, the young man affixed a household item that he used as a ligature, to a structure at the front of his relative's house, and hanged himself, with the intention of taking his life. He died shortly afterwards. It is likely that his level of intoxication contributed to disinhibiting him. I am satisfied that he knew the foreseeable consequence of hanging himself was death, and that he was able to form the requisite intention for this finding. I am satisfied that the young man acted alone to use the item as a ligature in a manner that resulted in his death.

833. **I find that the manner of the young man's death in Case No.9 was Suicide.**

CASE No. 10

Introduction

834. This young man was born on 11 January 1994 at Derby District Hospital and he died at a time between 10.30 am on 19 November

2012 and 5.30 am on 20 November 2012, at the age of 18 years, at the remote Violet Valley station, near Warmun. At the time of his death, he had recently moved out of his mother's home in Halls Creek, and gone with friends to Frog Hollow Community, with a view to finding work.[559]

835. In the period before his death, the young man had unfortunately started to drink alcohol to excess, and he frequently used cannabis. These intoxicants had an adverse impact upon his physical and mental state, and made him vulnerable to confused and irrational thinking. They also impacted upon his ability to secure work.[560]

836. Shortly before his death, the young man and his friends went to the Violet Valley station, near Frog Hollow Community. He socialised with his friends, but after a time, his behaviour became erratic. He went missing and was later found deceased.[561]

837. The young man had not ever been the subject of a child protection order under the *Children and Community Services Act* 2004 (or equivalent legislation). An investigation was conducted for the purpose of ascertaining whether, when he was a child, he may have been in need of protection. On that occasion no harm was substantiated.

838. Through her lawyers the KCLS, the young man's mother elected not to give evidence at the Inquest and having regard to the information already before me and the circumstances attending the death, no compulsions were issued.[562]

839. The details appear below.

Physical health

840. The young man was born on 11 January 1994 at Derby District Hospital and at birth his weight was normal (recorded as 3,375 grams as at day 3). There is no medical record made of his mother having consumed alcohol during the pregnancy.[563]

841. During the young man's childhood years he mainly presented to Halls Creek Hospital Emergency Department or outpatient clinic

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[559] Exhibit 1.11, Tab 10; Exhibit 6, Volume 1, Tabs 2, 9 and 10.
[560] Ibid.
[561] Exhibit 6, Volume 1, Tab 2.
[562] ts 8 to 10; ts 369; ts 803 to 807.
[563] Exhibit 1.11, Tab 10.

with illnesses that included recurrent tonsillitis, conjunctivitis, ear infections, persistent diarrhoea and gastroenteritis and ringworm.[564]

Home environment

842. As a child he had primarily lived with either his mother or father in the Halls Creek area. In the year before his death, he was residing with his mother and he had stayed at home a lot more than usual. Unfortunately he was known to drink alcohol to excess. In November 2012, approximately two weeks before his death, he decided to leave his home in Halls Creek, in the company of members of his extended family to travel to Frog Hollow, with a view to finding work.[565]

843. The young man did not have regular employment and he was hoping to be placed on the Commonwealth Development Employment Program in Frog Hollow. He and his friends were offered accommodation by a community member at Frog Hollow and the plan was for him to help by working at the Frog Hollow community garden. Over this period he continued to abuse alcohol and smoke cannabis, and it had an adverse impact upon his mental state.[566]

844. The details of the events leading to his death appear under the heading *Cause and manner of death*, below.

Mental health treatment

845. There is no evidence of the young man being in contact with any mental health or counselling services during his life, or that he sought treatment for his cannabis usage. A review of his school records indicates that he did not see a psychologist while at school.[567]

846. Notwithstanding his erratic behaviour and an apparent self-harm attempt shortly before his death (described in more detail under the heading *Cause and manner of death*) those who he was with did not make contact with mental health or emergency services on

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[564] Ibid.
[565] Exhibit 6, Volume 1, Tabs 2, 9, 11 and 29.
[566] Exhibit 6, Volume 1, Tabs 2, 10 and 11.
[567] Exhibit 1.11, Tab 10; Exhibit 6, Volume 1, Tab 23; Exhibit 6, Volume 2, Tabs 1, 1A and 1B.

his behalf. Nor can I be satisfied that they would necessarily have apprehended the seriousness of the situation, or known who to turn to.

School attendance

847. As a student, the young man attended the Halls Creek District School for most of his childhood, apart from a period in 2007 when he was enrolled at the Esperance Senior High School.[568]

848. His attendance rate in 2008 (Year 9) was 67% and his average grade was a "C", which indicates that, academically, he may have performed quite well had he attended school more frequently.[569]

849. His early NAPLAN results from 2002 (Year 3), 2004 (Year 5) and 2006 (Year 7) reflect an aptitude in Numeracy. By 2008 (Year 9) his results showed below average abilities in Reading, Writing and Language, and he was not assessed in Numeracy.[570]

850. Unfortunately his attendance rate in 2009 (Year 10) is recorded as "0", and it is clear that by this stage, he was not receiving any schooling.[571]

851. Though his school Behaviour Details Reports (2004 to 2008) show he was repeatedly reprimanded for assault, swearing, fighting and threatening and disruptive behaviour towards students and staff, there is no record of him ever seeing a school psychologist. Most of the infractions resulted in a reprimand or loss of privilege.[572]

Cause and manner of death

852. On 17 November 2012 the young man travelled with his friends from his temporary accommodation at Frog Hollow to the Violet Valley Station, near Warmun. This station was an operating cattle and horse station that offered training to people. His attendance had not been planned as he joined up with other friends he knew

[568] Exhibit 6, Volume 2, Tabs 1, 1A and 1B.
[569] Ibid.
[570] Exhibit 6, Volume 2, Tabs 1 and 1A.
[571] Ibid.
[572] Exhibit 6.1, Volume 2, Tab 1, 1A and 1B.

who were on their way to the station. The young man hoped to do a bit of work there.[573]

853. The station manager knew the young man's mother. He allowed the young man and his friends to look around the station. They were not being paid, so they were free to do what they wanted and come and go as they pleased. The station manager observed the young man to be in good spirits, happy and with no signs of trouble. The young men were permitted to sleep in swags on the station property.[574]

854. On the morning of 18 November 2012, the station manager told the young man and his friends to have the day off, and the station manager himself left the property for the day to attend to work commitments elsewhere. This was the last occasion upon which the station manager saw the young man alive. The young man continued to drink alcohol and smoke cannabis.[575]

855. Later that day the young man began to behave erratically, stating that he could hear voices and claiming that the devil was inside him. During one session of drinking alcohol and smoking cannabis with friends at the Violet Valley Station he said that he had to leave and that something was wrong with him. He was described as "*talking silly*." He then left the house carrying a length of rope which he had got from his swag. Concerned about his behaviour, two of his friends went and found him, taking the rope off him, and returning him back to the house, where he was observed to sit quietly.[576]

856. Later that day the young man travelled with his friends back to Frog Hollow to attend a family and community event, concerning a commemoration ceremony. He slept for a while, watched over by some members of the Frog Hollow community, who had been informed that he had been "*talking silly*" (which in some Aboriginal communities, has come to be associated with the risk of self-harm).[577]

857. When the young man awoke, it appears he decided to walk from Frog Hollow to Halls Creek on his own. In the afternoon of 18 November 2012, at approximately 4.00 pm a community member saw him walking along the road on his own, and returned him to Frog Hollow. Community members tried to comfort him by

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573 Exhibit 6, Volume 1, Tabs 2, 7, 17, 17A and 19.
574 Ibid.
575 Ibid.
576 Exhibit 6.1, Volume 1, Tabs 16 and 19.
577 Ibid.

traditional healing methods, as he said he had been unable to sleep at Violet Valley Station. A community member contacted the young man's mother.[578]

858. Later that night, the young man and his friends returned to the Violet Valley Station, and retired for the night. The next morning, 19 November 2012, the young man was observed by friends to initially appear to be alright, and he made some food and ate it. Then he returned to smoking cannabis.[579]

859. Through her lawyers, the young man's mother has expressed her concern about her son being the victim of an assault on the night of 18 November 2012. The information before me as to whether the young man was assaulted is inconsistent and cannot be objectively reconciled. The difficulties are compounded by the fact that a number of persons were intoxicated that night, affecting the reliability of recollections.

860. Section 25(5) of the Coroners Act precludes me from framing a finding or comment in such a way as to appear to suggest that any person is guilty of an offence. Relevantly, the subsequent post mortem examination showed no external evidence of recent injury to the soft tissues or bones of the limbs, and no fracture to the skull, rib cage, cerebral column or pelvis, though this does not negate the possibility of an assault.[580]

861. I do not make any finding or comment as to whether the young man was assaulted by any person on the night of 18 November 2012. I am satisfied that I am able to make my findings with respect to cause and manner of death without resolving this issue, because there is no evidence of an assault having contributed to his death.

862. On the morning of 19 November 2012, after the young man had been smoking cannabis, he again stated to friends that the devil had been put in his head by a person and that he had to do something because his head was not thinking properly. He had earlier described hearing voices, and believing that people were talking about him. He then packed two bottles of water in his bag and walked out of his accommodation towards the front gate of the station, which was a distance away. His friends followed after

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[578] Exhibit 6, Volume 1, Tabs 20 and 22.
[579] Exhibit 6, Volume 1, Tabs 2 and 22.
[580] Exhibit 6, Volume 1, Tab 5

him, imploring him to stop and come back, but their calls went unheeded.[581]

863. As the young man's friends were following him, they encountered the station manager who was in his vehicle with a station hand, leaving for work. He told them to continue to look for the young man, and they did so. The young man was last sighted alive by one of his friends, a few hundred metres in front of him, near the front gate, still walking away, towards a creek on lower ground. The friend then lost sight of the young man, and when he got to the creek, was unable to find him.[582]

864. After their attempts to locate him were unsuccessful, his friends ceased searching for him, forming the view that he would return once he recovered his equanimity. Unfortunately the young man did not return, and at approximately 2.00 pm on 19 November 2012 family members were informed that the young man was missing. One of the station hands who had remained on the property, and a station worker (who was a relative of the young man) continued to search for him during the rest of that day, to no avail.[583]

865. The station manager returned to Violet Valley Station at approximately 6.30 pm on 19 November 212, and upon being informed that the young man was missing, he and others drove and walked around the station, to search for him, also to no avail. At approximately 7.30 pm the station manager reported the young man as missing to the police, and he provided them with some contextual background. Police did not immediately attend, and reported severe weather conditions, with lightning and thunder storms, and heavy rain.[584]

866. Overnight the young man's mother who was very worried, arrived with others and she searched the Violet Valley Station tracks for her son, also to no avail. It was 1.30 am on 20 November 2012 when she arrived at the station, and it must have been traumatising for her.[585]

867. By 4.30 am on 20 November 2012 the station hand awoke and went to the station manger's house. At first light, the station manager, station hand and others resumed the search for the young man. By now a group of people had formed and they set

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[581] Exhibit 6, Volume 1, Tabs 7, 8, 16 and 19.
[582] Exhibit 6, Volume 1, Tabs 2, 7, 8, 16 and 19.
[583] Exhibit 6, Volume 1, Tabs 2, 16, 17 and 20.
[584] Exhibit 6, Volume 1, Tabs 2 and 7.
[585] Exhibit 6, Volume 1, Tabs 2 and 8.

out to cover a number of areas. After approximately one to one and a half hours of searching, shockingly, the station hand sighted the young man in the distance, hanging from a ligature that had been affixed to a tree on the station property. He raised the alarm and he went and released the young man from the ligature.[586]

868. At approximately 6.00 am on 20 November 2012 the station manager notified police, who attended and conveyed the young man's body to the Warmun Clinic. The registered nurse at the clinic pronounced the young man dead at 10.30 am on 20 November 2012.[587]

869. The young man's body was outside for an unknown length of time between approximately 10.30 am on 19 November 2012 and 5.30 am on 20 November 2012. It is noted that the temperatures for Warmun at the material time were reported to be as follows:

a. On 19 November 2012: Maximum temperature of 39c and nil rainfall to 3.00 pm;

b. On 20 November 2012: Temperature of 32c at 9.00 am with 22mm rainfall.

870. On 28 November 2012 the forensic pathologist made a post mortem examination at the State Mortuary on the young man's body and on that date formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging). The forensic pathologist noted the severity of decomposition change, leading him to give a cause of death on a "*consistent with*" basis. The forensic pathologist also noted the marking on the young man's neck that was in keeping with the application of the ligature that was provided to him. He did not note any preceding pathology of significance.[588]

871. As a result of the decomposition changes, only limited toxicological analysis was able to be performed. That subsequent toxicological analysis showed the presence of a cannabis product in the liver. The forensic pathologist's opinion on cause of death remained unchanged.[589]

872. I have taken account of the forensic pathologist's report and his opinion on cause of death, the toxicological analysis, and the evidence concerning the events leading to the death and the circumstances whereby he was found hanging from the tree, and

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[586] Exhibit 6, Volume 1, Tabs 2, 7 and 8.
[587] Exhibit 6, Volume 1, Tabs 2, 4 and 7.
[588] Exhibit 6, Volume 1, Tab 5.
[589] Exhibit 6, Volume 1, Tabs 5 and 6.

specifically the evidence of the ligature and its placement. I have also taken account of the evidence of decomposition of the body, and the weather for the Warmun area at the material time.

873. **I find that the cause of the young man's death in Case No. 10 was ligature compression of the neck (hanging).**

874. The young man was known to consume alcohol and smoke cannabis on a regular basis. He was doing so to excess in the days leading up to his death. His behaviour shortly before his death could suggest that he was experiencing some form of drug induced psychotic episode. However, he does not have a history of known mental illness. I take account of the fact that his actions were deliberate, that he had expressed an intention to self-harm by similar means a day before he went missing, and that a degree of planning was required in order to affix the ligature to a tree in a remote area where he would not be readily located. I am satisfied that he acted on his own.

875. At a time between approximately 10.30 am on 19 November 2012 and 5.30 am on 20 November 2012, the young man affixed an item that he used as a ligature to tree, and hanged himself, with the intention of taking his life. It is likely that his level of intoxication contributed to disinhibiting him. I am satisfied that he knew the foreseeable consequence of hanging himself was death. Taking account of his state of mind and all of his actions, I am satisfied that he had sufficient capacity to form the requisite intention for this finding.

876. **I find that the manner of the young man's death in Case No. 10 was Suicide.**

CASE No. 11

Introduction

877. This male child was born on 18 January 2001 at Royal Darwin Hospital and he died at a time between approximately 8.30 pm on 11 January 2014, and 8.00 am on 12 January 2014 at the age of 12 years at Halls Creek. At the time of his death he was living with his parents and siblings.[590]

[590] Exhibit 1.11, Tab 11; Exhibit 7, Volume 1, Tabs 2 and 17.

878. In the hours before his death, a family member had been arrested and removed from the home due to an incident concerning the child's mother. The child became upset about the incident and the removal of the family member, when he later heard his mother informing her other children about it.[591]

879. The child had been awarded a scholarship and he was due to leave his home on 29 January 2014 to travel to Melbourne to attend a school there. By all accounts he was looking forward to this.[592]

880. The child had not been the subject of an investigation or a protection order under the *Children and Community Services Act* 2004.

881. Through their lawyers the KCLS, the child's mother and aunt elected not to give evidence at the Inquest and having regard to the information already before me and the circumstances attending the death, including a statement made by the mother at the time of the child's death, no compulsions were issued.[593]

882. The details appear below.

Physical health

883. The child's birth weight was normal at 3,790 grams. There were no concerns noted and shortly after his birth on 18 January 2001 at Royal Darwin Hospital, he was discharged into the care of his mother. They returned to Halls Creek to live there. There is no medical record made of the mother having consumed alcohol during the pregnancy.[594]

884. The child was not treated in respect of any major medical ailments prior to his death. Records from Halls Creek Hospital reflect that he was reviewed in 2011 (February and April) and 2012 (May) in connection with a possible resolving acute streptococcal glomerulonephritis (kidney disease) and following review that he was found to be well.[595]

885. The visiting paediatrician who reviewed the child on 1 May 2012 in connection with the possible kidney disease wrote of a "*delightful 11 year old boy*" who "*attends school regularly and is in*

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[591] Exhibit 7, Volume 1, Tabs 2, 7 and 10.
[592] Exhibit 7, Volume 1, Tabs 2 and 7.
[593] ts 8 to 10; ts 369; ts 803 to 807; Exhibit 7, Volume 1, Tab 7.
[594] Exhibit 1.11, Tab 11.
[595] Ibid.

Year 6. He enjoys school and hopes to become an RFDS pilot. There are no other current parental concerns."[596]

886. On 11 September 2013 he presented to the Halls Creek Hospital Emergency Department for worsening abdominal pain and was transferred to Broome Hospital by Royal Flying Doctor Service. There he was admitted, no cause for the pain was found, and the pain improved and he was discharged on 15 September 2013, with planned follow up in Halls Creek.[597]

Home environment

887. This child was the second eldest of his parents' four children. Both parents also had a child from their relationships with previous partners. The parents had an occasionally volatile relationship and records reflect that there had been prior family domestic violence incidents. Intermittently, the father lived in the family home.[598]

888. On 9 March 2008 the Department of Child Protection and Family Support became involved with the family following a police referral concerning an allegation of harm to an extra-familial child. Following investigation, no charges were laid in relation to this matter. However, in the course of dealing with the referral, the Department of Child Protection and Family Support became aware of information concerning a relevant prior conviction that gave them cause to assess the safety of the children of the household.[599]

889. The outcome of the Department of Child Protection and Family Support's assessment was that there was no harm substantiated in respect of any of the children of the household. However, the department was unable to conclude that there was risk to the children. Further assessments in March 2012 concluded that despite some risk due to past events, there was no evidence to suggest there was any current child protection concerns. There was no investigation initiated under s 32(1)(d) of the *Children and Community Services Act* 2004.[600]

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[596] Ibid.
[597] Ibid.
[598] Exhibit 7, Volume 1, Tabs 17 and 20; Exhibit 7, Volume 2, Tab 2.
[599] Exhibit 7, Volume 1, Tab 2; Exhibit 7, Volume 2, tab 20.
[600] Ibid.

890. The events leading to the child's death are outlined under the heading *Cause and manner of death*, below.

Mental health treatment

891. This child had no known history of illicit drug or alcohol use. Nor is there any evidence of previous self-harm attempts or statements made by the child to indicate that he may have been contemplating an act of self-harm. There is no evidence that he sought, or his parents, teachers or anyone else referred him to, any mental health or counselling services.[601]

892. Department of Education records reflect that this child may have had informal contact with the school psychologist on an occasion on 9 May 2012, when he was 11 years old. The file note on the school psychology file is brief, does not refer to any concerns regarding the child, and does not reflect the author's name. The School Psychologist for the Kimberley Education Office has no record of any formal contact between the child and any school psychologist.[602]

School attendance

893. This child attended the Halls Creek District High School campus from 2008 (Year 2) to 2013 (Year 7). His overall attendance rate was often above 90%, and sat at 96.3% for semester 1 of Year 6 (in 2012). It was 84.9% for semester 2 of Year 7 (in 2013).[603]

894. Despite the child's positive attendance rate, he had a below average performance at school, as reflected by his NAPLAN results for Years 3 (2009), 5 (2011) and 7 (2013), though he did exhibit some aptitude in the areas of writing or spelling. His school grades were of a similar outcome, though it is recorded that he did show results when he applied himself.[604]

895. The child was included in the Aboriginal Tutorial Assistance Scheme, and in 2012 he progressed swiftly through the six levels of the program and showed himself to be a competent reader. He

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[601] Exhibit 1.11, Tab 11; Exhibit 7, Volume 1, Tab 2; Exhibit 7, Volume 2, Tab 2.
[602] Exhibit 7, Volume 2, Tabs 1A and 1C.
[603] Exhibit 7, Volume 2, Tab 1A.
[604] Ibid.

was an enthusiastic participant in the program, and showed immense pride in his work, but he was easily distracted.[605]

896. Individual Behaviour Reports also reflect that he was easily distracted, and inclined to impulsive behaviour. They also show that he frequently refused to work or follow instructions, and that he exhibited disruptive behaviour, including verbal abuse and physical assault of students and physical assault or intimidation of teachers.[606]

897. He was suspended on six occasions for matters that included verbal abuse or physical assault, the last being on 15 August 2013.[607]

898. He was also the subject of positive Individual Behaviour Reports, reflecting that he was able to display excellent reading strategies, a great attitude, and respectful behaviour, that he set a good example for his peers, and that he demonstrated good manners and great leadership qualities.[608]

899. A full scholarship had been awarded to the child to attend a school in Victoria. This would have resulted in him living in Victoria for six years. The child's high school principal reported that he had not been identified as a student at risk and that he did not exhibit any behaviours to indicate that he would self-harm. He was reported to be a caring and much admired student who made strong positive relationships with staff, students and community leaders. He died approximately two weeks before he was due to leave for his boarding school in Victoria.[609]

Cause and manner of death

900. Shortly before midday on 11 January 2014 the child's parents were socialising and drinking with other family members at a house in Halls Creek, to mark a family event. An altercation took place at the house between the child's parents and after they both left the house the altercation escalated onto the road, resulting in injuries to both parents. A family member was arrested as an

[605] Ibid.
[606] Exhibit 7, Volume 2, Tabs 1A to 1C.
[607] Ibid.
[608] Ibid.
[609] Exhibit 7, Volume 1, Tab 2; Exhibit 7, Volume 2, Tabs 1A to 1C.

uncharged suspect and conveyed to the police station. The child was not present during these events.[610]

901. The physical altercation between the parents was considered by police to be minor, and no charges were laid. Following inquiries, at approximately midday on 11 January 2014, a family member was issued with a 72 hour Police Order, with the protected person being the child's mother.[611]

902. Following inquiries the family member was released from the police station at 5.10 pm on 11 January 2014, with the 72 hour Police Order in place and explained. Shortly afterwards, police were telephoned by the child's mother informing them that the family member was knocking on the front door, seeking access to an item. Following the police attendance, and their attempts to explain the restrictions to the family member, the matter escalated, and the family member was then arrested for breaching the 72 Hour Police Order. The child was not present during these events either.[612]

903. The child became aware of these events after he heard his mother relay them to her other children, on that same date (11 January 2014). The mother was unaware of her son becoming troubled by these events. However, in conversation with the child on that same date, the child's paternal uncle (who lived across the road) became aware that the child was angry and upset because his parents had had an argument, and police had locked up a family member. His uncle endeavoured to comfort him and encouraged him to spend time with his siblings, who were going to go to the pool for a swim.[613]

904. The child declined to go with his siblings for a swim and elected to stay at home. In the meantime, the child's mother decided to stay the night at the home of the child's paternal uncle, with her children. At approximately 7.30 pm on 11 January 2014, the child went to the home of his paternal uncle and spent time with his mother. He sought his mother's permission to go back home and watch a movie, and he undertook to return to his mother after the movie. His mother gave her permission and watched him return home at approximately 8.30 pm, as she was across the road. This is the last occasion upon which the child was seen alive.[614]

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[610] Exhibit 7, Volume 1, Tabs 2 and 22.
[611] Exhibit 7, Volume 1, Tab 22.
[612] Exhibit 7, Volume 1, Tabs 2 and 20.
[613] Exhibit 7, Volume 1, Tabs 2, 7 and 10.
[614] Ibid.

905. On all of the evidence, I am satisfied that the child was alone at home on the night of 11 January 2014. It is not known whether he watched a movie, and he did not return to his mother where she was staying at his uncle's home, across the road.

906. The following morning, 12 January 2014 at approximately 8.00 am, the child's neighbour was carrying out chores in his backyard, and as he looked across the fence into the child's backyard, alarmingly he saw the child slumped against an article at the rear of his home. The child was hanging by a ligature. Together with his wife, they raised the alarm and contacted the family and the emergency services. The paternal uncle and a neighbour released the child from the ligature. There was no other person at the child's home.[615]

907. Records reflect that the St John Ambulance Service received a call at 8.00 am on 12 January 2014 and that they arrived at the scene at 8.12 am. Police arrived shortly afterwards, having received a call at 8.16 am. Upon arrival the paramedics observed that the child had no pulse, no signs of respiration and his pupils were fixed and non-responsive to light. They attached a heart monitor and no rhythm was seen. They did not commence CPR as it was clear, tragically, that there were no signs of life.[616]

908. The child was conveyed by ambulance to the Halls Creek Hospital where a medical practitioner pronounced the child dead at 8.36 am on 12 January 2014, noting that the child was obviously deceased.[617]

909. On 21 January 2014, following authorisation, the forensic pathologist made an external only post-mortem examination at the State Mortuary on the child's body and on that date formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging). The forensic pathologist noted post mortem decomposition changes and some indented marking to the skin of the neck. There were no other apparent fresh injuries to the body surface. The ligature was made available to him.[618]

910. No toxicology samples were taken due to the degree of post-mortem decomposition change.[619]

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[615] Exhibit 7, Volume 1, Tabs 2, 8, 9 and 10.
[616] Exhibit 7, Volume 1, Tabs 2 and 19.
[617] Exhibit 7, Volume 1, Tabs 5 and 19.
[618] Exhibit 7, Volume 1, Tabs 2 and 6.
[619] Exhibit 1.11, Tab 11.

911. I have taken account of the forensic pathologist's report and his opinion on cause of death, and the evidence concerning the circumstances whereby the child was found hanging from the structure in the yard at the rear of his home, and specifically the evidence concerning the actual ligature and its placement.

912. **I find that the cause of the child's death in Case No. 11 was ligature compression of the neck (hanging).**

913. Shortly before the child died, he had been upset about the altercation between his parents, and a family member's subsequent arrest. He had not previously attempted to self-harm, nor had he expressed an intention to self-harm. He had no known mental health issues. He was not known to have used drugs or abused alcohol.

914. The child had recently been awarded a full scholarship to attend a school in Victoria and he would have been due to leave approximately two weeks after his death. There is no evidence that he was distressed about the impending separation from his family. Whilst it would have resulted in a significant change in his social circumstances, moving to a new State and a new school, he had told people that he was looking forward to it.

915. The child was known to behave impulsively, and his school records show reports of both very positive and very negative behaviours. The combination of the altercation between his parents, the concerns about his mother, the removal of his family member from the home, and his impending departure from his community may have combined to overwhelm him.

916. I have taken account of the evidence concerning the child's failure to return to the house where his mother was staying (despite his agreement with her) and the observations of the neighbours and the paternal uncle who released the child from the ligature. I am satisfied that the child was distressed by the events of the day, and whilst the intensity of his feelings may reflect his impulsivity, it is also clear that his actions showed a degree of planning and deliberateness.

917. At a time between approximately 8.30 pm on 11 January 2014, and 8.00 am on 12 January 2014, the child affixed a household item that he used as a ligature to a structure in the rear yard of his home and hanged himself, with the intention of taking his life. I am satisfied that he knew the foreseeable consequence of hanging himself was death, and that he was able to form the requisite intention for this finding. I am satisfied that the child acted alone to use the item as a ligature in a manner that resulted in his death.

918. **I find that the manner of the child's death in Case No. 11 was Suicide.**

CASE No. 12

919. This young man was born on 17 June 1994 at Halls Creek Hospital and he died on the afternoon of 5 January 2015 at the age of 20 years at a location near Wungu Community, via Halls Creek. At the time of his death he was residing with his mother, his partner and other members of his family, at Wungu Community.[620]

920. Shortly before Christmas 2014, the young man and his partner had left their home in Halls Creek and gone to Wungu Community, to stay with family there. However, on 5 January 2015, their provisions of food and fuel were running low, and they all decided to travel to the Halls Creek town site to replenish their provisions, needing to do so quite promptly due to the impending bad weather.[621]

921. The young man had been with his partner for a number of years and they had a troubled and complicated relationship, with intermittent separations. They argued from time to time, and on occasions she would hit him. They were very attached to each other, but had difficulty when it came to resolving disagreements. The young man's family had an ambivalent relationship with his partner, and on occasions, their respective attitudes would lead to friction, resulting in verbal altercations.[622]

922. There is unfortunately a history of domestic violence incidents concerning the young man's parents. In the years before his death, the young man had been exposed to witnessing a number of such incidents. As a child his health had been very poor, and concerns had been expressed about his failure to thrive. He had expressed an intention to take his life on numerous occasions, and troublingly, on an occasion when he was still so young that he could not have apprehended its import.[623]

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[620] Exhibit 1.11, Tab 12; Exhibit 8, Volume 1, Tabs 10 and 12.
[621] Exhibit 8, Volume 1, Tabs 10 to 12.
[622] Ibid.
[623] Exhibit 8, Volume 1, Tabs 18 and 19.

923. The young man was not at any stage the subject of an investigation or protection order under the *Children and Community Services Act* 2004 (or its equivalent legislation) during his childhood.

924. The young man's mother and brother gave evidence at the Inquest. At my request the young man's mother also provided me with a letter, and I have taken that into evidence.[624]

Physical health

925. The young man was born between 36 and 37 weeks' gestation. At birth on 17 June 1994 at Halls Creek Hospital he had a low birth weight of 2,440 grams. He was monitored and reviewed and then discharged into the care of his mother within the week of his birth. At that stage it was recorded that he was progressing well and being well cared for. There was no medical record made of his mother having consumed alcohol during the pregnancy.[625]

926. Unfortunately, during his infancy his health deteriorated. Hospital growth charts showed a dramatic drop in weight at seven months of age with his weight dropping from the 50th percentile to below the 3rd percentile. At the age of approximately 18 months he presented to Katherine Hospital in the Northern Territory, where he was admitted from 2 to 10 January 1996. He was diagnosed with failure to thrive, iron deficiency anaemia and gastroenteritis. It was recorded that he had gained only 1.3 kilograms over a period of 12 months. He had an abscess requiring surgical incision, drainage and antibiotics. His weight increased in hospital and he was discharged with a note being made to the effect that there be a low threshold for readmission and involvement of welfare.[626]

927. Halls Creek Hospital and clinic presentations between 1994 and 2002 were for continued treatment of various conditions including skin infections, bronchitis, tonsillitis and diarrhoea, anaemia and vaccinations.[627]

928. There are significant gaps in attendance from the available medical records (being a number of service providers from the Kimberley area, the Aboriginal Medical Service in Albany and Katherine in the Northern Territory) which suggests that a number of the young man's medical presentations are not before me.

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[624] ts 836 to 869; Exhibit 8, Tab 12A.
[625] Exhibit 1.11, Tab 12.
[626] Ibid.
[627] Ibid.

There are no mental health or drug related presentations on the information before me.

Home environment

929. The young man was the youngest of three siblings born to his parents. His parents separated when his mother was approximately three months pregnant with him, and he resided with his mother and siblings throughout most of his childhood.[628]

930. His parents reunited in July 2010, but separated again in May 2011 after a domestic violence incident. The Department of Child Protection and Family Support was notified by the Western Australia Police of incidents concerning family and domestic violence involving either one or both of the young man's parents on four separate occasions during 2010 and 2011.[629]

931. On 10 July 2010 there was a reported incident of domestic violence (not involving the father) that resulted in the mother requiring medical treatment. No children were recorded as present during this incident. On 5 December 2010 there was another reported incident of domestic violence, apparently associated with alcohol abuse, and whilst a child is recorded as being present (and unharmed), it was not this young man.[630]

932. On 2 March 2011, there was a further incident report in relation to a verbal argument between the young man's parents. Following this incident, Police issued a 24 hour Police Order. Again, whilst a child was recorded as being present, it was not this the young man.[631]

933. On 16 May 2011, a number of police officers attended in response to an incident of domestic violence between the young man's parents, whereupon they were also informed of further such incidents in the week prior. Their attendance resulted in the seizure of a firearm. The young man, then aged 16 years, was a witness to one of the May 2011 incidents. Later, on 21 September 2011, the father pleaded guilty to two charges of aggravated common assault and one charge of breach of protective bail conditions arising from these incidents.[632]

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[628] Exhibit 8, Volume 1, Tab 19.
[629] Ibid.
[630] Ibid.
[631] Ibid.
[632] Ibid.

934. Following the 16 May 2011 callout, the Department of Child Protection and Family Support had initiated an assessment due to concerns held for the children present during the May 2011 incidents, which included the young man. On 21 September 2011, that department completed the assessment and determined that there was no evidence that family violence was an ongoing issue. It was noted that the young man's mother was living in Wungu Community with her children, that she remained separated from the young man's father, who had commenced a new relationship, and that in addition to the geographical distance, there were relevant Court imposed conditions.[633]

935. There are no further records of domestic violence incidents after this time.

936. As at the time of his death in January 2015, the young man had been in a relationship with his partner for four years. They had latterly been living in Halls Creek with the young man's grandmother but shortly before Christmas 2014, they left Halls Creek for Wungu Community to stay with the young man's mother, who was also joined by other family members. Wungu Community is approximately 60 kilometres from Halls Creek, and is accessed by travelling 40 kilometres along the highway, and then a further 18 kilometres along an unsealed track.[634]

937. Unfortunately the young man's relationship with his partner was marred by arguments and acts of domestic violence which involved his partner hitting him. His partner stated that he was against hitting women.[635]

938. The young man had frequently expressed the intention to take his life by hanging, and was known to make such statements in the context of arguments. Family members had formed the view he said such things in an attempt to stop the arguments, and be listened to. They did not believe he intended to carry out any act of self-harm, and in closer discussion, he would disavow those sentiments. He was not known to have previously carried out any acts of self-harm.[636]

939. The events leading to the young man's death are outlined under the heading *Cause and manner of death*, below.

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[633] Ibid.
[634] Exhibit 8, Volume 1, Tabs 10 and 12.
[635] Exhibit 8, Volume 1, Tabs 10, 12 and 19.
[636] Exhibit 8, Volume 1, Tabs 11 and 12.

Mental health treatment

940. On 28 February 2001, when the young man was just six years old, he was referred to a school psychologist following the display of a number of aggressive and uncooperative behaviours. The school psychologist reviewed him and found that he had no attention span, displayed angry language and behaviour (swearing and throwing chairs) and demonstrated a refusal to comply with directions. At the interview with the school psychologist he spoke of hurting himself (showing a stabbing motion to his stomach) and, alarmingly, stated: *"I kill myself"*.[637]

941. He would not have understood the import of such a statement at the age of six years but he was clearly trying to convey his distress. I infer that he had observed similar behaviour in the context of the expression of anger or despair, and copied it. I do not speculate as to how he came to observe such behaviour, but its expression at such a young age is disturbing.

942. The school psychologist formulated a behavioural management plan to decrease the frequency of his failure to follow directions and his refusal to do work, and to reward good behaviours. The plan was to review him in week 8 of the term. However, there are no further psychological notes in his school file. There are no records of follow up or review of the underlying reasons for his difficult behaviour.[638]

943. On the records before me, apart from the psychological review as a six year old referred to above, there is no record of this young man being assessed at any other stage by any health professional in relation to mental health or drug usage.

944. The young man did not seek, nor did his partner or any relatives refer him to, any mental health or counselling services despite him frequently stating that he intended to hang himself. Nor can I be satisfied that they would have known who to turn to. There are no known previous self-harming behaviours.

School attendance

945. Department of Education records reflect that as a child the young man had been enrolled Halls Creek District High School and Derby District High School in 2008 (Year 9), and at Halls Creek District

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[637] Exhibit 8, Volume 1, Tab 18A.
[638] Exhibit 8, Volume 1, Tab 18A.

High School and North Albany Senior High School in 2009 and 2010 (Years 10 and 11). He was enrolled and attending more than one school over numerous terms, and unfortunately, with one notable exception, his attendance was generally very poor.[639]

946. More specifically, his attendance rate over the high school years reached lows of approximately 12% and 15%, sometimes he achieved attendance rates of 55% and 75% (which are still poor), but he did attain a positive 90% attendance rate in year 11 at North Albany Senior High School (notably when he was living at Albany Residential College, Amity Hostel), with his teacher there recording that he had a: "*great attitude*" to all his work.[640]

947. It is unsurprising that his greater engagement with school resulted in more positive remarks from his teachers. In his primary school report it was noted that he: "*....rarely attends school for more than four days at a time. This makes it very difficult for staff to help him build on his skills. At the beginning of the year his better attendance had him counting correctly. Now he has forgotten....*"[641]

948. The schools had various ways of encouraging greater attendance. When as a child he attended for only four out of 34 days over a seven week period in Year 8, there was an attempt to engage and offer help with transport and lunches, outlining the free breakfast program, and querying whether there was a problem with bullying. Behaviour reports throughout his school years record aggressive and uncooperative behaviours on his part, and instances of involvement in physical assaults. He was easily frustrated and had difficulty concentrating and controlling his anger.[642]

949. Given his overall lack of engagement with schooling, his academic performance was consistently poor, and was frequently unable to be assessed due to his absences. He was subsequently granted approval for education other than full time schooling, through part-time schooling and part-time tertiary and further education course (in 2010).[643]

Cause and manner of death

950. At approximately midday on 5 January 2015, the young man, his partner, his mother, brother and members of his extended family

[639] Exhibit 8, Volume 1, Tabs 18, and 18A to 18C.
[640] Ibid.
[641] Exhibit 8, Volume 1, Tab 18A.
[642] Ibid.
[643] Exhibit 8, Volume 1, Tabs 18, 18A, 18B and 18C.

decided to travel from the remote Wungu Community to Halls Creek, because the weather was becoming unfavourable and they were running low on food and fuel. If they did not leave promptly, there was a risk that the rains would make the unsealed track leading back to Halls Creek inaccessible.[644]

951. After they had been travelling for approximately one kilometre, their Toyota Landcruiser tray back ute became bogged in the sand and the occupants got out, with the intention of freeing the vehicle. A number from the group looked around for implements for this purpose.[645]

952. The young man and his partner initially stayed with the vehicle, but arguments developed between a number of the family members, tensions escalated and at one point, the young man's partner walked away from the group on her own, along the unsealed track in the direction of Halls Creek. She had been involved in an altercation with one of the family members, they were verbally insulting each other, and she had become anxious and upset. The young man followed her with the intention of persuading her to return to the group. Two family members who saw the young man following his partner heard him call out for her return, and saying: "*I am going to hang myself.*" They formed the view that he said that in order to garner her attention, and bring an end to their disagreement. They did not believe he meant it seriously.[646]

953. When the young man caught up with his partner, they began to argue and she described herself: "*hitting out to him and rolling around.*" After approximately half an hour, towards the mid-afternoon they returned to the group, to get some water. In the meantime, a number of persons from the group had walked back to Wungu Community to access cables or straps that could be used to free the vehicle.[647]

954. After they got water, the young man's partner walked away from the group again, with the intention of checking the next creek bed to see if it was "*soft*" which may relate to the question of whether the Landcruiser could safely cross it. The young man followed her again. The rest of the group remained with the vehicle, continuing to look around for implements to free it. They last saw the young

[644] Exhibit 8, Tabs 2, and Tabs 10 to 15.
[645] Ibid.
[646] Ibid.
[647] Ibid.

man alive as he was walking along the track on the fence line with the water bottle, in the direction that his partner had taken.[648]

955. At one stage as they were walking along the track, the young man was approximately 10 metres behind his partner. She heard him scream out to her from behind her: *"I love you so much"*. She turned around and alarmingly saw him hanging from an item of clothing that he had used as a ligature, that he had affixed to tree branch, as a suspension point. She raced towards him with the intention of releasing him from the ligature, but was only able to achieve this after she managed to snap the branch of the tree to which the ligature was affixed. It involved a number of attempts on her part. They were approximately one kilometre away from the rest of the group, in a remote location, and no other person was in the vicinity.[649]

956. After the young man's partner was able to release him from the ligature, she observed signs of life, in that she felt a carotid pulse, his breathing was laboured, and he made some bodily movements which she described: "*like he was taking a fit*". She attempted to perform CPR, but soon desisted and instead dragged him approximately one metre to the nearby creek with the stated aim of splashing water on him, and washing sand off him. She then dragged him back approximately one metre away from the creek, and ran back to the group to get help. She recalled the water in that section of the creek was approximately 15 centimetres in depth.[650]

957. When the young man's partner last saw him lying on the sand, she observed that his breathing remained laboured, and that he still had some bodily movement, in that he appeared to be rolling on the ground. After she had been running for approximately one kilometre along the fence line, she encountered the young man's brother and his wife, who had come along the fence line towards her after hearing her cries. She and told them what had happened. She continued to run along the fence line towards the young man's mother.[651]

958. Upon being informed, the young man's brother immediately ran to find him. Other family members joined the search, and by this stage, as the daylight was fading, they were using torches. The young man's brother followed tracks and located him. The young man appeared to be floating, face up, in the creek. The brother

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[648] Ibid.
[649] Exhibit 8, Volume 1, Tabs 2, 2A and 10.
[650] Ibid.
[651] Exhibit 8, Volume 1, Tabs 2, 10 and 11.

pulled him away from the water and attempted to perform CPR, but soon desisted. The brother's observations of the young man's body strongly indicate that by this time, the young man was deceased.[652]

959. In the meantime, the young man's partner had informed his mother and together they ran to the house at Wungu Community, to call the emergency services. Communications were through the Telstra supplied static satellite phone, as no mobile or satellite telephone signal was ordinarily able to be obtained.[653]

960. Records reflect that Halls Creek Police received a call at 5.40 pm on 5 January 2015, and that they departed for Wungu Community, with the intention of travelling there with hospital staff. However, as the police and ambulance attempted to drive along the highway, at approximately 6.35 pm they saw that the river crossing into Old Halls Creek was flowing extremely fast and that it was very deep. They waited, but saw the water level appear to rise. They assessed the risk and returned to Halls Creek and contact was made with Police Air Wing, to ascertain their availability.[654]

961. In the meantime, the young man's partner and his mother had run back along the fence line and located the young man, now deceased, his brother and other family members, who were distraught, and mourning. The young man's family members were unhappy with his partner's behaviour, and an altercation developed. At one stage she was struck, falling to the ground.[655]

962. Police had informed the family that they would be unable to attend that night and requested that they endeavour move the young man's body to the house at Wungu Community. There were concerns about the effect of the rain and exposure of the body to the elements. With very great difficulty, and overwhelmed by grief, the young man's family members carried his body along the fence line, for a long distance, back to the house at Wungu Community. It was an arduous and fraught journey.[656]

963. The altercations between members of the young man's family, and the young man's partner continued and escalated. The young man's family considered that she bore responsibility for his death, in that she had caused him to drown. When the young man's body

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[652] Exhibit 8, Volume 1, Tabs 2 and 11.
[653] Exhibit 8, Volume 1, Tabs 2, 10, 12 to 15, 21 and 31.3.
[654] Ibid.
[655] Ibid.
[656] Ibid.

was returned to the house at Wungu Community on the night of 5 January 2015, the family members remained at the house, as did his partner, keeping a vigil over his body. At the instruction of police, they turned on the air conditioner, to keep the body cool. It was a harrowing night for all of them.[657]

964. Early the next day, 6 January 2015, the altercations between the young man's family and his partner continued, and she left the house on her own, after some objects were thrown in her direction. The police later airlifted the young man, and separately his partner, out of Wungu Community. Through their lawyers the KCLS, the young man's family submits that an adverse finding be made against police for their failure to airlift the family out of Wungu Community, given the circumstances that they faced, and the grief that they bore. They eventually travelled back to Halls Creek on their own. This aspect is addressed later in this finding under the heading *Comment – Western Australia Police Force, Case No. 12*.[658]

965. The young man's body was airlifted out of Wungu Community at approximately 3.00 pm on 6 January 2015, and conveyed to Halls Creek Hospital where he was pronounced dead by the doctor.[659]

966. On 13 January 2015 the forensic pathologist made a post-mortem examination at the State Mortuary on the young man's body and on that date formed the opinion that the cause of death was ligature compression of the neck (hanging) in a man found immersed in water. There were early decompositional changes. The forensic pathologist noted some scattered soft tissue injuries with a part ligature mark to the neck. Unfortunately the ligature was not able to be provided to the State Mortuary for examination and comparison. The forensic pathologist also noted what appeared to be silt and sand over the body, which was also found with watery gastric content in the stomach.[660]

967. Subsequent toxicological analysis showed tetrahydro- cannabinol at a low level of less than 1ug/L, and consistent with recent use of cannabis. No alcohol or other common drugs were detected in the blood. The alcohol detected in the bile was likely related to the decomposition process. The forensic pathologist's opinion on cause of death remained unchanged.[661]

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[657] Ibid.
[658] Ibid.
[659] Exhibit 8, Volume 1, Tab 7.
[660] Exhibit 8, Volume 1, Tab 8.
[661] Exhibit 8, Volume 1, Tabs 8 and 9.

968. As outlined above, the young man's family had formed the view that his death was caused by drowning, and that his partner was responsible for causing him to drown. At the Inquest the young man's brother testified that he found his brother in the creek, faced up in the water, with the back of his head in the water, and his face above the water, with his body floating in the water. He pulled his bother out of the water. He also gave evidence that when he attempted to perform CPR, water came out of his brother's mouth, and nose.[662]

969. His mother felt that he would not have taken his life, that he was a happy-go-lucky boy, and that they had made future plans for his 21st birthday and her 40th birthday. The young man's partner was excused from giving evidence at the Inquest, upon her application through counsel assisting, based upon her ongoing stress and trauma. The various statements reflect that she had vehemently denied causing his death.[663]

970. It is important at this juncture that I again outline the coroner's role, which is to find, if possible, the cause of death, and how the person died (the manner of death). It is not the coroner's role to blame a person or persons for a death, or to hold a person or persons accountable for a death. The law prohibits the coroner from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence.

971. As a result of the evidence of the young man's mother and brother at the Inquest, to assist me in finding the cause and manner of death, I directed that further inquiries be made of the forensic pathologist Dr White, and she provided a supplementary written report and subsequently gave evidence at the Inquest.

972. The forensic pathologist was provided with the information concerning the death that was before me, from the young man's partner, his brother, and the police report. She took that information into account in providing her opinions. The further evidence of the forensic pathologist assisted me in assessing the contribution to the death, if any, of the young man's immersion into water.[664]

973. For the reasons outlined below, I am satisfied that the young man had died before his immersion into water:

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[662] Exhibit 8, Volume 1, Tab 11; ts 841 to 843; ts 849 to 850.
[663] ts 727; ts 860 to 861.
[664] Exhibit 8, Volume 1, Tab 8A; ts 1511 to 1518.

a. Dr White explained that the addition of the words: "*in a man found immersed in water*" (to her written opinion on cause of death) is often done where people die in and around water, in that they are found deceased in a body of water; the addition of that phrase acknowledges the potential contribution, if any to the death, by the person being found in a body of water: "*it does not imply a direct or definite contribution*";

b. Dr White was unable to say with complete certainty as to whether the young man was breathing at any point when he entered or was immersed into water. He may already have died, and was therefore not breathing or was near death and was having agonal breathing (that is, intermittent and shallow respiration);

c. Dr White took account of the description of the young man's bodily movements after his partner released him from the ligature, that was described as "*fitting*" (when he was close to the water's edge) and noted that it is a description often found in such circumstances, and is also considered to be an agonal event, and specifically a sign of profound hypoxia, and a strong indication that he was dying;

d. Dr White explained that the watery gastric content in the stomach that she noted on examination may have occurred as part of the young man drinking water prior to death, due to agonal breathing movements (drawing water in), due to the passive movement of the water once the young man was in the water (for example if the mouth is open and there is water going across the face) and/or during movement as part of retrieving the young man (when he was pulled out of the water); she further explained that:

    i. The fact that she found no water or silt in the airway led her to think that: "*maybe his airway was protected by his epiglottis and just the water might have passed into the stomach which, perhaps, is more likely to be after death*"; and

    ii. The fact that water came out of the young man's mouth and/or nose when his brother commenced to perform CPR may be due to any of the above possibilities, and is not direct evidence of the young man being alive before he was immersed in water;

e. Dr White took a range of matters into consideration, and in her opinion, it is: "*highly likely that he was deceased prior to entering the water*".[665]

974. I have considered Dr White's opinion to the effect that she is unable to say with complete certainty as to whether the young man was breathing at any point when he entered or was immersed into water, but that it is highly likely that he was deceased prior to entering the water, in the light of the ***Briginshaw*** standard. I am satisfied on all of the evidence before me, to the requisite standard, that the young man had died before his immersion into water.

975. I have taken account of the forensic pathologist's written reports, her evidence concerning her opinion on the cause of death, the toxicological analysis, the evidence concerning the circumstances whereby the young man was found hanging by his partner, her observations upon releasing him from the ligature and all of her subsequent observations (noting that the fitting movements she observed are consistent with Dr White's evidence) and the evidence of the circumstances whereby he was found floating in the creek by his brother, and all of his subsequent actions and observations.

976. **I find that the cause of the young man's death in Case No. 12 was ligature compression of the neck (hanging).**

977. In the past the young man had frequently stated that he would hang himself when he was arguing with his partner of four years, though he had never previously attempted to do so. On the day of his death, he had become increasingly distressed after the vehicle he was in became bogged, and arguments developed between his partner and members of his family. He also argued with his partner and another family member. He again said he would hang himself during the course of some of those arguments, whilst in a distressed state.

978. Having regard to his past course of conduct, his family assumed that he would threaten to hang himself in order to garner the attention of the person he was arguing with, and to bring the argument to a close. They assumed that he would not carry out such an act of self-harm. On previous occasions when questioned more closely, he had subsequently disavowed an actual intention to take his life.

979. He was clearly a very troubled young man. When a person expresses an intention to take his or her life, it is important to

[665] Exhibit 8, Volume 1, Tabs 8 and 8A; ts 1510 to 1518.

promptly seek medical assistance. As at 5 January 2015, his family were aware that he had stated that he would hang himself on many ("*thousands*") of occasions, when he was in a state of agitation or distress.[666]

980. I have taken account of the family's submission through their lawyer the KCLS, to the effect that they do not believe the young man intended to take his life, and that they consider his partner to be responsible for his death. I have carefully considered the evidence but can find no alternative verdict.

981. On the afternoon of 5 January 2015 the young man affixed an item of clothing that he used as a ligature to the branch of a tree and hanged himself, with the intention of taking his life. I am satisfied that he knew the foreseeable consequence of hanging himself was death, and that he was able to form the requisite intention for this finding. I am satisfied that he acted alone to use the item as a ligature in a manner that resulted in his death.

982. **I find that the manner of the young man's death in Case No. 12 was Suicide.**

CASE No. 13

Introduction

983. This young man was born on 29 March 1994 at Derby Hospital and he died at a time between approximately 2.00 am and 3.05 am on 22 May 2015 at the age of 21 years in Halls Creek. At the time of his death he was living with his partner and members of her family in Halls Creek.[667]

984. His early years were spent living with his family at Oombulgurri Community until it was closed down. He later moved between Wyndham, Kununurra and Halls Creek. His health during his childhood was characterised by frequent preventable illnesses.

985. As a child he lived with his mother and siblings, and during some of his adolescence he resided with his maternal grandmother, who was also carer to a number of her other grandchildren.[668]

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[666] Exhibit 8, Volume 1 Tabs 11 and 12
[667] Exhibit 9, Volume 1, Tabs 2, 8 and 9; Exhibit 1.11, Tab 13.
[668] Exhibit 9, Volume 1, Tab 17.

986. When he was 11 years old, his older brother (then 21 years old) tragically died by suicide at Oombulgurri Community. The circumstances surrounding that death were confronting for him and had a lasting and disturbing impact upon him as he grew up. There is no record of him having received any mental health treatment for the burden of grief and trauma that he carried.

987. In the year before his death, the young man had commenced a relationship with his partner. They had lived together in Kununurra before moving to Halls Creek approximately two weeks before he died. Unfortunately, this relationship had initially been marred by acts of domestic violence, though his partner reported that these incidents ceased in the period prior to his death.[669]

988. The young man was known to abuse alcohol, and this behaviour continued up to the time of his death. At one stage during his adolescence, having regard to his early problematic alcohol use, consideration had been given to drug and alcohol counselling for him. However, this did not eventuate. Later in life, when he was drinking he would talk about joining his older brother, who had died by suicide.

989. The young man had not ever been the subject of a child protection order under the *Children and Community Services Act* 2004 (or equivalent legislation). Investigations were conducted for the purpose of ascertaining whether, when he was a child, he may have been in need of protection. On one occasion neglect was substantiated.

990. Through her lawyer the KCLS, the young man's sister submits that the closure of the Oombulgurri Community had a detrimental effect on her brother, and that his relocation to Wyndham exposed him to alcohol use, and other negative influences.

991. The young man's partner and his partner's mother gave evidence at the Inquest about their observations in the period shortly before his death. His parents are sadly deceased.[670]

992. The details appear below.

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[669] Exhibit 9, Volume 1, Tab 8.
[670] ts 1218 to 1227.

Physical health

993. The young man was born at term with a normal birth weight of 3,230 grams on 29 March 1994 at Derby Hospital. Records reflect that his mother's pregnancy was complicated by infection, gestational diabetes, anaemia and alcohol abuse with pancreatitis. It is suggestive of a high level of alcohol consumption during pregnancy.[671]

994. Between 25 July and 3 August 1994, at the age of four months, he was first admitted to Wyndham Hospital with diarrhoea, infected scabies sores and an ear infection. Nursing notes record concerns for his wellbeing.[672]

995. During his childhood, he received frequent medical attention at Oombulgurri Community Clinic and Wyndham Hospital. He required treatment for urinary tract infections, anaemia, recurrent skin infections including scabies infections, ear infections with chronic perforations, gastroenteritis and parasitic infections. He was admitted to Wyndham Hospital at the age of approximately seven months for failure to thrive (poor growth). This diagnosis was sadly a recurrent feature in his early childhood medical records.[673]

996. It was also thought that as a child he likely suffered from a type of kidney disease called IgA nephropathy and this was monitored by kidney specialists.[674]

997. Unfortunately, during his childhood, there were also instances where his hospital presentations reflected on his mother's incapacity to adequately care for him, due to the dire circumstances of her own life, exacerbated by her problematic alcohol usage:

a. In December 1994 when he was approximately nine months old he was taken to Wyndham Hospital by police as his mother was found to be intoxicated and there did not appear to be anyone attending to his needs; on this occasion neglect concerns were reported to the Department of Child Protection and Family Support; whilst neglect was not substantiated by that department, he was discharged from Wyndham Hospital on the same day into the care of relatives;

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[671] Exhibit 1.11, Tab 13.
[672] Ibid.
[673] Ibid.
[674] Ibid.

b. In June 1995 when he was a just over one year old he had a prolonged admission of approximately one months' duration to the Wyndham and Derby Hospitals (transferring between the two) with gastroenteritis, a urinary tract infection and failure to thrive; records reflect that during this admission his mother attended the ward in an intoxicated state on some occasions and it was considered that she was unable to care for him safely; Medical staff reported their concerns to the Department of Child Protection and Family Support and he was discharged to Ombulgurri Community in the care of relatives; on this occasion Department of Child Protection and Family Support records indicate that neglect was investigated and substantiated;

c. Medical records from Oombugurri Community Clinic frequently documented that the child's mother was intoxicated and record that he was taken to the clinic for review by his mother and by various family and other community members; records also reflect that at times he did not receive appropriate nutrition as there was no money and no food in the house.[675]

998. As outlined above, in 2006 when he was 11 years old his brother died by suicide. Records reflect that he was supported by members of the community, school and Oombulgurri Community Clinic staff. It is also recorded that mental health and counselling services were advised of the event, but there are no records of him being reviewed by these services.[676]

999. The young man's first presentation for alcohol related trauma was to Kununurra District Hospital when he was 15 years old. Sadly, there were multiple hospital emergency department presentations and admissions for injuries sustained in the setting of alcohol use, including a number of instances of him suffering fractures following alleged assaults (at Kununurra, Halls Creek and Wyndham Hospitals).[677]

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[675] Exhibit 1.11, Tab 13; Exhibit 9, Volume 1, Tab 17.
[676] Exhibit 1.11, Tab 13.
[677] Ibid.

Home environment

1000. Sadly the young man's mother died in 2003 and his father died in 2007. As outlined above, his older brother died by suicide in 2006. His sister was represented at the Inquest by KCLS.[678]

1001. The young man was originally raised in the Oombulgurri Community and when that community was closed down, he moved between Wyndham, Kununurra and Halls Creek. Early medical records indicate that he suffered environmental neglect resulting in avoidable illnesses. As outlined above, neglect concerns were investigated and substantiated by the Department of Child Protection and Family Support in June 1995 following a report from a hospital health worker from Wyndham.[679]

1002. In addition to residing with his parents, Department of Child Protection and Family Support records indicate that he spent periods of time residing with his maternal grandmother during 2006 to 2009, and some departmental support was provided to her. The records also indicate that his maternal grandmother had the responsibility of caring for six grandchildren (five boys and one girl) aged between 12 and 15 years in various periods during 2008 to 2010. At times, understandably, she struggled to manage her grandchildren's behaviour and was more likely than not to have experienced financial and practical difficulties.[680]

1003. On 16 September 2009 the Department of Child Protection and Family Support received a referral from Kununurra District Hospital concerning the young man, who was then aged 15 years. That referral raised the possibility of the Department of Child Protection and Family Support providing drug and alcohol counselling to him. He had been brought into the hospital in a heavily intoxicated state after being involved in an assault which had caused a possible fracture to his right arm, and this precipitated the referral. There is no further information in the departmental records as to the outcome of this referral.[681]

1004. In the year before his death the young man entered into a de facto relationship with his partner. In the earlier period of their relationship, on occasions when he was intoxicated, he struck his

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[678] Exhibit 9, Volume 1, Tab 17.
[679] Exhibit 11.1, Tab 13; Exhibit 9, Volume 1, Tab 17.
[680] Exhibit 9, Volume 1, Tab 17.
[681] Ibid.

partner. During that earlier period, on occasions he told his partner that he intended to take his life.[682]

1005. His partner also reported that from her perspective, in the period before his death, their relationship had improved, and that his aggressive behaviour had ceased. She recalled this change occurring after he had served a three month prison sentence. She formed the view that at a general level, shortly before his death, he was happy. The earlier incidents where he struck his partner were not reported to the police at the material time, or at any time prior to his death.[683]

Mental health treatment

1006. There is no record of the young man accessing any mental health or counselling services, nor is there any record of referrals having been made for him to see a mental health clinician, despite having previously expressed the intention to take his life on a number of occasions. I am not satisfied that those who heard him say this would have known who to turn to for help.

School attendance

1007. Reports from the Oombulgurri Remote Community School for when the young man had been attending kindergarten and pre-primary are positive, describing him as being confident, friendly, positive and motivated. However there is then a gap of five years in the Department of Education's school records and it is not clear where he was attending school.[684]

1008. The next set of available school reports are in respect of semester 2 of Year 7 in 2006 at Oombulgurri Remote Community School. He continued attending that school until the end of Year 9 in 2008, showing a particular aptitude in the areas of physical education and the visual arts, though other educational outcomes were primarily recorded as being limited or very low. Unfortunately by semester 2 of Year 9 he was frequently absent and no assessment

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[682] Exhibit 9, Volume 1, Tab 8.
[683] Exhibit 9, Volume 1, Tab 8; ts 1219 to 1220.
[684] Exhibit 9, Volume 1, ab 16B.

could be made of his schoolwork. By this stage his attendance rate was close to or below 40%.[685]

1009. Records reflect that the young man was also enrolled at Wyndham District High School over the same time period with variable attendance rate. In 2009 (Year 10) he attended 116 of a possible 384 sessions. There are no school reports from Wyndham High School, though there are numerous Individual Behaviour Reports that record problematic behaviours requiring attention, including verbal abuse, harassment, physical assault and/or intimidation of other students.[686]

1010. He was suspended for the last two days of semester 1 in 2009 (Year 10) after throwing a chair that hit another child. Following this incident, counselling with the school psychologist was recommended. It was also recorded that he would require specific permission to re-enter the school grounds. There is no record of counselling or contact with the school psychologist. There is no record of whether he returned to that school.[687]

Cause and manner of death

1011. The young man died in the early hours of 22 May 2015. On the previous day he had been drinking from early in the morning and this continued throughout the day and night. The alcohol consisted initially of beer and then spirits. He drank in the company of others, and at multiple addresses in Halls Creek, in the course of visiting various friends and family members. His partner commenced drinking herself in the early evening of that previous day.[688]

1012. The young man and his partner returned home shortly before midnight on 21 May 2015. He was heavily intoxicated. His partner was anxious to go to sleep. They had only been asleep a short time before they were awoken by others, who wanted to continue drinking. They left the home at approximately midnight, in company, in order to purchase more alcohol. However, they returned home shortly afterwards, at his partner's insistence, and she made the young man some dinner.[689]

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[685] Exhibit 9, Volume 1, Tab 16, 16A, 16B.
[686] Exhibit 9, Volume 1, Tab C.
[687] Ibid.
[688] Exhibit 9, Volume 1, Tabs 2, 8 and 9.
[689] Ibid.

1013. Between approximately 1.00 am and 2.00 am on 22 May 2015, the young man argued with his partner and he threatened to hit her. He remained heavily intoxicated. His partner's mother was at the home and she woke up and intervened in order to settle them down. After the argument subsided, the young man's partner went to her mother's room. Shortly afterwards, the young man announced that he was going to sit outside.[690]

1014. His partner followed him to ascertain why he had gone outside. However, she could not see him, and she searched the street, calling out his name, without success. She became concerned and when she could not find him, she returned home and her mother called the police. Shortly afterwards, the young man's partner also called the police.[691]

1015. Records reflect a number of telephone calls being made to police as follows:

a. at 2.17 am on 22 May 2015, a police constable at Halls Creek Police Station received a telephone call from the mother of the young man's partner, who informed that the young man had left the home with a ligature, expressing his intention to die by hanging;

b. at 2.20 am on 22 May 2015, another police constable at Halls Creek Police Station received a telephone call from the young man's partner, who informed that the young man had walked into bushland holding a ligature and expressing his intention to die by hanging;

c. at 2.25 am on 22 May 2015, the mother of the young man's partner again contacted Halls Creek Police Station and requested police assistance to locate the young man.[692]

1016. In the meantime, following the first telephone call at 2.17 am on 22 May 2015 a police officer was recalled from duty, and two officers attended at the young man's home, arriving at approximately 2.30 am. One officer was required to remain at the Halls Creek Police Station due a high risk event there.[693]

1017. Very shortly after their arrival, as police were conducting a foot patrol, they sadly found the young man hanging by a ligature from the branch of a tree in bushland near his home. He had made an

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[690] Exhibit 9, Volume 1, Tabs 2, 8 and 9; ts 1223 to 1224.
[691] Exhibit 9, Volume 1, Tabs 2, 8 and 9.
[692] Exhibit 9, Volume 1, Tabs 2, 8, 9 and 10; ts 1224.
[693] Exhibit 9, Volume 1, Tabs 2 and 10.

audible sound that had alerted police to his whereabouts. Police promptly released him from his ligature, commenced to perform CPR, and called for an ambulance.[694]

1018. Records reflect that police contacted the Halls Creek Hospital at 2.35 am, and that the St John Ambulance Service received a call at 2.38 am, arriving at the scene at 2.45 am on 22 May 2015. Upon arrival the two nurses took over the CPR, but despite all efforts, tragically, the young man was unable to be resuscitated. He remained in asystole, with dilated and fixed pupils and no pulse or breathing. The nurses ceased CPR and conveyed the young man by ambulance to the Halls Creek Hospital where the doctor pronounced him to be dead, at 3.05 am on 22 May 2015.[695]

1019. On 26 May 2015 the forensic pathologist made a post-mortem examination at the State Mortuary on the young man's body and on that date formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging). The forensic pathologist noted a faint ligature mark around the neck, fluid in the lungs and thickening of the wall of the heart. The ligature was provided to her, and its width was consistent with the areas of indentation around the neck.[696]

1020. Subsequent toxicological analysis of blood showed an alcohol level of 0.275%, and analysis of urine showed an alcohol level of 0.375%. No other common drugs were detected. The forensic pathologist's opinion on cause of death remained unchanged.[697]

1021. I have taken account of the forensic pathologist's report and her opinion on case of death, the toxicological analysis, and the evidence concerning the circumstances whereby the young man was found hanging in the bushland near his home, and specifically the evidence concerning the ligature and its placement.

1022. **I find that the cause of the young man's death in Case No. 13 was ligature compression of the neck (hanging).**

1023. The young man had a very high blood alcohol level at the time of death. He had an older brother who had died by suicide (hanging) at a similar age approximately eight years earlier. His mother had died in 2003 and his father had died in 2007. The cumulative

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[694] Exhibit 9, Volume 1, Tabs 2 and 3.
[695] Exhibit 9, Volume 1, Tabs 2, 3, 5, 12 and 15.
[696] Exhibit 9, Volume 1, Tab 6.
[697] Exhibit 9, Volume 1, Tabs 6 and 7.

trauma occasioned by the deaths of his family members was overwhelming.

1024. By the age of 15 years he was abusing alcohol and as a consequence, taking unacceptable risks with his health and safety. On numerous previous occasions, when intoxicated, he had expressed an intention to take his life, by hanging. It is clear that shortly after he went outside in the early hours of 22 May 2015, his partner and her mother both held fears for his safety, and were concerned that he would engage in an act of self-harm.

1025. At a time between approximately 2.00 am and 2.35 am on 22 May 2015, the young man affixed a ligature to a tree in bushland near his home and hanged himself, with the intention of taking his life. It is likely that his level of intoxication contributed to disinhibiting him. I am satisfied that he knew the foreseeable consequence of hanging himself was death, and that he was able to form the requisite intention for this finding. I am satisfied that he acted alone to use the item as a ligature in a manner that resulted in his death.

1026. **I find that the manner of the young man's death in case No. 13 was Suicide.**

COMMENTS ON TREATMENT AND CARE

1027. In the course of outlining the circumstances attending a number of the deaths, I have foreshadowed that any comment, or adverse comment I make will be separately addressed. These comments, and the reasoning for them appear below.

1028. As required by s 44(2) of the Coroners Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding. This opportunity has been provided and the parties have made their submissions.

1029. In making these my adverse comments I have taken into account the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, referred to under the heading *The Inquest*, above.

1030. I have taken account of the submissions made by the lawyers for the families, some of whom have expressed their concerns and disappointment regarding the actions of some of the service providers and the police.

1031. I have taken account of the submissions made by the lawyers of the service providers and the police, and the evidence of numerous witnesses working as service providers in the Kimberley Region as to their workloads, the shortage of staff and turnover of staff, distances that need to be covered and all of the other practical problems that arise when working in this remote region.

1032. It is important that I outline, at the commencement of this part, that where I have made adverse comment, the subject conduct has not caused or contributed to the death.

1033. Given the multifactorial problems that have been experienced in the Kimberley Region for generations, there is no justification for finding that the act or omission of a particular person, officer or agency caused or contributed to a suicide.

1034. Those multifactorial problems (described previously under the heading *Intergenerational trauma*) have created the environment that has generated despair amongst many Aboriginal children and young persons and some have tragically been overwhelmed by it and have acted to end their lives.

1035. The flow on effects of intergenerational trauma include domestic violence within families, alcohol and illicit drug abuse, child sexual abuse, poverty, neglect, low school attendance, lack of employment opportunities, overcrowding in houses, poor physical health and untreated mental health conditions.

1036. As outlined at the beginning of this finding, no adverse comment is made against any family member. These are the people who have themselves endured significant trauma and disadvantage.

ADVERSE COMMENT - DEPARTMENT OF CORRECTIVE SERVICES (now Department of Justice)

CASE No. 5

1037. This child died by suicide between 14 and 15 February 2013, in circumstances where her referral to the mental health services had been delayed, and then her planned appointment with the visiting mental health clinician was cancelled and rescheduled. She died before any contact with the mental health services.

1038. By way of introductory comment, as a result of the Machinery of Government changes on 30 June 2017 the Department of Corrective Services joined the Department of the Attorney General to become part of the Department of Justice. At the material time the responsible department was the Department of Corrective Services.

1039. The Department of Corrective Services was represented at the Inquest in relation to the involvement of this child with Youth Justice Services in Wyndham. Youth Justice Services is now a directorate of the Department of Justice that has since assumed the responsibility for the safety, security and rehabilitation of young people in custody and those engaged with its services in the community.

1040. The role of Youth Justice Services is to reduce the reoffending of young people through:

a. Services to divert young people away from the criminal justice system;
b. Programs and services for young people on orders in the community; and/or
c. Programs and services in custody.[698]

1041. Youth Justice Services in Wyndham forms part of Regional Youth Justice Services in the East Kimberley. Specifically in that area it undertakes supervision of young people on community based orders and those referred to Juvenile Justice Teams.[699]

1042. At the Inquest, I heard evidence concerning the conduct of one of the team leaders at Youth Justice Services (the Team Leader), primarily in connection with the child's referral to the mental health services.

1043. As at mid-2012, when based in Kununurra, her position was Team Leader of the Youth Justice Prevention and Diversion Team, East Kimberley Region ("the Prevention and Diversion Team"). She had oversight of 12 staff based in three different locations: Kununurra, Halls Creek and Wyndham. Of that staff, eight or nine at any one time were Aboriginal persons.[700]

1044. It is evident that the Team Leader's workload was significant for the 18 months she held this position. The Prevention and Diversion

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[698] Ex 1.6 Tab 55.1
[699] Ex 1.6 Tab 55.
[700] ts 1088-1089.

Team was responsible for between 60 and 80 children and it would not be unusual for her to work up to 70 hours per week.[701]

1045. I accept that the position that the Team Leader held could be very demanding. There is no doubt that she was a very dedicated employee who did her best in often very challenging and stressful circumstances.

1046. The child died in February 2013. The Team Leader was very short staffed, particularly during the month of January 2013, a fact conceded by the Department of Corrective Services in their report into the death of this child:

> *"Staffing issues, including significant staff absence during the period* [this child] *was managed, are considered to have impacted on the deficiencies identified."* [702]

1047. I have considered whether the Department of Corrective Services failed to address the staffing issues that the Prevention and Diversion Team had prior to and in January 2013 and whether this staffing shortage led to the oversight outlined below in relation to this child.

1048. This child was open to the Prevention and Diversion Team from 13 August 2012. As already referred to previously in this finding, a risk assessment was completed for this child on that day which indicated she was at serious risk given her age, transience, school disengagement and suspensions and use of alcohol and drugs.[703]

1049. Though the Team Leader had never met this child she was aware of the concerns for this child through her attendance as the representative from Youth Justice at the Wyndham Children at Risk meetings. On 23 November 2013, she had received an email from the Acting OIC of Wyndham Police Station indicating concerns about this child's behaviour after police attended a disturbance at her home in the early hours of that morning.

1050. It was evident from that visit that the child's home was prone to excessive drinking incidents and violent behaviour from adults. Department of Child Protection and Family Support and the Prevention and Diversion Team liaised that same day and a joint planned approach was developed to target matters including the child's street presence late at night, her not being adequately

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[701] ts 1090.
[702] Exhibit 14.2, Volume 2, Tab 2.
[703] Exhibit 14.2, Volume 2, Tab 2A and Ibid

supervised (thereby being at serious risk) and her school attendance which had dropped.[704]

1051. On 4 December 2012 at the Wyndham Children at Risk meeting, which the Team Leader attended, the child was added to the agenda.[705]

1052. On 16 January 2013 at the Wyndham Children at Risk meeting the OIC of Wyndham Police Station reported that the child's family had rung to say that she had run off and wanted to hang herself. It was recommended that a referral to the Child and Adolescent Mental Health Services (CAMHS) be completed and that task was assigned to Youth Justice which was represented by the Team Leader.[706]

1053. Counsel Assisting and KCLS submit to me that as the child was at significant risk, this referral should have been completed by staff from Department of Corrective Services in a timely manner that reflected the well-founded concerns for her wellbeing.

1054. However, by the next fortnightly Children at Risk meeting at Wyndham on Wednesday, 30 January 2013 that referral had not been done. Once again concerns were raised at that meeting about the child's wellbeing after a recent night time visit to the house by police ascertained that the child had threatened to kill herself. Once again it was determined that the child was at significant risk and the written referral to CAMHS was again assigned to Youth Justice to complete. That referral was sent by facsimile transmission to the CAMHS by the Team Leader on Saturday, 2 February 2013.[707]

1055. The referral, however, was not actioned by a staff member at the CAMHS until the next working day, Monday, 4 February 2013.[708]

1056. The next scheduled visit to Wyndham (where the child resided) by a mental health professional from CAMHS on Monday 11 February 2013 did not take place due to clinical priorities in Kununurra (though the Consultant Psychiatrist's recollection was that the cancellation was due to clinical priorities in Kalumburu).[709]

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704 ts 1092; These meetings were held fortnightly and comprised of representatives from the Police, Department of Corrective Services, Department of Education, Department of Health and DCPFS; ts 1092; Exhibit 14.2, Volume 2 Tab 2 and Exhibit 14.2, Volume 2 Tab 2A, p2.

705 Ibid.

706 Exhibit 14.2, Volume 2, Tab 2A; ts 1156 and 1157; ts 1102.

707 Ibid.

708 Exhibit 14.1, Volume 1, Tab 29A.

709 Ibid and ts 1128.

1057. Unfortunately the rescheduled CAMHS trip to Wyndham on Friday, 15 February 2013 was again cancelled due to ongoing priorities at Kalumburu. It was on 15 February 2013 that this child's body was discovered. [710]

1058. In her Briefing Note completed shortly after the child's death the Team Leader gave an explanation for the delay in referring the matter to CAMHS:

> *"The delay was due in part to the absence of the caseworker due to illness and the PDO (on leave from the 31/01/2013-08/02/2013) the TL travel commitments to Halls Creek and focus on the Up and Go program."* [711]

1059. In her evidence before the Inquest the Team Leader, who was very genuinely and deeply distressed, provided explanations consistent with those in her Briefing Note for the delay in preparing the referral to CAMHS. She testified that it was partly due to the case worker for the child being on extended sick leave at a time when other staff were also absent on annual leave. The Team Leader also explained that her workload was particularly excessive for that month. Her team had had 28 juvenile justice referrals, she had been to Kalumburu because of some serious offending and she had children at high risk in lock-ups. It was also her understanding that the Department of Child Protection and Family Support (DCPFS) were conducting regular welfare checks upon the child at the time.[712]

1060. Her evidence continued:

> *"It was just one of a bigger – bigger picture and as soon as I realised that it had not been done, either by [staff member] or by my team – I did that on Saturday morning to try and get someone out there straight away... And I was constantly working on the weekend."* [713]

1061. The Team Leader had an extremely heavy workload and the Prevention and Diversion Team was short staffed. This was not just the case in January 2013 but had existed for some time. There is some merit in her view expressed at the Inquest that there should have been a team leader based in each of Kununurra, Halls Creek

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[710] ts 1130.
[711] Exhibit 14.2, Volume 2, Tab 2A.
[712] ts 1103 and Exhibit 14.2, Volume 2, Tab 2A; ts 1104.
[713] ts 1103.

and Wyndham rather than just the one team leader based in Kununurra overseeing all three locations.[714]

1062. Ms Rachel Green, the Deputy Commissioner for Youth Justice Services, gave evidence at the Inquest on behalf of the Department of Justice (and on behalf of the former Department of Corrective Services). Ms Green agreed with the assessment of the Team Leader to the effect that she lacked sufficient staff.[715]

1063. There are now two team leaders with a combined caseload of 102 young people covering the same areas that the team leader was supervising by herself in 2012 and 2013.[716]

1064. There are now 11 positions for youth justice officers for the region; however at the time of Ms Green's evidence, eight of those positions had not been filled.[717]

1065. Ms Green also testified that the Department of Corrective Services report into the death of this child was not a criticism of the Team Leader, rather a *"general criticism"* and a factual acknowledgement that: *"We can do things better."* [718]

1066. The departmental Case Review recognised that action to progress the referral to the Child and Adolescent Mental Health Service required greater urgency, given the identified concerns about the child's risk of self-harm. The departmental Case Review identified that staffing issues, including significant staff absence during the period this child was managed, had an impact on the deficiencies identified.[719]

1067. Things should have been done better by the Department of Corrective Services with respect to the onerous workload that the Team Leader and the Prevention and Diversion Team had and it was this workload which led to the failure to complete and forward the referral regarding the child to Child and Adolescent Mental Health Service in a timely manner. The delay in forwarding the referral onto Child and Adolescent Mental Health Service meant that the Child and Adolescent Mental Health Service were not able to action it until nearly three weeks after the Children at Risk meeting had first recommended the referral.

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[714] ts 1107.
[715] ts 1911.
[716] ts 1913.
[717] ts 1913.
[718] Exhibit 14.2, Volume 2 Tab 2, ts 1910 and 1911.
[719] Exhibit Tab 55.11; Exhibit 1.6 Tab 55.18.

1068. The Team Leader's evidence at the Inquest was that she rang Child and Adolescent Mental Health Service on Monday, 4 February 2013 to confirm they had received the referral. She also said she was made aware that a Child and Adolescent Mental Health Service representative was going to visit Wyndham that week.[720]

1069. That account is not entirely consistent with the notes made by Child and Adolescent Mental Health Services Community Mental Health Professional (the CAMHS Officer). Those handwritten entries indicate that on 4 February 2013 at 11.00 am he left a message with Youth Justice *"re interim management plan"*. On 5 February 2013 at 2.00pm he wrote *"also in contact I (with) the Team Leader and feels matter is non-urgent but child may be vulnerable. Plan CAMHS Wyndham visit next Monday."*[721]

1070. The record reflects that whilst the Team Leader advised the CAMHS Officer, that the matter was *"non-urgent"* she also said that the child *"may be vulnerable"*. It is also evident from the CAMHS Officer's handwritten notes on 5 February 2013 that the outcome of his contact with an officer at Wyndham Department of Child Support and Family Services was that the Department would arrange a welfare check. That is consistent with the Team Leader's understanding at the time. [722]

1071. Whilst the Department of Justice had no responsibility in this area at the material time, the former Department of Corrective Services is now part of it. Accordingly, the Department of Justice makes the submissions to me concerning the adverse comment regarding the child's supervision.

1072. The Department of Justice through its lawyer the SSO, accepts this adverse comment, in that it accepts there were issues with the Department of Corrective Services' regional staffing in the East Kimberley. This was compounded by unplanned leave which may have contributed to the delay in sending the referral regarding this child to the Kimberley Child and Adolescent Mental Health Service. The Department of Justice submits that this case sadly highlights the limitations that it has as a result of staffing shortfalls.

1073. Whilst the Department of Justice accepts that there was a delay in making the referral, it submits that this delay should be viewed in the context of the Team Leader's evidence that the majority of her staff were on leave at the time and that this child was not an

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[720] ts 1104.
[721] Exhibit 14.1, Volume 1, Tab 29A.
[722] Exhibit 14.1, Volume 1, Tab 29A.

open statutory case with the Regional Youth Justice Services in the East Kimberley.[723]

1074. The Department of Justice refers to the evidence of the Deputy Commissioner of Youth Justice Services in Western Australia, Ms Green, as to the challenges that continue to exist for the that Department in recruiting, particularly for Kununurra and the Regional Youth Justice Services in the East Kimberley. It also refers to the evidence as to the difficulty in maintaining Aboriginal staff.[724]

1075. Specifically, in addition to recruitment challenges, the Department of Justice submits that there are challenges for Aboriginal staff working for Youth Justice Services in relation to cultural obligations, and impacts on their capacity to work with all clients.[725]

1076. The Department of Justice submits to me that the primary responsibility for seeking assistance for the child's increasing apparent issues lay with her parents, but that it also accepts that it had an opportunity to intervene by reason of its involvement with the child.

1077. The Department of Justice draws attention to the internal review conducted at the time of the child's death, which recognised its shortcomings in the management of the child's case and made recommendations for improvement.

1078. The Department of Justice outlines steps it has undertaken as part of its continual review to improve processes and outcomes, and they include the following:

a. It has undertaken a functional review of delivery of services in Pilbara and Kimberley regions, and implemented a range of measures including converting prevention and diversion officer positions to substantive Youth Justice Officer positions in accordance with the functions of the *Young Offenders Act 1994* and issuing an instruction for monthly, in addition to periodic, case review practices;

b. It has increased staffing numbers so now there are two Team Leaders supervising 11 staff in the Kimberley;

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[723] ts 1099; Exhibit 1.6 Tab 55.11.

[724] ts 1090.

[725] Exhibit 1.6 Tab 55.

c. It has issued an instruction to ensure that all staff are clear as to their responsibilities and their role in the event they identify a risk of harm to a young person in the community.

1079. On all of the evidence before me and taking account of the submissions made, I have determined that an adverse comment is warranted notwithstanding the submission concerning the lack of staffing.

Adverse comment: the Department of Corrective Services as it then was failed to send to the Child and Adolescent Mental Health Service in a timely manner the referral regarding this child (Case No. 5)

1080. I do not find that the failure by the Department of Corrective Services to send the referral in a timely manner caused or contributed to the child's death. It cannot now be known what the outcome of that referral might have been. Suicide is very difficult, if not impossible, to predict. With the benefit of hindsight the matter was clearly urgent. The child was very vulnerable as a result of long-standing and entrenched trauma and she had already expressed an intention to take her life. Numerous attempts had been made by agencies over an extended period to help her and her family under very difficult and trying circumstances.

1081. Nonetheless a timely referral clearly had the potential to help the child, and this was, sadly, a missed opportunity.

ADVERSE COMMENT - DEPARTMENT OF CHILD PROTECTION AND FAMILY SUPPORT (now Department of Communities)

1082. As outlined earlier in this finding, up until 30 June 2017, the department responsible for child protection was the Department of Child Protection and Family Support. As a result of the Machinery of Government changes the Department of Child Protection and Family Support became part of the Department of Communities.

1083. The *Children and Community Services Act 2004* ("Children and Community Services Act") makes provisions about the protection and care of children, and its objects are defined in s 6 to include the following:

a. *"to promote the wellbeing of children …;"*

b. *"to acknowledge the primary role of parents, families and communities in safeguarding and promoting the wellbeing of children;"*

c. *"to encourage and support parents, families and communities in carrying out that role;"*

d. *"to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely or unable to give, that protection and care."*[726]

1084. The paramount consideration in performing a function or exercising a power under the Children and Community Services Act is the best interests of the child. A non-exclusive list of matters to be taken into account when determining the child's best interests includes the need to protect the child from harm, the nature of the child's relationship with the parents and the importance of continuity and stability in the child's living arrangements and the likely effect on the child of disruption of those living arrangements, including separation from the child's parents.[727]

1085. The Children and Community Services Act has specific sections as regards the placement of Indigenous children, within the context of the principle that allows Indigenous persons to participate in the protection and care of their children with as much self-determination as possible, and the principle that provides for opportunity and assistance for community participation (such as the child's kinship group) in certain decision making processes.[728]

1086. Pursuant to the Children and Community Services Act, the objective of maintaining an Indigenous child's connection with family and culture is to be achieved by the principle requiring any placement of that child (so far as is consistent with the child's best interests and is otherwise practicable) to be in accordance with a specified order of priority, namely:

a. Placement with a member of the child's family;

b. Placement with an Indigenous person in the child's community in accordance with local customary practice;

c. Placement with an Indigenous person;

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[726] s.6(d).
[727] s 7 and s 8.
[728] ss 12 to 14.

d. Placement with a non-Indigenous person who is sensitive to the needs of the child and capable of promoting the child's ongoing affiliation with the child's culture and, where possible, the child's family.[729]

1087. The provisions of s 32 of the Children and Community Services Act set out what must be done by the Chief Executive Officer of the Department of Communities if he or she determines that action should be taken to safeguard or to promote a child's wellbeing. Those actions include the following:

a. Causing *"an investigation to be conducted by an authorised officer for the purpose of ascertaining whether the child may be in need of protection;"*

b. Taking, or causing to be taken "*intervention action in respect of the child;"* and/or

c. Taking, or causing to be taken *"any other action in respect of the child that the CEO considers reasonably necessary."*[730]

1088. The intervention action under s 32(2) of the Children and Community Services Act can include taking the child into provisional care and protection, and making a protection application. Exercise of the power to intervene is conditional upon the need to establish that a child is "*in need of care and protection*" and is considered by the Children's Court of Western Australia.[731]

1089. The Children's Court of Western Australia is empowered to make a protection order and must not make a protection order unless it is satisfied that the making of the order would be better for the child than making no order at all (the "*no order principle*").[732]

1090. The Department of Premier and Cabinet, through its lawyer the SSO, draws my attention to the efforts of the former Department of Child Protection and Family Support's Aboriginal Employment and Learning Strategy, as part of an effort to increase Aboriginal employment within that agency.[733]

1091. It is self-evident that an increase in the number of Aboriginal staff members paves the way for a better understanding of the cultural

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[729] s 12.
[730] s.32(1)(d) s.32(1)(e s.32(1)(f).
[731] ss 35 to 38.
[732] ss 45 to 46.
[733] Exhibit 1.7, Tab 58.

protocols, and the unremitting sorrow that is generated by removals.

1092. The matter of the removal of Aboriginal children from their families, by either formal or informal arrangement has historically created a level of anguish amongst Aboriginal communities that reverberates through the generations and is profoundly felt to this very day.

1093. My attention is also drawn to the former Department of Child Protection and Family Support's Signs of Safety Framework, its efforts towards a greater recognition of the consequences of cumulative harm and the Intensive Family Support Framework. The Department of Child Protection and Family Support has been involved with other agencies in the Young People/Children at Risk meetings, the Kimberley Joint Response Team and the Critical Incident Response process.[734]

1094. I am informed that the Department of Child Protection and Family Support's longer-term objective is to provide earlier and appropriate supports for parents caring for their children rather than that department taking more children into care or providing those services outside the home.

1095. With respect to a number of the deceased who the Department of Child Protection and Family Support had contact with, Counsel Assisting submits that there are potential adverse findings to be made regarding the that Department's failure to take proper actions to safe guard the wellbeing of these children. In making the submissions for potential adverse findings Counsel Assisting fully acknowledges the Department of Child Protection and Family Support's well-meaning efforts to ensure a child is cared for either by their parents or members of their extended family. The provisions of the Children and Community Services Act make that particularly so for Indigenous children.[735]

1096. The dilemma faced by the staff of the Department of Child Protection and Family Support is a difficult one, and some decisions are challenging and very finely balanced.

1097. There is anguish and sorrow, magnified by the knowledge of the historical removals, if a child is removed from a family or kinship group. There is the potential for unremitting recriminations if a child is not removed and suffers harm.

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[734] Exhibit 1.3, Tab 24.
[735] s.12 of the Act.

1098. At the Inquest the Executive Director of Country Services and Therapeutic Care with the Department of Communities, Mr Andrew Geddes, was questioned on the practical application of the principles governing the placement of Indigenous children under the Children and Community Services Act. Mr Geddes highlighted the need to keep the child safe:

> *"[Y]ou are certainly highlighting the day-to-day struggle in terms of professional decision-making around child protection but there should be no difference if a child is at immediate risk or significant risk of harm in terms of the decision to remove that child from that harm or not based on cultural reasons or – or not. … That is not the way that you keep children safe."* [736]

1099. Within Child Protection the average percentage of Aboriginal employment in the East and West Kimberley between 2007-08 and 2015-16 was 40% and 30% respectively. In his report to the coroner, Mr Geddes outlined the challenges faced by the Department of Communities in attracting and retaining staff:

> *"Most positions need to be advertised at least twice, and often three times, to attract a limited pool of suitable applicants. Significant investment is required in training, orientation and development, however despite this many appointments, particularly from interstate or overseas, last for short term periods only."*[737]

1100. In Mr Geddes' considerable experience, having worked as a public servant in the child protection area for approximately 20 years, he was better able to find people who are prepared to be part of a Safety Plan around an Indigenous child in the Kimberley area, in contrast to his experience in the Perth area. In Mr Geddes' opinion, this was as a result of the strength of the culture and family network and the degree of collective effort involved in working towards a Safety Plan. He highlighted the importance of the Department of Communities' Aboriginal Practice Leaders, who provide valuable input into the decision making surrounding these difficult questions.[738]

1101. The difficulty of this decision-making process is exacerbated with respect to the Kimberley Region when regard is had to the size of the region, the workloads of staff, the high turnover of staff and the magnitude of the poverty and the dysfunction. The problems facing the then Department of Child Protection and Family Support (and

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[736] ts 2152 – 2153.
[737] Exhibit. 1.7, Tab 58.
[738] ts 2152 to 2153.

now faced by the Department of Communities) were summed up by Mr Geddes in his answer to the following question by Counsel for the State Solicitors Office:

> *"We've heard of specific cases here about children being found walking the streets at night, or not attending school, or in some cases both of those things. As those two factors stand alone, are they a high priority of concern for the department? --- Yes, they are high priority. The – I mean, we're talking about communities, towns where we have, you know, multi-generational trauma and all the negative indicators that we have discussed, and it's more about how we actually can work with those communities to try and turn it around at a broader level. It is very difficult to try and work with an individual family when all the influences that surround that family are actually feeding into the negative aspects of the community, or reinforcing the negative behaviours, when what we're really looking for is something that actually starts to move the whole community out of those – those behaviours and that – the dysfunction and the poverty."* [739]

1102. There has been unanimity from the witnesses before the Inquest about the need for a collaborative approach between government service providers and the Aboriginal community to address the myriad of factors responsible for the high rate of suicide amongst Aboriginal children and young persons in the Kimberley.

1103. In respect of a number of deaths investigated at the Inquest, Counsel Assisting submits to me that the Department of Child Protection and Family Support failed, given the information available to it, to undertake a proper assessment regarding the child's wellbeing. Counsel Assisting further submits that these were situations in which it should have been obvious to the Department of Child Protection and Family Support that the wellbeing of these children was at risk due to their parents or other caregivers not being able to provide the necessary care and protection for the child. In those circumstances, it is submitted, the objects of the Children and Community Services Act were not being met and it was incumbent upon the Department of Child Protection and Family Support, using its powers under that legislation, to make the arrangements to have that care and protection provided. [740]

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[739] ts 2244 – 2245.
[740] S 6(a) and (d) of the Act.

1104. I accept Mr Geddes' evidence that removing a child from their family can itself cause trauma.[741]

1105. For the reasons outlined below, I am satisfied that in each of the following four cases, there was a deficiency or failing on the part of the Department of Child Protection and Family Support's response. I do not find that these deficiencies or failures caused or contributed to the deaths, but on each occasion there was potentially, a missed opportunity to help the child.

CASE No. 1

1106. This child died by suicide on 8 January 2013 in circumstances where there had been a number of reports to the Department of Child Protection and Family Support expressing concerns for her welfare.

1107. On 16 March 2005 the Department of Child Protection and Family Support was advised that this child's mother was unable to provide adequate care for her daughter. Since 2004 the child appeared to have been cared for by a relative. In mid-2005 the child was sent to Kalumburu to be cared for by extended family. There is no record of any assessment or investigation being undertaken by the Department of Child Protection and Family Support regarding the concerns expressed in March 2005.[742]

1108. On 12 April 2006, the Department of Child Protection and Family Support was contacted by an unidentified "*notifier*" who had reported apparent neglect of the child by her mother. This person requested that the Department of Child Protection and Family Support make relevant inquiries. There is no record of that Department having undertaken any investigation as a consequence.[743]

1109. Given these two notifications to the Department of Child Protection and Family Support it is of concern that with respect to its records *"there is limited information in relation to the* [child's] *living arrangements from 2006 up until the time of her death."*[744]

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[741] ts 2140.
[742] Exhibit 2, Volume 1, Tab 26.
[743] Ibid.
[744] Ibid.

1110. The electronic records of the Department of Child Protection and Family Support make reference to the child being cared for by her maternal aunts at varying times throughout her childhood.[745]

1111. These were only informal family arrangements meaning that the mother, who had difficulties adequately caring for her children, was able to remove the child from those family members.

1112. In her report to the coroner dated 3 August 2016 the following conclusion was drawn by the Department of Child Protection and Family Support's previous Executive Director of Country Services and Therapeutic Care, Ms Julianne Davis, with respect to the child's death:

> *"A retrospective review of* [the child's] *case highlights the prominence of alcohol abuse, domestic violence, neglectful parenting, the absence of a responsible legal guardian and the presence of cumulative harm. It is also evident that on a number of occasions no assessment was undertaken in relation to* [her] *safety and wellbeing and care arrangements."*[746]

1113. At the Inquest, the Department of Child Protection and Family Support's Senior Community Child Protection Worker in Kalumburu at the time of the child's death (the DCP Worker) provided the following insight:

> *"I would be concerned from a child protection perspective about the issues of DV and neglect in Derby and what action the Department took to protect* [the child]. *Alarmingly, often neglect and/or abuse is substantiated by DCP and instead of taking the child into care then formally assessing suitable family members for the child to be placed with, the short cut is simply to substantiate and send the child off as a "family arrangement" without any checks or assessments being done."*[747]

1114. At the Inquest Mr Geddes accepted the validity of that comment, and explained that there had previously been more reliance placed by the Department of Child Protection and Family Support upon the informal placement of a child with a member of the child's extended family, pursuant to a negotiated placement agreement. The Department of Child Protection and Family Support has now moved to more formal placement arrangements. An example is a

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[745] Ibid.
[746] Exhibit 2, Volume 1, Tab 26.
[747] Exhibit 2, Volume 1, Tab 12.

three-month placement with an extended family member, subject to checks, support and review to see if it is working.[748]

1115. Mr Geddes, in his evidence before the Inquest, accepted that with respect to those occasions in which no assessments were undertaken they ought to have been.[749]

1116. The child was not in the care of the CEO of the Department of Child Protection and Family Support immediately before her death, nor at any time throughout her life.[750]

1117. The Department of Communities through its lawyer the SSO, submits to me that an adverse comment should not be made for a range of reasons that include a lack of evidence to substantiate that the child was at ongoing risk, and that the March 2005 and April 2006 reports to the Department of Child Protection and Family Support were too remote from her death to be relevant to how her death occurred.

1118. However the Department of Communities through its lawyer also the SSO acknowledges that the nature of the report in April 2006 was such that an assessment of this child's safety should have occurred by the Department of Child Protection and Family Support.

Adverse comment: By the time of the second report in April 2006, taking account of the nature of that report, and the fact that an earlier report along similar lines had been made in March 2005, the Department of Child Protection and Family Support ought to have undertaken an assessment of the child's wellbeing, and failed to do so.

1119. It cannot in retrospect be known what the outcome of that assessment would have been, but I am satisfied that it could potentially have helped this child.

1120. Because the child was not in the care of the CEO of the Department of Child Protection and Family Support, that department did not incur any obligation to assess her wellbeing on an ongoing basis. There were, potentially, missed opportunities to refer her to the mental health services. Removal of the child was not the only available option for consideration.

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[748] ts 2215.
[749] ts 2213 – 2214.
[750] Exhibit 2 Tab 26.

1121. I accept that, despite two adults having become aware that the child was sad and had made threats to kill herself shortly before her death, there is no evidence of the Department of Child Protection and Family Support being informed of that information.[751]

1122. I do not find that the failure by the Department of Child Protection and Family Support to undertake an assessment of this child's wellbeing in or about April 2006 contributed to her death.

CASE No. 2

1123. This child died by suicide at a time between 4 and 5 April 2015 in circumstances where there had been a number of reports made to the Department of Child Protection and Family Support expressing concerns for his welfare.

1124. The evidence established that this child had an extremely dysfunctional life from the moment he was born. As stated by the Executive Director Country Services and Therapeutic Care (the Executive Director, DCP) in her report to the coroner dated 3 August 2016 with respect to this child's death:

> *"Early life for* [this child] *was chaotic and transient, and it is likely that he had little routine, security or stability. Records reflect that* [this child] *experienced repeated exposure to cumulative harm during his early childhood. Contemporary literature including the Ombudsman Western Australia, 2014 Report on Youth Suicide confirms that a history of maltreatment during childhood has been identified as a significant risk factor in youth suicide."*[752]

1125. The Department of Child Protection and Family Support investigated concerns that were reported to it in the first two years of this child's life. However with respect to those investigations, the Executive Director DCP *noted that: "statutory action was not taken (although it was referred to on occasion)"* and *"inadequate assessment of his care arrangements occurred in his early childhood."*[753]

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[751] ts 380-381.
[752] Exhibit 4, Volume 1, Tab 15.
[753] Exhibit 4, Volume 1, Tab 15.

1126. As conceded by Mr Geddes in his evidence at the Inquest *"there was opportunity there* [in those earlier years] *to do that more holistic, cumulative harm work."*[754]

1127. Even though it must be considered that the response by the Department of Communities is in relation to events that happened back in 1998 and 1999, the traumatic existence that this child was enduring in these early years warranted greater action than the Department of Child Protection and Family Support undertook.

1128. Counsel Assisting submits to me that the admitted inadequate assessment of this child's care arrangements by the Department of Child Protection and Family Support in his early childhood ought to be the subject of an adverse comment.

1129. Counsel Assisting also submits to me that a further adverse comment with respect to this child's care should be made against the Department of Child Protection and Family Support in relation to its response following contact made by his carer in 2011 requesting that they rescue the child. As the Executive Director DCP acknowledged, this report by his carer *"was not subject to further investigation."*[755]

1130. The Executive Director DCP stated that *"the Department's first response is to work with parents and strong family members to ensure the safety, wellbeing and placement of children."*[756]

1131. There was no such response by the Department of Child Protection and Family Support following his carer's report to it in 2011. Counsel Assisting submits to me that that was a significant oversight. As Mr Geddes conceded in his evidence at the Inquest:

> *"In 2011, as a 14 year old, I think the opportunity there to engage with him and look at what's happening for him and try and put him straight* [indistinct] *brought him into adulthood would have been a – you know, there's a missed opportunity there, from what I can see in terms of our Department."*[757]

1132. The Department of Communities through its lawyer the SSO, submits to me that an adverse comment should not be made for a range of reasons that include a lack of evidence to substantiate harm to this child from the time of the 2011 report to the time of his death in April 2015, and that the reports to the Department of

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[754] ts 2208.
[755] Exhibit 4, Volume 1, Tab 15.
[756] Exhibit 4, Volume 1, Tab 15.
[757] ts 2208.

Child Protection and Family Support were too remote from his death to be relevant to how his death occurred.

1133. However the Department of Communities through its lawyer the SSO also acknowledges that the reports to the Department of Child Protection and Family Support in relation to this child in 1998, 1999 and 2011 warranted an assessment that on the records, appears not to have occurred.

Adverse Comment: The Department of Child Protection and Family Support ought to have undertaken an assessment of this child's wellbeing after the reports in 1998, 1999 and 2011, and on each occasion failed to do so.

1134. It cannot in retrospect be known what the outcome of those assessments would have been, but I am satisfied that they could potentially have helped this child.

1135. Because this child was not in the care of the CEO of the Department of Child Protection and Family Support, that department did not incur any obligation to assess his wellbeing on an ongoing basis. There were, potentially, missed opportunities to refer him to the mental health services. Removal of the child was not the only available option for consideration.

1136. I do not find that the failure by the Department of Child Protection and Family Support to undertake those assessments of the child's wellbeing in 1998, 1999 and 2011 contributed to this child's death.

CASE No. 4

1137. This child died by suicide on 6 March 2016 in circumstances where there had been a number of reports made to the Department of Child Protection and Family Services expressing concerns for her welfare.

1138. On 17 October 2013 a social worker contacted the Department of Child Protection and Family Support expressing concern for the safety and wellbeing of this child after she had disclosed to the social worker she had been hit by a carer at her home. On 25 October 2013 Department of Child Protection and Family Support's staff contacted the social worker to discuss her concerns and on that occasion the social worker also advised that the child had mentioned her older sister had died by suicide. The social

worker, in addition, advised that the child was talking about violence she had witnessed in the past between her parents.[758]

1139. As conceded by the Executive Director DCP in her report to the coroner dated 3 October 2016 regarding the child:

> *"With the benefit of hindsight staff should have made further inquiries in relation to* [the child] *on 17 October 2013 when the school social worker reported to the Department* [the child] *had disclosed being hit at home. Staff should have followed up with the social worker. However,* [the child] *was not interviewed about her home situation."* [759]

1140. Mr Geddes in his evidence at the Inquest also accepted that the child should have been interviewed about her home situation in these circumstances.[760]

1141. Counsel assisting submits that an adverse finding should be made regarding the Department of Child Protection and Family Support's failure to do so in respect of the 17 October 2013 contact.

1142. On 10 February 2014 the above social worker contacted the Department of Child Protection and Family Support advising that by the end of the last term of school the previous year, the child's carer was no longer engaging with the social worker and that the child had stopped attending school. The social worker had since heard that the child had returned to the Kimberley. She sought confirmation from the Department of Child Protection and Family Support that it would follow up and monitor the child.[761]

1143. The Department of Child Protection and Family Support's staff member who took the call from the social worker advised her that the case was closed and no child protection concerns had been noted at the time of the closure in January 2014.

1144. As conceded by the Executive Director DCP in her report:

> *"Further inquiries should have also been undertaken when staff were advised by a Parkerville social worker in February 2014* [the child's] *school attendance had fallen and she had moved back up North. The safety plan signed by [names suppressed] required that the Department was notified by [name suppressed] if she left Midland. Due to the violent nature of her*

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[758] Exhibit 3, Volume 1, Tab 42.
[759] Ibid.
[760] ts 2228.
[761] Exhibit 3, Volume 1, Tab 42.

parents' background, the Department should have confirmed the care arrangements for the children.

There is no documentation in relation to the change in family arrangement when the children left [name suppressed] in Midland and moved to [name suppressed] in Looma".[762]

1145. Mr Geddes accepted in his evidence at the Inquest that the Department of Child Protection and Family Support should have confirmed the care arrangements for the child after this contact.[763]

1146. Counsel Assisting submits that given the dysfunctional nature of her upbringing, this failure is serious enough to warrant the making of an adverse comment against the Department of Child Protection and Family Support in respect of the February 2014 contact.

1147. Further, on a number of occasions between April 2015 and October 2015 the Department of Child Protection and Family Support was aware of concern raised in respect of another member of the child's household. However, this child's situation was not considered.[764]

1148. In his evidence at the Inquest, Mr Geddes stated that the Department of Communities' policy now is that where there is more than one child in a household and a concern is raised about one of those children, then an assessment has to be done on the other children as well.[765]

1149. Counsel assisting submits to me that even though Mr Geddes was not aware when that policy came into effect, an assessment ought to have been made of the child's wellbeing after April 2015. That is because even a cursory review of the information the Department of Child Protection and Family Support had as of 2015 would have highlighted the prominence of alcohol abuse, the entrenched pattern of domestic violence between her parents, previous neglectful parenting, the trauma associated with an older sister having already died by hanging and the presence of cumulative harm. Such information ought to have cried out for an assessment to also be made of the child. Counsel Assisting therefore submits to me that the failure by the Department of Child Protection and Family Support to do so warrants an adverse finding.

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[762] Exhibit 3, Volume 1, Tab 42.
[763] ts 2228.
[764] Ibid.
[765] ts 2229.

1150. A particularly troubling aspect is that in October 2013, they were aware that this young child had mentioned her older sister had died by suicide.

1151. The Department of Communities through its lawyer the SSO, submits to me that an adverse comment should not be made for a range of reasons that include a lack of evidence to substantiate harm to the child in her current environment in respect of the October 2013 report and the 2015 concerns regarding the other member of the household, and that all of the reports to the Department of Child Protection and Family Support were too remote from her death to be relevant to how her death occurred.

1152. Specifically in respect of the 2013 report, the Department of Communities draws my attention to the evidence of a departmental officer, who at the Inquest that indicated that the reported violence had occurred in the past, not the child's current home environment.[766]

1153. The Department of Communities also draws my attention to the fact that the 2015 concerns largely related to the particular needs of another member of the child's household. Further, they submit that while assessing the other children in the household is clearly desirable (and now Departmental policy) there is no evidence of this child being at risk of harm at this time.

1154. However, the Department of Communities through its lawyer the SSO acknowledges that the reports to the Department of Child Protection and Family Support in relation to the child in October 2013 and February 2014 and the reports of concerns raised about the other member of her household between April and October 2015 warranted an assessment for the child that on the records, appears not to have occurred.

Adverse comment: The Department of Child Protection and Family Support ought to have undertaken an assessment of the child's wellbeing after the reports in October 2013, February 2014 and between April and October 2015, and on each occasion failed do so.

1155. It cannot in retrospect be known what the outcome of those assessments would have been, but I am satisfied that they could potentially have helped this child.

[766] ts 457-458.

1156. Because the child was not in the care of the CEO of the Department of Child Protection and Family Support, that department did not incur any obligation to assess her wellbeing on an ongoing basis.

1157. As a result of those failures to undertake an assessment there were, potentially, missed opportunities to work with the child's carers and/or refer her to the mental health services. Removal of the child was not the only available option for consideration.

1158. I do not find that the failure by the Department of Child Protection and Family Support to undertake assessments of the child's wellbeing in October 2013, February 2014 and between April and October 2015 contributed to her death.

CASE No. 5

1159. This child died by suicide at a time between 14 and 15 February 2013 in circumstances where information available to the Department of Child Protection and Family Support raised a concern about her welfare.

1160. On 11 February 2009 the Department of Child Protection and Family Support became aware of relevant criminal charges regarding alleged offences (they did not concern the children of the household).[767]

1161. As a result of those charges, an assessment was required to be made by the Department of Child Protection and Family Support to determine the safety of the children of the household.

1162. However the Department of Child Protection and Family Support made no contact with the family for over five months until 23 July 2009. Even then, when staff from the Department of Child Protection and Family Support undertook a visit to the family in the Oombulgurri Community, they conducted an assessment and formulated a Safety Plan, but the children were not interviewed due to *"time constraints."*[768]

1163. It was also noted that it would have been extremely difficult to enforce such a Safety Plan.[769]

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[767] Exhibit 14.2, Volume 2, Tab 1.
[768] Ibid.
[769] ts 2173.

1164. Mr Geddes gave evidence that under the Department of Communities' current processes, the children of the household would have been interviewed. And he also accepted that they should have been interviewed back in 2009 in accordance with the Department of Child Protection and Family Support's processes.[770]

1165. As conceded by the Executive Director DCP in her report to the coroner regarding this child:

> *"…it would have been better if those children had also been interviewed. This is now standard practice in all such cases."*[771]

1166. Counsel assisting submits to me that this is an oversight that warrants an adverse comment.

1167. I have already outlined this child's home environment from March 2012 until her death on or about 14 February 2013. By the time she was 12 years old, her life had become completely dysfunctional. There is no dispute that the Department of Child Protection and Family Support was fully aware of this child's *"at risk"* behaviour in 2012. As reported by the department's manager, case practice, metropolitan services, in her letter dated 22 May 2013 to police:

> *"In summary, there is significant information on the Department's file to indicate that this child was a 12 year old child who was using drugs, alcohol and increasingly out on the streets late at night. There were referrals made by two medical practitioners indicating a level of concern for her welfare and vulnerability. Both referrals further indicated that given the history of [name suppressed] that further investigation by the Department may be warranted."*[772]

1168. Similarly, the Executive Director DCP noted:

> *"There is no information available in the Department's records on this child prior to 2005. However, it does emerge that [this child's] parents' lifestyle impacted on her care and development. Records reflect chronic alcohol use by her parents and neglectful parenting towards this child during 2012 and early 2013 records reflect that [this child] was unsupervised and out late on the streets. It is not possible to determine when [this child's]*

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[770] ts 2168.
[771] Exhibit 14.2, Volume 2, Tab 1.
[772] Ibid.

alcohol and gunja use commenced and the extent to which these factors were impacting on her behaviour." [773]

1169. The Executive Director DCP then conceded:

> *"On the basis of the information available to me, it is evident that on multiple occasions the Department did not undertake a thorough assessment regarding [this child's] wellbeing, health and safety. Had this been obtained it may have enabled Departmental Officers to work in a holistic way with the family."*[774]

1170. Mr Geddes, in his evidence at the Inquest was in agreement with these conclusions. He was asked the following questions:

> *"Should your Department have conducted a risk assessment of [this child] by August 2012, in light of the information that it had? ---In light of the information we had, I would have expected that a Safety and Wellbeing Assessment would have been undertaken, or some kind of intervention undertaken.*
>
> *And there wasn't, was there? --- It doesn't – not to the level which would have satisfied me at the time."* [775]

1171. After Mr Geddes was referred to an Action Plan jointly developed by staff members from the Department of Child Protection and Family Support and the Department of Corrective Services Youth Justice team on 30 November 2012, he conceded there should have been more to that Action Plan.[776]

1172. Mr Geddes accepted that the manner in which the Department of Child Protection and Family Support dealt with this child in the last 11 months of her life was not adequate. He also accepted that at the material time she was: *"currently not in a safe place."*[777]

1173. Mr Geddes also accepted that no alternative option apart from the child remaining in the care of her parents was ever considered. He was asked the following questions:

> *"But in those 11 months, those alternative options hadn't even been explored by the Department? --- No. They hadn't, and I acknowledge that.*

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[773] Ibid.
[774] Ibid.
[775] ts 2185.
[776] ts 2193; Exhibit 14.2, Volume 2, Tab 2A.
[777] ts 2198-2199.

And those factors that I just listed for you – they are all a relevant consideration to be taken into account when you are looking at cumulative harm? --- Yes. Yes.

And so the relevance of cumulative harm would have been recognised by the Department? --- At that stage, yes.

As of September 2012? --- Yes."[778]

1174. Counsel assisting submits to me that the Department of Child Protection and Family Support's failure to explore alternative options for this child over this 11 month period from March 2012 to her death in February 2013 meant that it failed to safeguard this child's wellbeing. It would have been clear to the Department of Child Protection and Family Support by the end of 2012 that her parents had not given, nor were likely or able to give, protection and care to this child. Counsel Assisting therefore submits that an adverse comment regarding this failure is warranted.[779]

1175. The Department of Communities, now incorporating the Department of Child Protection and Family Support, through its lawyer the SSO, makes a number of submissions against the making of comments adverse to its interests.

1176. The Department of Communities acknowledges that in or about February 2009, the Department of Child Protection and Family Support should have interviewed the children of the household after becoming aware of relevant criminal charges (of which there was later an acquittal). They inform me that it is now standard practice to interview the children of the family in such circumstances. However they submit to me that these events are too remote from the child's death to be relevant to how death occurred.

1177. The Department of Communities also acknowledges that the Department of Child Protection and Family Support failed to undertake adequate assessments of this child and her home environment in the 11 months leading up to her death, being March 2012 to February 2013.

Adverse Comment: The Department of Child Protection and Family Support failed to undertake adequate assessments in relation to this child's wellbeing in 2009 and between March 2012 and her death in February 2013.

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[778] ts 2199; Exhibit 1.7, Tab 58 and Tab 58.10.
[779] s.6(d) of the Act.

1178. It cannot in retrospect be known what the outcome of those assessments would have been, but I am satisfied that they could potentially have helped this child.

1179. Because the child was not in the care of the CEO of the Department of Child Protection and Family Support, that department did not incur any obligation to assess her wellbeing on an ongoing basis. As a result of those failures to undertake an assessment there were, potentially, missed opportunities to work with the child's family and/or refer her to the mental health services. Removal of the child was not the only available option for consideration.

1180. I do not find that the failure by the Department of Child Protection and Family Support to undertake those assessments of the child's wellbeing between March 2012 and February 2013 contributed to her death.

1181. The Department of Communities informs me that the practice of child protection continues to be revised and improved. They point to the passing of the Children and Community Services Act which was operational in 2006, the adoption of the Signs of Safety framework in 2008, the development of the policy on neglect in 2008, the increased understanding of cumulative harm in 2012 and the implementation of the Aboriginal Services Framework in 2009 (relaunched in 2016).[780]

1182. The Department of Communities also draws my attention to the fact that the Minister for Child Protection is required to carry out a statutory review on the operation and effectiveness of the Children and Community Services Act every five years. They inform the court that the Minister tabled a report of the current Review in Parliament on 28 November 2017.[781]

1183. Within the context of the housing accommodation for the child and her family, the Department of Communities draws attention to the evidence of the number of occupants and the perception of it being a "*party house*" and suggests it may have appeared overcrowded in the evenings because it was a location where people congregated to drink alcohol.

1184. The Department of Communities outlines that the child's parents made an application for housing assistance in 2010 and were registered on the Housing Authority's waitlist for assistance. That application was withdrawn (by the Housing Authority) in 2014 after

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[780] Exhibit 1.7 Tab 58.

[781] *Children and Community Services Act* 2004 (WA) s 249.

the Housing Authority could not contact the family. The child's older sister also made an application for housing which was made available on 23 February 2011.[782]

1185. In evidence Mr Lonsdale, who has almost 30 years' working experience with the Housing Authority, and is now Director, Client Services North and Aboriginal Housing, provided his views on the likely reasons for the child's family's application for housing assistance not being progressed. He believed there would have been successive unsuccessful attempts by the Housing Authority to contact the family, and that they often rely on families to keep in touch and advise of their current circumstances.[783]

1186. Mr Lonsdale referred to the information families can provide to assist the Housing Authority in determining who is permanently residing in the home, and who is staying for a short period. With the amalgamation of the various departments into the Department of Communities, it is submitted, and I accept that there will be the opportunity to strengthen the exchange of information and connection with previously separate departments.[784]

1187. Through their lawyer, the parents of this child have expressed their concerns about there being no residential rehabilitation programs or counselling programs for young people in the Kimberley where they could have sent their daughter for assistance. I have taken this concern into account with respect to my Recommendation 28 concerning a mental health facility in the East Kimberley, and Recommendation 34, concerning alcohol and drug rehabilitation for children.

1188. Through their lawyer the parents of this child have also expressed their disappointment about having wanted a "*grog ban*" on their home, prior to their daughter's death that did not eventuate. They did not know that government agencies had been discussing this at meetings. I have taken this concern into account with respect to a number of my recommendations regarding the limitations on the availability of alcohol in the Kimberley Region, being Recommendation 8 (restrictions on take away alcohol), and Recommendation 9 (banned drinkers' register).

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[782] ts 1823.
[783] ts 1804-1806.
[784] ts 1804-1805.

COMMENT – WESTERN AUSTRALIA POLICE FORCE

CASE No. 2

1189. The ALS make submissions to me regarding the night of 4 April 2015, when Broome Police took this child to his nominated home at approximately 8.30 pm, after informing him he would be summonsed in relation to the possession of a knife. They accept that it is not known if the interaction with police caused this child any psychological distress, but they do note he died overnight between 4 and 5 April 2015.

1190. They submit therefore that this incident raises the question as to whether his encounter with police could have been a possible stressor to his suicide. I have now found that this child died by suicide.

1191. The ALS also submit that the child, being a minor, should have been returned to the care of a responsible adult, and that the self-harm alert on the police computer system ought to have been sufficient to identify this child as a vulnerable person.

1192. At the Inquest, the attending police officer explained that the police focus is on alerts that need actioning. In a sad acknowledgment of the realities of policing in the Kimberley Region, the attending officer testified that many persons that police encounter have warnings or alerts recorded on the police computer system. It is important however not to become inured to their meaning, and each warning or alert requires a careful consideration in respect of the individual person.

1193. To police, the child appeared to be an adult of approximately 25 years of age, and he was observed to be calm, compliant, alert and attentive. They offered him a lift to his nominated home and he accepted it. He was not under arrest.[785]

1194. In order for police to have taken the child to a medical practitioner for assessment, they would have needed to reasonably suspect that he had a mental illness and that because of that mental illness it was necessary to apprehend him to protect his own health or safety or to protect the safety of another person, or to prevent him causing serious damage to property. The SSO submits, and I

[785] ts 499 to 506.

accept, that the police officer did not have the requisite suspicion.[786]

1195. I am satisfied that the encounter with police did not contribute to this child's death.

CASE No. 12

1196. Through their lawyer the KCLS, the family of the young man referred to under Case No. 12 submit to me that an adverse comment be made against the Western Australia Police and the State Emergency Services for failing to ensure that they were safely conveyed to Halls Creek after being stranded at Wungu Community.

1197. The circumstances surrounding the actions of police and emergency services in not evacuating the family from Wungu Community after the young man's death are outside the scope of my role, insofar as that role relates to the making of adverse comment. There is an insufficient nexus between the cause and manner of the young man's death on the one hand, and the decisions made regarding the requests by the young man's family for assistance to evacuate from Wungu Community on the other hand. For this reason, an adverse comment will not be made.

1198. However, the circumstances surrounding the dealings with the family in the immediate aftermath of the young man's death are within the broader scope of my role in ensuring that the coronial system is administered and operates efficiently, and specifically having regard to the coroner's role in the healing process for all persons who come into contact with the coronial system. For this reason, those circumstances are explored, below.

1199. At the time of the young man's death there had been a large amount of rain in the Halls Creek area. So much so that it was necessary for police to attend the Wungu Community via a chartered helicopter. All the roadways were flooded and not even a four wheel drive vehicle was able to use them. At 7.40 pm on 5 January 2015, after discovering that they could not traverse the river crossing into Old Halls Creek, police requested that a recovery helicopter be available at first light on 6 January 2015.[787]

1200. At 9.50 am on 6 January 2015 the police arrived by helicopter at Wungu Community (departure from Kununurra, via Halls Creek,

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[786] See s156 of the *Mental Health Act* 2014 (WA).
[787] Exhibit 8, Volume 1, Tabs 5 and 31,1; ts 1519 to 1520; ts 1525.

had been delayed due to low cloud). The helicopter was then used to convey the young man's brother and police officers to the location where the young man had been found, for investigative purposes.[788]

1201. In the meantime, police received information about the young man's partner having left Wungu Community on foot after an altercation with the family. She was now a missing person, there were concerns for her wellbeing, and police officers used the helicopter at Wungu Community to conduct a land search for her. The young man's partner was located on a remote stretch of road shortly before 2.00 pm on 6 January 2015, and conveyed by helicopter to Halls Creek, where she was taken to hospital. Then the helicopter returned to Wungu Community to collect the young man's body.[789]

1202. As described previously in this finding, the young man's body was airlifted by helicopter out of Wungu Community by police at approximately 3.00 pm on 6 January 2015 and conveyed to the Halls Creek Hospital.

1203. The family were not able to be accommodated onto the helicopter that conveyed the young man's body back to Halls Creek, as there was no room on board. The helicopter was also carrying forensic equipment and four police officers. That left six members of the family at Wungu Community. They ranged in ages from five years of age to 60 years of age. The family were distressed about having to remain at Wungu Community, and claimed hardship. The roads were inaccessible due to the rains.[790]

1204. Despite repeated requests from the family, police did not return by helicopter to airlift the family out of Wungu Community on 6 January 2015. The Inspector at the Kimberley District Office decided that the family would not be evacuated by the Western Australia Police, nor would police facilitate a re-supply of essential items to the community. The Inspector determined that this was the responsibility of the Department of Fire and Emergency Services.[791]

1205. Shortly after 1.00 pm on 6 January 2015, police at the Kimberley District Office contacted the Department of Fire and Emergency Services and advised them of the incident at Wungu Community. Consequently the Department of Fire and Emergency Services also contacted the family on that same date and commenced to make inquiries about the availability of a pilot and helicopter. Following

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[788] Exhibit 8, Volume 1, Tabs 5 and 31.1; ts 1526.
[789] Exhibit 8, Volume 1, Tab 31.1.
[790] ts 855; ts 867; ts 1520; ts 1526.
[791] Exhibit 1.8, Tab 59; Exhibit 8, Volume 1, Tab 31.3.

inquiries, it was ascertained that there were no other helicopters available for the afternoon of 6 January 2015. A request was made for a helicopter and pilot for the following morning.[792]

1206. The family have expressed their distress and disappointment about being left at the Wungu Community overnight without also being taken to Halls Creek by air, and further they claim that there were no arrangements made for their safe passage out from the Wungu Community to Halls Creek. They felt stranded, with little or no food and supplies.[793]

1207. The Western Australia Police through their lawyer the SSO, submit to me that police took all reasonable and appropriate action in the circumstances to ensure the safety of all persons at the Wungu Community after they attended on 6 January 2015 in response to the report of the young man's death, and draw my attention to a range of factors including the following:

a. the decision by police not to return to airlift the family by helicopter out of Wungu Community on 6 January 2015 is consistent with the role of police officers in Western Australia, and they cite section 7(1) of the *Police Act* 1892, being for: "….*preservation of peace and order throughout the said State….*";

b. the Fire and Emergency Commissioner is the Hazard Management Agency for flood, and they cite the *Fire and Emergency Services Act* 1998, and regulation 17 of the *Emergency Management Regulations* 2006 (WA);

c. police in the Kimberley District Office did in fact contact the Department of Fire and Emergency Services to manage the evacuation or resupply of the Wungu Community; that department advised police that they would liaise with the charter company for the use of the same helicopter to re-attend the community and recover the remaining community members to airlift them to Halls Creek;

d. as it transpired, with no other helicopter available on the afternoon of 6 January 2015, the Department of Fire and Emergency Services planned to airlift the family out of Wungu Community the following morning (7 January 2015);

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[792] Exhibit 8, Volume 1, Tab 31.2.
[793] Exhibit 8, Volume 1, Tabs 11, 12, 12A, 13, and 15; ts 846; ts 853; ts 867.

e. on 6 January 2015 one of the attending police officers had checked and ascertained that the family at Wungu Community had water for drinking, and supplies of food described as "*limited*", but that police nonetheless considered were sufficient to last until the next morning, when it was expected that Department of Fire and Emergency Services would transfer the family to Halls Creek; and

f. the attending police officers advised the family that they were best placed to wait at the home at Wungu Community with supplies in water, food and communication rather than make their own way to Halls Creek through inclement weather and flooded rivers.[794]

1208. At the Inquest, one of the attending police officers, a Detective Sergeant, was questioned regarding this complaint made by the family, and provided the following insight concerning the decision of police at the Kimberley District Office, on 6 January 2015, not to return on that date by helicopter to Wungu Community to evacuate the family:

> "*So the decision was made by* [the] *superintendent that police would not be responsible for conveying the family back to the town and that would come under the department of emergency services for them to bring the deceased back. I explained my opinion to my boss in relation to bringing the family back; however, it was deemed that it would be the department of emergency services and, therefore, we had no responsibility of bringing them back.*
>
> *What was your opinion? --- Look, I believed that we should have made an attempt to bring them back given that they had assisted us with putting their deceased family member inside a house, and anybody that's aware of the cultural sensitivities around that, it causes an issue for the family to remain there, where the deceased had been. So I would think sensitivity – with the cultural awareness, we should have brought them back. However, the decision was made not to bring them back.*
>
> *And how would that have been achieved if it was the responsibility of the police? --- We would have then come back in the helicopter with the deceased and then one of us would*

[794] Exhibit 1.8, Tab 59; Exhibit 8, Volume 1, Tabs 31.1, 31.3, 59,

have gone back out with the helicopter to the community, collected the family and then brought them back."[795]

1209. In the circumstances, the young man's maternal uncle drove from Derby to Wungu Community to collect the family. Shortly after the police airlifted the young man's body out of Wungu Community, the family also left by vehicle. A number of calls made by the Department of Fire and Emergency Services to the family at Wungu Community on the night of 6 January 2015, to arrange their transfer the next morning, remained unanswered.[796]

1210. Because of the poor road conditions, the young man's maternal uncle was not able to drive all the way to Wungu Community and due to the flooding, the family ended up walking to where he was able to park his car. At the Inquest he testified that when he found them, they were walking in "*knee-deep water*" towards him. It was an arduous journey for the family, who were grieving and mourning the loss of their loved one.[797]

1211. Clearly, the Detective Sergeant was aware of the cultural sensitivities regarding the young man's family remaining in a house where they had recently placed his body. There was some doubt as to whether the other houses in the Wungu Community had adequate power. The KCLS submit to me that family members were vulnerable and the circumstances were sufficient for a rescue in ordinary circumstances, regardless of cultural considerations.[798]

1212. In his report to the coroner, the Superintendent of the Kimberley District Office stated that should a similar situation arise in the future, being cognisant of the stress and trauma experienced by the young man's family, under his direction the Kimberley Police District will consider the circumstances of the family at the earliest possible opportunity.[799]

1213. At the Inquest, with the benefit of hindsight, the Superintendent also agreed that there could be room for improvement. Whilst he did not agree that the family were left abandoned (having regard to the plans that were being made for their evacuation the next day by the Department of Fire and Emergency Services), he acknowledged the need for police to learn from this experience.[800]

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[795] ts 1525.
[796] ts 868; Exhibit 1.8, Tab 59.
[797] ts 868.
[798] ts 1525.
[799] Exhibit 1.8, Tab 59.
[800] ts 1860.

1214. Regard must be had to the enormous loss that had been suffered by the young man's family, the trauma involved in conveying his body over a long distance back to the house at Wungu Community (which assisted police) and keeping vigil over him overnight, and keeping his body cool (which also assisted police), the limited food and fuel supplies, the fact that the family was cut off from Halls Creek because of the wet season weather, the terrain and the impassable roads, and the presence of an elderly community member and a very young child. Considering all of these factors, as well as the cultural sensitivities involved, all possible steps ought to have been taken to evacuate the family on 6 January 2015.

1215. On 6 January 2015, the attending Detective Senior Constable at Wungu Community had explained the vulnerable situation of the family to his supervisor at the Kimberley District Office, and inquired about evacuation (as it was not his decision to make). As described above, the attending Detective Sergeant also felt that the family ought to have been evacuated that day. They were present with the family at Wungu Community, and were able to see for themselves their evident distress and assess their vulnerability.[801]

1216. It appears that, in denying the request, the Inspector acted in accordance with the relevant policies at the time. There were a number of competing factors for police to take into account including the remoteness of the location and the weather. The helicopter had already made two trips to and from the Wungu Community.

1217. At the Inquest the Superintendent could not guarantee that in future families would be picked up and moved immediately, as there may be other issues that preclude that happening. Clearly the decision would need to be made in the context at the relevant time.[802]

1218. A more cohesive approach, and better communication between the agencies, would maximise the opportunities for a rescue in similar circumstances, and for assuaging the grief. Better communication might have averted the return of the chartered helicopter to Kununurra, and allowed for one more trip from Halls Creek to Wungu Community on 6 January 2015. By the time the family left Wungu Community, they were not only traumatised, but also frustrated with the responses to their pleas for assistance, and the reallocation of responsibilities for the evacuation between agencies.

1219. There was a real and not imagined risk of further tragedy when the family embarked on their own journey out of Wungu Community, due to the flooding on the roads. The ensuing trauma would not be

[801] Exhibit 8, Volume 1, Tab 31.3.
[802] Ibid.

alleviated by maintaining that they left Wungu Community against the advice of the Western Australia Police and the Department of Fire and Emergency Services.

RECOMMENDATIONS

1220. I have made my recommendations having regard to all of the evidence before me concerning the tragic and preventable deaths of 13 children and young persons. I have found that 12 of those deaths occurred by way of suicide.

1221. The evidence of the circumstances surrounding their short and tragic lives was of a similar nature and reflects upon a level of trauma that is being endured not only by the families involved, but by entire communities in the Kimberley Region.

1222. That trauma, much of it intergenerational has given rise to dysfunctionality within some families, with the inevitable result that the children and young persons have borne the brunt of the suffering.

1223. The recommendations are aimed at preventing deaths occurring in similar circumstances, through healing and supporting communities that have been marginalised and disadvantaged over generations.

1224. The Department of Premier and Cabinet through their lawyer the SSO, submit to me that it is tempting to think that simply providing Government departments with more funding is the solution, but that the evidence presented to the Inquest confirmed that there is already considerable State and Commonwealth Government expenditure in the Kimberley. I accept that simply providing existing Government departments with more funding is not the solution.

1225. The Department of Premier and Cabinet also submit that Government cannot provide a whole range of services to every community in regional and remote Western Australia. It is necessary for Government to concentrate its finite resources to achieve greatest benefit and is consequently unable to provide the same level of services and infrastructure where populations are small and highly dispersed. I have had regard to this submission, within the context of my recommendations.

1226. The KCLS acknowledge that the region's dispersed population and remoteness pose difficulties for service delivery. They also point to high staff turnover and *"burn out"* adding to the challenges.

1227. The Department of Premier and Cabinet's submission focusses on informing the court of the Government's commitment to growing a sustainable and skilled Aboriginal workforce from entry level to leadership roles using a variety of career pathways and employment opportunities. Furthermore, they have an emphasis on building a non-Aboriginal workforce that is able to understand and respond to the needs of Aboriginal people. The State Government's Service Priority Review has made recommendations to address these issues. This approach is to be commended and supported

1228. They also sound a note of caution to the effect that a program which is effective in one area with a defined group may not be effective elsewhere in the Kimberley, given that language, traditions and cultural practices vary across the Kimberley and reflect the diversity of Aboriginal people. This concern is consistent with the evidence at the Inquest. The diversity of Aboriginal peoples is to be recognised in connection with the offering of programs.

1229. Dr Paul Simons, the Kimberley Region's Child and Adolescent Psychiatrist, employed with the WACHS' Kimberley Mental Health and Drug Service, whose evidence is referred to previously in this finding, has had the experience of working in the Kimberley Region at different times over 18 years. Over this time, unfortunately Dr Simons has not seen a significant or meaningful reduction in the exposure of children to factors that will impact negatively on their mental health. This is despite it being apparent to Dr Simons that over this same period there has been a significant increase in the services being provided to that region by various Government and non-Government agencies.[803]

1230. Dr Simons has seen an increase in the broader use of marijuana and amphetamines, with its use being "*normalised*" at a young age, and a high level of exposure to pornography at a young age, contributing to early sexualisation of children and their vulnerability to abuse. Dr Simons describes the difficulties for disempowered and traumatised communities to take a stand against some of the entrenched problems, and suggests that:

a. there is required an acknowledgment of, and active decision by communities that they can no longer accept the factors that result in the perpetuation of their trauma;

[803] Exhibit 1.4, Tab 40.

b. all community members need to feel safe to be able to speak up; and

c. the communities need to feel safe and supported in dealing with the problems, requiring significant commitments from relevant Government bodies. [804]

1231. The evidence before me concerning the importance of consulting with Aboriginal persons in the formulation of programs and services is extensive and I have devoted various parts of this finding to this. The recommendations are made in light of, and accepting of, this very fundamental requirement.

Recommendation 1 - FASD and screening

1232. The ALS acknowledges that many of the children and young persons the subject of the Inquest had some history and characteristics associated with Foetal Alcohol Spectrum Disorder (FASD), but note that none had been formally diagnosed with FASD. They submit that a finding that any child or young person had FASD is adverse to the interests of his or her family. It is to be borne in mind that if this condition is to be properly diagnosed and treated, there ought to be no stigma attached to it. Otherwise, disclosures regarding alcohol consumption during pregnancy will be initiated, to the possible detriment of the child.

1233. I have not found that any of the children and young persons had FASD but a number of them were clearly vulnerable to the development of this disorder. Further, whilst none had been diagnosed with FASD, the circumstantial evidence would suggest that a number of them were likely to have been on the spectrum for FASD.

1234. Dr James Fitzpatrick and A/Professor Carmela Pestell, both recognised experts in the field of FASD assessment and diagnosis, together produced a report for the coroner and gave evidence at the Inquest. Their experience includes the following assessments and analyses:

a. Approximately 120 FASD assessments in the Lililwan Project FASD prevalence study in Fitzroy Crossing (Dr Fitzpatrick, founding leadership team member); this

[804] Ibid.

study was initiated by community organisations Marninwarntikura Fitzroy Womens' Resource Centre and Nindilingarri Cultural Health Services;

b. Approximately 112 FASD assessments in the Banksia Hill Juvenile Detention Centre study (A/Professor Pestell, associate investigator);

c. Approximately 40 assessments for the Western Australian Juvenile Justice system (Dr Fitzpatrick and A/Professor Pestell);

d. Research data analysis of approximately 80 FASD assessments undertaken at the Neurosciences Unit;

e. Approximately 50 community-based or child-protection based FASD assessments (Dr Fitzpatrick and A/Professor Pestell). [805]

1235. The majority of their assessments have been for Aboriginal young people from remote communities aged four to 20 years. [806]

1236. At the Inquest Ms Carter, whose evidence has been referred to previously, testified that the Lililwan Project FASD prevalence study in Fitzroy Crossing was community led by the Marninwarntikura Fitzroy Womens' Resource Centre and Nindilingarri Cultural Health Services. This is one of the key reasons for its success.[807]

1237. Dr Fitzpatrick explained that FASD is a condition of lifelong behavioural and or developmental disability that is associated with exposure of the foetus to alcohol consumption during pregnancy. Certain regions of the brain may be damaged or less well-formed as a result of alcohol exposure and this damage maps to certain developmental, behavioural and cognitive functional impairment. These impairments often lead to disrupted education and trouble with the law, and secondary disabilities including problems with mental health, and drug and alcohol misuse.[808]

1238. In their oral evidence A/Professor Pestell and Dr Fitzpatrick discussed the Australian National Diagnostic Criteria for FASD outlining that a diagnosis can only be made when there is demonstrated severe impairment (lowest 3% of function expected for their age) in 3 or more neurodevelopmental domains. Dr Cleland

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[805] Exhibit 1.3, Tab 11; ts 271 to 358.
[806] Ibid.
[807] ts 733.
[808] ts 278; Exhibit 1.3, Tab 11.

who evidence is referred to previously concurred. The neurodevelopmental domains were described in various ways in evidence through the Inquest however taken directly from the *Australian Guide to the diagnosis of FASD* they are:

a. Brain structure/Neurology;
b. Motor skills;
c. Cognition;
d. Language;
e. Academic Achievement;
f. Memory;
g. Attention;
h. Executive Function, including impulse control and hyperactivity;
i. Affect Regulation; and
j. Adaptive Behaviour, Social Skills or Social Communication.[809]

1239. To diagnose FASD severe impairment in at least three of the ten domains above must be accompanied by either confirmation of prenatal alcohol exposure or the presence of three sentinel facial features. Establishing prenatal alcohol exposure is typically achieved through enquiries with the patient's mother. For this reason, it is important not to stigmatise the behaviour.[810]

1240. As an indication of its general prevalence, Dr Fitzpatrick and Associate Professor Pestell informed the coroner that Australian studies estimate FASD prevalence to range from 0.01 to 0.68 per 1000 live births. However, this does not include population based data in communities with high-risk drinking patterns. They are concerned about the lack of data on pre-natal alcohol exposure and FASD, the limited awareness among health professionals of FASD, and the fact that there are no agreed Australian FASD diagnostic guidelines.[811]

1241. On 13 February 2018, the British Medical Journal published the Telethon Kids Institute research paper titled *"Foetal alcohol spectrum disorders and youth justice: a prevalence study among young people sentenced to detention in Western Australia"*. This paper documents a high prevalence of FASD and severe neurodevelopmental impairment, the majority of which had not been previously identified, among a representative sample of young people in detention in Western Australia. The study diagnosed 36%

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[809] ts 276; ts 28; ts 617
[810] ts 282.
[811] Exhibit. 1.3, Tab 11.

of the sample with FASD but a total of 89% of the sample were found to have severe impairment in one or more domains assessed.[812]

1242. This study had been approved by the then Departments of Corrective Services and Child Protection and Family Support, to identify the prevalence of FASD among sentenced young people in Banksia Hill Detention Centre and evaluate the feasibility and effectiveness of FASD screening diagnosis and workforce development.

1243. The Department of Justice currently organises FASD assessments by a paediatrician, neuropsychologist, speech pathologist and occupational therapist for young people in detention when an assessment is requested. The Department of Justice recognises that the findings of the Telethon Kids Institute Study highlight the vulnerability of young people, particularly Aboriginal youth, within the justice system and their significant need for improved diagnosis to identify their strengths and difficulties, and to guide and improve their rehabilitation.

1244. As outlined by Dr Cleland, formal assessment of each of those ten areas of development requires a paediatrician, a psychologist, a clinical psychologist, and a speech therapist and a physiotherapist. This is not to say that each domain is assessed by each specialist. A FASD diagnosis can be made simply with a paediatrician and a speech therapist if the requisite three impairments are demonstrated. However, to perform a comprehensive assessment of the patient's strengths, impairments and needs for all areas of FASD you would need to assess all 10 domains with all of the required professionals.[813]

1245. The Department of Health and the Western Australian Country Health Service through their lawyer the SSO, draw my attention to the limitations, and unhelpfulness, of focussing only upon a diagnosis of FASD. These are outlined below.

1246. First, if FASD diagnosis becomes the focus, assessment can stop when that is achieved (for example after examination by only one or two specialists) rather than more fully exploring the specific strengths and impairments of each individual. A diagnosis alone also provides very little guidance regarding care and management of the individual. It is submitted that patients are better served

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[812] Publicly available at: http://bmjopen.bmj.com/content/8/2/eO19605.

[813] ts 617 to 618.

by person centred holistic assessments rather than focussing on a diagnosis like FASD.

1247. Secondly, and with regard to Dr Fitzpatrick's evidence, it is hard to be certain about the exact impact of alcohol exposure on later cognitive deficits or behavioural problems: *"when there's a context of significant early life trauma or chronic childhood illness or other factors such as physical trauma or head injury."* Also Dr Cleland's evidence was that the alcohol consumption during pregnancy that produces FASD typically occurs in circumstances where there are multiple other issues that are causing potential damage to the child's brain and further, that drinking during pregnancy may not produce FASD.[814]

1248. Dr Cleland detailed a number of factors which can produce the developmental, behavioural and cognitive functional impairment which FASD can also produce. These included inadequate nutrition, family disruption, domestic violence, intergenerational trauma, child abuse and neglect, incarceration or death of a caregiver and attachment disorder. He concluded: *"So we don't see Foetal alcohol spectrum disorder as a specific disorder that exists in isolation, but* it *exists alongside multiple other factors that are causing impact to that child's early life development, which have lifelong impacts.*"[815]

1249. Thirdly a FASD diagnosis is not an adequate substitute for identifying the severity of functional impairment. FASD is a spectrum disorder. Associate Professor Pestell explained that at one end of the spectrum a patient may have a very severe intellectual disability with global impairment (below the third percentile) across the range of neurodevelopmental domains with associated physical and medical problems. Dr Fitzpatrick continued:

> *"So at the other end of the spectrum, FASD being a spectrum disorder, you might have somebody who meets criterion for FASD on areas such as attention. So they might have a formal diagnosis of ADHD. They might have expressive language disorder or an inability to communicate well verbally. And they might have troubles with their fine motor control. So based on those three impairments, people could still be brought under the diagnostic umbrella of FASD. And, obviously, those three impairments alone are disruptive to learning but they're not as profound as having an intellectual disability."*[816]

[814] ts 287; ts 597 and 617.
[815] ts 614 and 621.
[816] ts 286, 287.

1250. Associate Professor Pestell touched on a fourth issue with diagnosing FASD. That is that in many cases, despite the presence of the requisite impairments, a diagnosis of FASD cannot be made without confirmation of prenatal alcohol exposure. If treatment access, funding and other assistance attaches only to the diagnosis of FASD rather than the presence of impairments, then the inability to establish alcohol consumption during pregnancy could mean that those patients are deprived of the resources they require despite having an established need. Of course it is not hard to imagine a mother who denies having consumed alcohol to the point of damaging the brain of her child even where this has occurred. As one of the witnesses explained: *"you're essentially asking somebody to disclose in the first instance whether they consumed alcohol during their pregnancy. Not many people are going to disclose that."*[817]

1251. Telethon Kids Institute Study also noted the difficulty in confirming pre-natal alcohol exposure.

1252. This raises a fifth issue with diagnosing FASD which is that the diagnosis itself can have significant repercussions within a family system due to potential stigma, guilt and blame. These potentially harmful repercussions are noted by Dr Cleland as well as by Dr Fitzpatrick and A/Professor Pestell. The stigma, guilt and blame are more significant factors for FASD than for other diagnoses like global developmental delay or for a holistic assessment of neurodevelopmental impairment because in the case of FASD there is a direct link to the actions of the patient's mother.[818]

1253. Sixthly, a FASD diagnosis, as outlined above, is a formal diagnosis that often requires a multidisciplinary team performing a range of assessments. As a rule, these tests have not been standardised and validated for application in remote Aboriginal populations making their interpretation problematic.[819]

1254. What has emerged in recent times is the significance of FASD on the lives of Aboriginal people. Prevalent in the deaths the subject of this Inquest was the impulsivity of the actions taken, which does not negate a suicide. Rather, impulsivity may contribute to a vulnerability to self-harming behaviour.

1255. Some of the identified symptoms of FASD include difficulty in nearly every aspect of behaviour; from paying attention, learning and

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[817] ts 283; ts 1742.

[818] Exhibit 1.3 Tab 20; Exhibit 1.3 Tab II.

[819] Exhibit 1.3 Tab 20.

remembering, controlling emotions and urges and applying what has been learned to every day experiences.[820]

1256. It is not the case that all those who meet the diagnostic criteria for FASD will have all of the identified symptoms. Associate Professor Pestell gave evidence that FASD is a heterogeneous disorder in that is does not affect everybody in the same way, but there are certain domains of areas that are likely to be affected. She explained that not all children with FASD will end up with a diagnosable intellectual disability and that for any particular individual suffering FASD, one of these functions might be more impaired than another. Those patients who meet the diagnosis of FASD may have some or all of the identified symptoms. Similarly, others who do not meet the criteria for FASD diagnosis may have some or all of these symptoms. Furthermore, some patients who do not meet the criteria for FASD diagnosis may suffer all of these symptoms, and to a greater extent than some who do meet the criteria for FASD diagnosis. So a diagnosis of FASD alone is not indicative of the severity of impairment or of the magnitude of the need for care and treatment. As a result, the Department of Health and WACHS consider that merely diagnosing FASD is less important for an individual's health than screening for developmental and behavioural impairments and disorders.[821]

1257. The Department of Justice through its lawyer the SSO, submits to me, with reference to the Telethon Kids Institute Study, that it identified many persons in the sample who had neurological impairment, but who were not diagnosed with FASD. The Department of Justice also submits that any recommendation for assessment should not focus on or be limited to FASD. The Department of Justice remains of the view that such assessments are only useful if they provide guidance on the care and management of the individual.

1258. As to its relevance to suicide, Dr Fitzpatrick and A/Professor Pestell have stated:

> *"Previous researchers have also established that individuals with FASD are at risk for suicide. Indeed, a person with a typical clinical profile for FASD will demonstrate several risk factors for suicide (for example, impulsivity, a co-morbid mood disorder, and substance abuse problems), often within the context of relationships problems and disrupted attachment to caregivers as well as past trauma. It is thus imperative that they be*

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[820] Exhibit 1.3, Volume 3, Tab 11.

[821] ts 284.

monitored closely, regardless of their level of intellectual functioning." [822]

1259. Dr Paul Simons, Child and Adolescent Psychiatrist employed by WACHS' Kimberley Mental Health and Drug Service, referring to the high prevalence of FASD in the Kimberley Region, describes it as a tragic and preventable problem. Whilst he does not diagnose FASD (as it requires a multidisciplinary assessment) he is familiar with the multiple difficulties arising from the cognitive effects of FASD, including difficulties with impulse control and emotional regulation, which he perceives as risk factors for accidental and non-accidental physical harm.[823]

1260. In Dr Simons' opinion, and consistent with Dr Cleland's opinion, the situation is also complicated by the fact that early attachment disturbances and trauma can impose similar cognitive and behavioural difficulties, and that trauma and FASD likely overlap to a significant degree. In his experience, it is important to be aware of FASD, but children generally do not have FASD in isolation.[824]

1261. Counsel assisting submits to me that I recommend that measures be put in place to (i) diagnose those who have FASD; and (ii) reduce the number of FASD sufferers in future generations.

1262. At the Inquest Dr Fitzpatrick outlined the opportunities for mandatory universal screening and/or diagnosis for FASD if he were designing a system, as follows:

a. During infant health assessments, particularly if midwives have been taking a history of alcohol and other exposures during pregnancy, to screen and note (flag) those children for early child development follow-up, given their risks of developmental delay;

b. When a child enters the child protection system; sadly children often enter at a young age, and some are from a cohort that are at particularly high risk for early life trauma and FASD – mandatory screening at this stage could usefully focus on developmental and behavioural problems, that could then trigger the more intensive assessment process, including the initiation of therapy;

c. When a child comes into contact with the justice system or becomes known to the police – again mandatory

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[822] Exhibit 1.3, Volume 3, Tab 11A.
[823] Exhibit 1.4, Tab 40.
[824] Ibid.

screening at this stage could usefully focus on developmental and behavioural problems that could then trigger the more intensive assessment process, including the initiation of therapy.

1263. As outlined above the WACHS, through its lawyers the SSO, draws to my attention the important distinction between FASD assessment and FASD diagnosis and I have taken account of their reasons for not supporting a focus on diagnosis of FASD. WACHS submits that universal *"testing"* for FASD will almost undoubtedly result in over-diagnosis, under-emphasis on other causes of impairment and stigmatisation of mothers. They also point to the cost.

1264. WACHS supports assessments that focus on neurodevelopmental impairments (including the developmental, behavioural and cognitive impairments which feature in the 10 FASD diagnosis domains) rather than FASD itself. WACHS draws my attention to the screening that already takes place under "*The Healthy Country Kids Strategy*" by community child health nurses employed by WACHS or Aboriginal Medical Services depending on the region, who deliver the "*Ages and Stages Questionnaire.*"

1265. The court is informed that the costs of FASD assessments start from $1,000 (for a paediatrician conducting a comprehensive developmental assessment of a child in their first year of life) to between $4,000 and $5,000 for a person in the justice system who requires psychiatric and/or comprehensive neurocognitive assessments.[825]

1266. The Department of Justice submits to me that evidence provided during the Inquest highlighted the likely high cost of FASD assessments and, in the absence of a less costly screening tool, it is of the view that implementation of FASD assessments across the board is likely to be prohibitively expensive. It does however agree that neurodevelopmental assessment diagnosis and intervention for young people in the justice system is crucial in order to identify young people with neurodevelopmental impairment and provide them with appropriate evidence-based care and management.

1267. The Department of Communities through its lawyer the SSO, submits to me that there is no evidence that a FASD assessment is warranted for all children entering care, particularly given the significant cost implications. They inform me that in 2016-17, there

[825] ts 288; ts 290 and 291.

were 4795 children in care, with 925 children entering care that year. They do not support universal screening.

1268. The Department of Communities is aware of the increasing number of children in the Kimberley Region being diagnosed with FASD, but submits to me that there is no specific treatment for a child diagnosed with FASD.

1269. Similar to the Department of Health and WACHS, the Department of Communities submits that the approach to treatment for a child with FASD is the same as a child not diagnosed with FASD, but having some similar characteristics and behaviours such as a child with Attention Deficit Hyperactivity Disorder, Autism, Bipolar Disorder, Reactive Attachment Disorder and Sensory Integration Disorder.

1270. The Department of Communities sounds a note of caution about screening singularly for FASD to identify suicide risk in children. It is self-evident that there are a range of contributing factors. They posit that an assessment of a child's overall intelligence quotient (IQ) and functional capacity can enable a more comprehensive and individualised treatment plan for the child and management for the carers.

1271. The Department of Communities has helpfully outlined an approach to the provision of services and support for children entering into the child protection system, that does not focus upon, but includes, FASD, as follows:

a. Preliminary assessments and screening of children in care being undertaken by departmental district psychologists;
b. Referrals for comprehensive IQ and functional capacity assessments where and when required by presentation and behaviours; and
c. Referrals to other treatment and therapy services for trauma-related developmental and behavioural issues, including mental health issues, impulsivity, and harmful sexual behaviours that may or may not include cognitive impairments and neuro-disabilities such as FASD.

1272. Whilst I accept the SSO submissions to the effect that developmental impairment is broader than neurodevelopmental impairment (the latter being a subset), and recognise that the process of diagnosis for FASD can be challenging, the catastrophic prevalence of alcohol abuse in regional and remote communities supports a particular focus on FASD (though not to the exclusion of other neurological impairments).

1273. It is understood that FASD will often be present in conjunction with other conditions that may stem from early life trauma. Associate Professor Pestell drew attention to the likelihood that mothers who drink at high risk during pregnancy can often have other associated pressures on family which add to the vulnerability of a particular child with FASD.[826]

1274. At the Inquest Dr Fitzpatrick highlighted the risks associated with the cumulative effects of FASD, family trauma and personal trauma:

> "*So we know that they're much more likely to suffer from depression and from anxiety and have – because of the brain damage and the organic nature of FASD, they will have trouble when they experience psychological distress actually being able to calm themselves down in a way that you or I might be able to. They will have particular difficulties with that and so it tends to escalate to situations where they might have a limited repertoire of ways of coping with that distress.*
>
> *And if they've had particular family experiences, you know, we know that children, for example, have been sexually abused, they've got much higher rates of suicide or if they've had the traumatic backgrounds, or if they've had other family members or people significant in their immediate environment that have attempted suicide, then we also know that there's a contagion effect. They are also more likely to choose that as an option for solving their current situation. And I would imagine it's about not being able to – wanting to escape from the pain or the psychological distress that they're feeling.*"[827]

1275. Associate Professor Pestell added that combining this with alcohol or substance abuse results in even more disinhibited behaviour, and the risk of acting in impulsive ways.[828]

1276. Notwithstanding the expense, it is clear that early diagnosis and early intervention for FASD can greatly benefit children who are affected by it. It can also be very cost effective in the longer term. It is estimated that the lifetime cost of service usage for someone with FASD is around $US2.5 million.[829]

1277. It is likely that if a supportive approach is adopted for the mothers, then as Dr Fitzpatrick outlined, one can be highly confident of the reliability of alcohol exposure during pregnancy. He has been

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[826] ts 293
[827] ts 294 to 295.
[828] ts 295.
[829] ts 289 and 306.

involved in an extensive research study on FASD and has also run a practice that has delivered around 200 FASD assessments in multiple contexts – a tragic factor, but one that ought not to be ignored.[830]

1278. The prevalence of FASD needs to be understood, in order to consider how best to address the underlying causes. I accept Dr Fitzpatrick's opinion that: "*….the best spend on FASD is prevention.*" The next best spend is early intervention therapies. From his extensive knowledge in the area, he pointed to the largest study of outcomes for 500 individuals with FASD at 21 years of age. They found that of those who were diagnosed early in life and who had a therapies in a supportive environment, the incidence of secondary effects like mental health and drug and alcohol problems was reduced two to fourfold.[831]

1279. At the Inquest Ms Carter testified that service providers are operating reactively and in "*crisis mode*". In her view long-term programs are needed for people living in a traumatised community. This is problematical when funding is provided for one or two years. She highlighted the need for services and programs delivered by local community organisations to be adequately resourced over a long, rather than a short, term period.[832]

1280. A number of the children and young persons whose deaths have been investigated at the Inquest appear to have acted impulsively and I cannot exclude some of them having been on the spectrum for FASD with disturbances to their executive functions and affect regulation, making them more vulnerable to suicidal behaviour.

Recommendation 1:

a. that there be universal screening for FASD at the following points: during infant health assessments and upon a child entering into the child protection system or justice system for the first time;

b. that all children identified as at risk of neurodevelopmental impairment on the basis of antenatal exposure to alcohol or early life trauma be assessed by a paediatrician for developmental and

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[830] ts 287 to 288.
[831] ts 288 to 289.
[832] ts 737.

behavioural impairments at the age of one year and in the year prior to school entry;

c. **in respect of a child entering the child protection system for the first time in addition to FASD universal screening:**

   i. **that preliminary assessments and screening be undertaken by Department of Communities' district psychologists;**
   ii. **that referrals be made for comprehensive IQ and functional capacity assessments where and when required by presentation and behaviours; and**
   iii. **that there be referrals to other treatment and therapy services for trauma-related developmental and behavioural issues, including mental health issues, impulsivity, and harmful sexual behaviours, that may or may not include cognitive impairments and neuro-disabilities such as FASD.**

1281. WACHS through its lawyer the SSO, sounded a note of caution about attaching financial benefits to a diagnosis of FASD, that may coerce a parent into falsely reporting alcohol use during pregnancy, or that may apply pressure to a clinician to make a diagnosis of FASD, with the aim of accessing needed support.

1282. I have carefully considered this but come to the view that similar arguments may be made in respect to a range of neurodevelopmental impairments. On balance the possibility of over-diagnosis ought not to obscure the more realistic likelihood of its prevalence, and the need to meet the challenges of identifying the degree of the problem.

1283. The mechanisms for addressing financial support for FASD are addressed in connection with Recommendations 2 to 4.

Recommendation 2 - FASD and NDIS

1284. The National Disability Insurance Scheme (NDIS) website explains that to meet disability requirements, a person needs to provide clinical evidence that they have a permanent impairment with substantially reduces functional capacity in everyday activities, or

meets the early intervention requirements; this includes children under six years of age with developmental delay.[833]

1285. FASD is not separately listed in the diagnosis lists utilised by the National Disability Insurance Agency (NDIA). These are not the only eligible conditions, but they list the conditions that the NDIA: "*have already identified as always resulting in permanent impairment and substantially reduced functional capacity*" and hence, they do not require any further information to be provided on functional impairment.[834]

1286. Dr Fitzpatrick drew attention to the report that he, together with the team at Telethon Kids Institute submitted to the NDIA. They indicated that similar to autism, FASD is a lifelong developmental condition and that there are therapy and support programs that can improve outcomes. They submitted that it should be considered within the funding protocols of the NDIS.[835]

1287. Dr Fitzpatrick was confident that the NDIS is ready to recognise the impairments of FASD as triggering funding eligibility. He also drew attention to the fact that, for example in the State school system, FASD is not recognised as one of the diagnostic groups that trigger eligibility for school based therapy funding, that can help a young person remain engaged in the education system.[836]

1288. However, WACHS through its lawyer the SSO, submits to me that recognition of FASD as a disability in the NDIS would mean that two individuals with identical impairments could receive different levels of support if one had a confirmed history of a mother who consumed alcohol during pregnancy and the other did not, and suggested wording for the recommendation that would facilitate access to support for all people who have the same level of impairment due to another cause.

1289. The Department of Communities through its lawyer the SSO, draws attention to the evidence of Dr Fitzpatrick who explained that people with FASD are on a spectrum, and it is the assessment of the impact of their impairments that is taken into account in making a referral to the disability services. Many of the individuals that they diagnose

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833 https://www.ndis.gov.au/operational-guideline/access/early-intervention requirements https://www.ndis.gov.au/operational-guideline /access/disability-requirements.html

834 https://www.ndis.gov.au/people-with-disability/access- requirements/completing-your-access-request-form/evidence-of-disability

835 ts 292.

836 Ibid.

with FASD are not referred on to the disability services, because they do not meet the NDIS criteria.[837]

1290. The Department of Communities also submits that people with FASD are not precluded from accessing NDIS, and that a person with FASD may be found eligible based on having a permanent neurological, cognitive or intellectual impairment that leads to substantial reduction in functional capacity. Alternatively, they may meet early intervention requirements.

1291. I have taken account of Dr Fitzpatrick's evidence concerning his report to the NDIA, that addresses the FASD severity guidance scale. Similar to process for rating Autism severity, it indicates whether an individual has moderate, severe or profound impairment, having regard to the specific brain domains that are impaired. He and his team have developed a formula within their severity guidance that allows for this determination.[838]

1292. Whilst I accept that people with FASD are not precluded from accessing NDIS, I consider there is merit in recognising FASD as a disability where there has been a diagnosis and it meets an appropriate level of severity. There is also merit in ensuring that neurological impairments also be captured within the disability criteria. It will enable access to much needed therapy funding, and allow for early interventions at adequate consistency, intensity and frequency, to improve neurodevelopmental and functional outcomes and reduce social and mental health problems later in life.[839]

Recommendation 2:

a. that neurodevelopmental impairment (an umbrella term which includes behavioural, developmental and cognitive impairments) incorporating the criteria defined in the Australian Guide to the diagnosis of FASD be recognised as a disability within the National Disability Insurance Scheme ("the NDIS");

b. that where FASD has actually been diagnosed at the appropriate level of severity, it is separately recognised as a disability within the NDIS.

[837] ts 314.
[838] ts 314; Exhibit. 1.3, Tab 11.
[839] Dudley, Fitzpatrick et al, 2015.

Recommendation 3 - FASD and Medicare item number

1293. The benefit of a separate Medicare item number was made clear by Dr Fitzpatrick in his evidence at the Inquest:

> *"So one of the strongest drivers of diagnostic activity is having a funding mechanism that clinicians can access to enable diagnosis. An example is autism. In the MBS item numbers, there is a specific diagnostic item number for a paediatrician to conduct an autism assessment, and there are specific autism-focused item numbers for a speech therapist, and a psychologist to conduct their components of the multi-disciplinary assessment.*
>
> *There are no such item numbers for diagnosing FASD at this point in time, and this is a very simple, and will be a very effective mechanism, at the Federal level for liberating the diagnosis of FASD so that clinicians can access item numbers that enable them to conduct the assessments. What that would probably lead to, as in autism, is increased diagnostic activity. Therefore, increased access to therapy and support services. Increased diagnostic activity will also increase the community's awareness of FASD and the link between drinking and pregnancy and brain damage. So diagnosis will become and is a very potent driver of FASD prevention."* [840]

1294. The Department of Communities through its lawyer the SSO, supports this recommendation (whilst noting it is a matter to be addressed at the Commonwealth level). They posit that there is a general lack of access to diagnosis and that Medicare Benefits Scheme item numbers for diagnosis and assessment could be of assistance in ensuring greater access. Consideration would need to be given as to which therapy services would fall within the scope of the NDIS.

1295. It follows from my Recommendation 2 that appropriate service delivery for persons who are diagnosed with FASD would be facilitated by the allocation of a separate Medicare item number. I do not consider that this would result in a neglect of other causes of impairment.

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[840] ts 312.

Recommendation 3:

That consideration be given to whether appropriate Medicare Benefits Scheme item numbers ought to be allocated for FASD

Recommendation 4 - FASD and diagnostic capacity

1296. In Dr Fitzpatrick's experience, it is likely that there is a degree of lack of knowledge about the diagnostic features of FASD among primary health care professionals. He referred to a federal government supported training course that that he and A/Professor Pestell will be developing at the University of Western Australia, concerning a tertiary educational course culminating in a graduate certificate in the assessment and diagnosis of FASD.[841]

1297. In Dr Fitzpatrick's opinion, there is a lack of resources available in the Kimberley Region to address not just the diagnosis of FASD but also the developmental follow-up once the possibility of FASD has been flagged.[842]

1298. The Department of Health and WACHS through their lawyer the SSO, draw my attention to the well documented and regularly reviewed data showing the burden of developmental vulnerabilities in children across different areas in all jurisdictions across Australia. They point to Commonwealth initiatives such as *The Australian Early Developmental Census* that examines data from universal screening.

1299. The Department of Health and WACHS submit that diagnostic and therapeutic capacity needs to be increased for all forms of neurodevelopmental impairment, noting that the Commonwealth is the main funder of primary health care.

1300. The Department of Communities, through its lawyer the SSO, supports this recommendation, subject to there being a commensurate increase in resources to respond to the diagnosis.

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[841] ts 313.
[842] ts 290.

Recommendation 4:

That consideration be given to additional funding for primary care services in areas with a high burden of neurodevelopmental impairment to increase diagnostic capacity for complex conditions including FASD, and to respond to the diagnosis by way of therapeutic services for children and young people diagnosed with FASD.

Recommendation 5 – "Making FASD history"

1301. At the Inquest Dr Fitzpatrick outlined his work on the FASD prevention model titled "*Making FASD History*". The project was introduced in the Fitzroy Valley from 2010 to 2016 with outstanding success as it had an impact on the rates of drinking amongst pregnant women and on the knowledge of and attitudes towards FASD in that region.[843]

1302. Before the commencement of the project, during the consultation phase in the Fitzroy Valley, the results of a study interviewing 127 women who had been pregnant in 2002 or 2003 indicated that 55% of women drank alcohol during pregnancy, and of those, 95% drank at high risk levels. The most common drinking patterns were revealed to be the consumption of 10 or more standard drinks per drinking occasion, and to do that two to three times per week, or month.[844]

1303. By way of follow up as part of the project in the Fitzroy Valley, FASD assessments were conducted involving a paediatric assessment, a psychological assessment, a speech and language assessment and an occupational therapy assessment. They assessed 108 children aged between seven and nine years of age, and found that 19.4% of the children who had documented exposure to alcohol during pregnancy met the diagnostic criteria for FASD, with significant impairment in three or more functional domains. Another 12% of children who had no documented exposure to alcohol during pregnancy were found to have significant neurological impairments,

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[843] ts 303.
[844] ts 280.

leading Dr Fitzpatrick to surmise that the prevalence of FASD may be higher than they documented.[845]

1304. These catastrophic statistics are to be compared with the data analysed by Dr Fitzpatrick in order to evaluate the outcomes following the implementation of the project in the Fitzroy Valley.

1305. Dr Fitzpatrick informed the court that data collected in over 600 pregnancies during that period of the implementation of the project in the Fitzroy Valley showed that rates of drinking in the first trimester reduced from 65% in 2010 to between 15% and 18% in 2017. Data over a similar period and location, drawn from approximately 400 surveys with community members indicated very high rates of knowledge of FASD and its causes and effects. In Dr Fitzpatrick's opinion, that I accept, it is the first data, internationally, to suggest a highly effective FASD prevention model.[846]

1306. In Dr Fitzpatrick's considerable experience in the area, he has found through his own observations and research data that women drink in pregnancy due to anxiety and stress. Reasons include exposure to domestic violence or abuse, a partner, family or community that has high rates of alcohol use, and the ongoing legacy of the trauma associated with the historical dispossession of land and culture.[847]

1307. The project in the Fitzroy Valley followed four strategy elements that had been successful in Canada in regard to FASD prevention. Those elements comprised of :

a. a mass media campaign targeting health promotion that was evidence-based and culturally appropriate,

b. support for pregnant women and their families to provide an alcohol free pregnancy,

c. post-natal support for the woman and her family and

d. developmental follow-up for the child.[848]

1308. This strategy that was successfully employed in the Fitzroy Valley has now been replicated in areas within the Pilbara region, with funding for five years, from similar sources of funding. These comprise a combination of funding at State and Federal level, and

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845 ts 281.
846 ts 304; Exhibit 1.3, Volume 3, Tab 11.
847 ts 304 to 305.
848 ts 304; Exhibit 1.3, Volume 3, Tab 11.

include the National Health and Medical Research Council and a philanthropic donation.[849]

1309. Dr Fitzpatrick drew attention to his awareness that Derby and Kununurra have their own FASD strategy under way, and that stakeholders in Broome and its surrounding communities are willing to begin to work on a FASD strategy. In assessing the Fitzroy Valley project, it is noteworthy that it was underpinned, and indeed supported, by alcohol restrictions that were advocated for by the community members themselves.[850]

1310. The Department of Health and WACHS through their lawyer the SSO, support the sentiment that there be government funding made available to extend the "*Making FASD History*" project to other regional centres in the Kimberley. Whilst they are not in a position to endorse the project without further information and evaluation, they are supportive of the aims of reducing the prevalence of FASD through education campaigns and support for pregnant women and their families to provide an alcohol free pregnancy.

1311. The Department of Health and WACHS submit to me that the prevalence of FASD in the Fitzroy Valley is extremely high, making the project there more cost effective. They also point to the dynamic of the project having commenced at the invitation of the Fitzroy Valley community, with community members willing to address the very sensitive issue of FASD holding leadership positions with the project, as outlined by Dr Fitzpatrick. Similar submissions are made by the Chief Psychiatrist, who also points to the successes of the project in the Fitzroy Valley being due to the relationships developed among the clinicians, the researchers, local individuals and the local community over many years.[851]

1312. The Department of Health and WACHS sound a note of caution, submitting to me that if, as submitted by the ALS, the project were to be extended across the whole of Western Australia, this would further reduce its cost effectiveness.

1313. Counsel Assisting submits to me that in light of the evidence heard at the Inquest it is obvious that the problems the Fitzroy Valley had encountered with alcohol consumption during pregnancy is not simply confined to that Region. Locations where the *"Making FASD History"* is not already underway would include Broome, Derby, Halls Creek and Kununurra.

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[849] ts 305 to 306.
[850] ts 304 to 305.
[851] ts 280.

1314. The Chief Psychiatrist notes that the process for community engagement and service development in the Fitzroy Valley was high quality, and acknowledges through his lawyer the SSO, that those broad principles are applicable in many settings.

1315. The Department of Communities through its lawyer the SSO, informs me that it supports initiatives aimed at reducing the incidence of FASD, but sounds a note of caution to the effect that the initiatives that worked well in Fitzroy Crossing may not work well in another community.

Recommendation 5:

That there be Government funding to extend to other regional centres in the Kimberley the *"Making FASD History"* project that ran in the Fitzroy Valley, adapted as appropriate to the prevailing circumstances of those communities.

Recommendation 6 - FASD education campaigns

1316. It is acknowledged that FASD can exist in any community. However, as Dr Fitzpatrick noted:

> *"FASD occurs in all socioeconomic clusters of society where there is a high rate of alcohol use in general. That generally translates into high rates of alcohol use including in pregnancy and particularly before the pregnancy is diagnosed or discovered. There are some pockets of communities that are – that are at particularly high risk, generally poor communities with limited access to public health and health and education resources and assistance."* [852] [853]

1317. Counsel Assisting submits to me that there is a greater need for such campaigns to be conducted in secondary schools in the Kimberley Region. Those campaigns ought to be focused towards, and be culturally relevant with respect to, Aboriginal children. The success of the FASD prevention program in the Fitzroy Valley would indicate

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[852] Ts 279
[853] Ibid.

that the implementation of such a campaign would have an impact on reducing the level of FASD sufferers in the future.

1318. The Department of Education through its lawyer the SSO, accepts the inherent value of educating students of, in particular, the dangers of consuming alcohol during pregnancy, and points to the following evidence in support of its efforts in this area in the government schools:

a. Departmental staff in the Kimberley being aware of FASD and of Principals and school psychologists conducting professional development training on FASD in their schools;[854]

b. Schools in the Kimberley having participated in prevention programs that educate adolescents regarding FASD, such as the School Drug Education Road Awareness Program, and discussion around health lessons including information on drinking whilst pregnant.[855]

Recommendation 6:

That education campaigns be conducted in all secondary schools in Western Australia to alert students to (i) the dangers of consuming alcohol during pregnancy and (ii) the prevalence of FASD (with a culturally relevant education campaign for Aboriginal children).

Recommendation 7 – Commissioner for Aboriginal Children

1319. The evidence reflected that, at a general level level, there are and will continue to be considerable number of Aboriginal children and young people who live in dysfunctional and traumatised home environments and communities in the Kimberley Region.

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[854] ts 515-16; ts 1404-1406; ts 1493-1494; Exhibit 1.5, Tab 50; Exhibit 1.5, Tab 50C.

[855] Exhibit 1.5, Tab 50; ts 517 to 518.

1320. In the 2002 report "*Putting the picture together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*" chaired by Her Honour Ms Sue Gordon (the Gordon Inquiry) the following two recommendations were made:

> *"The Inquiry recommends that a Children's Commissioner be established which independently reports directly to the Premier.*

and

> *The Inquiry recommends that the proposed Children's Commissioner should have a Deputy Children's Commissioner with responsibility to issues in relation to Aboriginal children."* [856]

1321. The report of the Statutory Review of the *Commissioner for Children and Young People Act 2006* (WA) (the Commissioner's Act) was tabled in Parliament on 20 August 2014. It reflects that there has been ongoing debate about whether there should be a Deputy Commissioner for Children and Young People with responsibility for issues in relation to Aboriginal children and young people, given their particular vulnerability. This option was originally recommended by the Gordon Inquiry, however, it was not adopted when the Commissioner's Act was enacted.

1322. There is now a Commissioner for Children and Young People in Western Australia though there has been no creation of a Deputy Commissioner's position with sole responsibility for Aboriginal children and young people.

1323. However, the counter argument to the appointment of such a Deputy Commissioner is that issues concerning Aboriginal children should not be assigned to a Deputy; instead they should remain the focus and responsibility of the Commissioner.

1324. The KCLS submit to me that a Deputy Commissioner for Aboriginal children be appointed, to monitor and report on the government's progress to improve the wellbeing of Aboriginal children and youth in Western Australia.

1325. However, the ALS submit that there is potential that, if these issues are delegated to a Deputy, the perception of their importance would be diminished. They submit that it would be preferable for either an additional Commissioner for Aboriginal children, or a Special

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[856] Ibid.

Advisor, to be appointed on a full-time basis to provide the Commissioner with expert advice and assistance in relation to the key issues affecting Aboriginal children and young people.

1326. It is noted that this recommendation was made by the Joint Standing Committee on the Commissioner for Children and Young People's Report, "*Everybody's Business: An examination into how the Commissioner for Children and Young People can enhance WA's response to child abuse.*"[857]

1327. The Department of Premier and Cabinet through its lawyer the SSO, draws my attention to section 20 of the Commissioner's Act that requires the Commissioner, in performing his or her functions, to give priority to and have special regard to the interests of Aboriginal and Torres Strait Islander children and young people, as well as children and young people who are vulnerable or disadvantaged for any reason. The report of the Statutory Review highlighted that this position elevates the needs and interests of these groups of children and young people to the highest level.

1328. By way of comparison, the State of Victoria not only has a Principal Commissioner for Children and Young People but also a Commissioner for Aboriginal Children and Young People. That latter position has existed in that State since July 2013. It is currently filled by an Indigenous person.[858]

1329. Although just over 6% of all children and teenagers in Western Australia are Aboriginal, figures from the Department of Communities show that as of 30 June 2017, 2,603 of the 4,795 children in the care of that department are Aboriginal. Aboriginal young people are also over-represented in juvenile detention accounting for more than three quarters of those in juvenile detention. These statistics, together with the alarming rate of suicides amongst Aboriginal children and young persons, warrant the appointment of another Commissioner with responsibilities confined to this group or a Special Advisor.[859]

1330. There would be merit in appointing an Aboriginal person for this role.

Recommendation 7:

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[857] *Report No. 7 June 2016, Parliament* of Western Australia, p. 58.
[858] ccyp.vic.gov.au/about-the-commission/our-commissioners
[859] Exhibit 1.7, Tab 58.25; Exhibit 1.9, Tab 63B.

That the State Government appoints a person who is a Special Advisor on matters concerning Aboriginal children and young persons, or considers appointing an additional Commissioner for Aboriginal children and young persons.

Recommendation 8 – Restrictions on take away alcohol

1331. I will not repeat the abundant evidence of the devastating effects of alcohol abuse on the home environments of the children and young persons whose deaths have been investigated at this Inquest. It is sufficient to say at this stage that it was yet another intolerable burden upon an already traumatic life, that elevated and magnified the vulnerability to self-harming behaviours. For this reason, I have made the following three recommendations aimed at curbing destructive alcohol-fuelled behaviours.

1332. Superintendent Allan Adams, officer in charge of the Kimberley District Office (whose evidence is referred to previously) identified that the alcohol problem in the Kimberley Region relates to the sale of pre-packaged take-away alcohol rather than alcohol purchased and consumed on licensed premises. With take-away alcohol significant amounts can be bought in a single purchase and the purchaser makes their own decision as to how much they will drink in a single sitting. In his experience the drinking behaviour around take-away alcohol contributes significantly to the Kimberley alcohol abuse problem.[860]

1333. Excessive alcohol use in households in the Kimberley communities has a significant impact on the health and wellbeing of children and young people. It is a major causal factor in disruptive behaviours, crime, domestic violence, broken families, children not attending school, and neurological impairment as a result of exposure to alcohol in utero. Further, there is the sadly inevitable outcome of it becoming normalised for children and young persons as a result of modelling of poor drinking behaviours.

1334. In his report to the coroner Superintendent Adams presented the 2016/2017 Kimberley police data. It indicated that 75% of domestic assaults investigated involved alcohol consumption by a party involved in that incident. It is in the domestic violence area that the impact upon children is at its most pronounced. Looking more broadly at all violent offences, approximately 66% of these in the

[860] Exhibit 1.8, Tab 59.

Kimberley occurred when the victim and/or perpetrator were influenced by alcohol.[861]

1335. Superintendent Adams noted that the Kimberley Region (which has a population of approximately 36,000 people, of which about 42% are Aboriginal) experiences the highest rate of offending, per head of population, in the State. It records the highest volume of violent offending across regional Western Australia and it is not unusual for the Kimberley to have more domestic assaults reported in any given week than any of the metropolitan police districts.[862]

1336. One very troubling outcome of the analysis of the police data is that alcohol featured in 56% of all self-harm incidents attended by police.[863]

1337. There are further statistics provided by Superintendent Adams from the police data which demonstrates that the connection between alcohol consumption and offending is more pronounced in the Kimberley Region than anywhere else in the State. The Superintendent reports that from 1 January 2013 to 30 Dec 2016, the rates of alcohol-related offending in the Kimberley District in comparison to the State and regional averages are as follows:

a. For total alcohol-related offences, 9.5 times the State rate, 4.2 times the Regional Western Australian rate and 14.4 times the Metropolitan Western Australian rate.

b. Average rates of alcohol-related domestic assaults are 13.5 times the State rate, 5.6 times the Regional Western Australian rate and 21.9 times the Metropolitan Western Australian rate.[864]

1338. The Liquor Control Act provides for restrictions in relation to the purchasing, consuming or possessing of alcohol: s 64 and s 175 of that Act.

1339. The imposition of restrictions has led to the existence of totally dry communities (in which alcohol is banned) to town sites that have restrictions to varying degrees; from particularly strict restrictions that exist in Halls Creek and Fitzroy Crossing to less strict restrictions for the town centres of Kununurra and Wyndham.

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[861] Exhibit 1.8, Tab 59.
[862] Ibid.
[863] Ibid.
[864] Ibid.

1340. In his report to the coroner, Dr Fitzpatrick (lead researcher, Lililwan Project, FASD prevalence study in Fitzroy Crossing) outlined the fact that it was the Aboriginal leaders in the Fitzroy Valley that successfully lobbied for alcohol restrictions in 2007 in order to stem the chronic oversupply of alcohol, having recognised the damage to the children and the threat to the continuation of their culture.[865]

1341. At the Inquest Ms Carter, Chief Executive Officer of Marniwarntikura Women's Resource Centre in Fitzroy Crossing (whose evidence is referred to previously) gave evidence about the local community efforts to address the alcohol abuse and its consequences:

> "*We don't see ourselves always as individuals, that we come from families and that families come from communities. So that has been a real shift for us. And, of course, we've seen the escalation of drinking. That's why the women of the Fitzroy Valley call for the alcohol restrictions in 2007. And it was around what we're here for today. It was around the fact that we saw domestic violence at its highest. We saw suicides. We saw the premature deaths of young people and old people. And we needed to have respite around that. We needed to think about what's happening in our communities. But we also said the restrictions were never the silver bullet to everything that we were experiencing in our community.*"

and

> "*I think it is a success because it really showed that communities can make hard decisions and that that decision wasn't imposed on us. It came from community.*"[866]

1342. Prior to the restrictions, annual sales of pure alcohol from one outlet in Fitzroy Crossing town (population 1,500) were 37,500L, almost five times the average Australian per capita consumption. A year after the restrictions, Dr Fitzpatrick found that sales of pure alcohol had dropped by 75%, with concomitant improvements in social, health and policing outcomes.[867]

1343. There are other town centres in the Kimberley where there are no restrictions on the purchase of take away alcohol, for example, Broome.

1344. What currently therefore exists are varying levels of alcohol availability across the Kimberley. Unfortunately, as noted by

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[865] Exhibit. 1.3, Tab 11.
[866] ts 734.
[867] Ibid.

Superintendent Adams, this disparate level of access to alcohol contributes to the displacement of people who move to an area where alcohol is more readily available (and also to sly grogging, which is addressed in Recommendation 10).[868]

1345. Counsel Assisting submits to me that there is considerable merit in Superintendent Adams' recommendation that the north of Western Australia (including but not necessarily confined to the Kimberley Region) should be looked at more as a zone in respect to liquor suppression tactics. At the Inquest the Superintendent suggested the consideration of a northern zone by reference to the areas including, and above, Karratha and Newman.[869]

1346. Superintendent Adams' was of the firm view that the established and severe liquor restrictions at Fitzroy Crossing and Halls Creek should not be diluted in any way, he described the results of these restrictions as "*fantastic*." He posited that, without altering these existing restrictions, a zonal effect could be achieved by adopting a consistent approach across the Kimberley, and suggested a general restriction of the daily take away alcohol to one carton of full strength beer or six bottles of wine.[870]

1347. In the meantime, the Superintendent reiterated that the current restrictions in Fitzroy Crossing and Halls Creek should remain, until a demonstrably more successful alternative is found.[871]

1348. It is conceded by police that to make the entire region dry would not be seen as a reasonable response by the community nor could it sustain the ongoing viability of the tourism industry.[872]

1349. There is merit in considering the implementation of a general restriction across the Kimberley Region on the sale of take away alcohol that does not affect the responsible consumers of alcohol but targets those who abuse it. That general restriction, in conjunction with more severe restrictions that currently exist in areas such as Fitzroy Crossing and Halls Creek, could be beneficial to the Kimberley Region as a whole.

1350. The Commissioner of Police through his lawyer the SSO, expresses the Western Australia Police Force's in principle support for further alcohol restrictions, and considers that the resource implications for the Western Australia Police Force and other agencies will be

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[868] ts 1839.
[869] ts 1838 to 1839; Exhibit 1.8, Tab 59.
[870] Ibid.
[871] Ibid.
[872] Ibid.

offset by the reduction in alcohol related harm resulting in a reduction in overall workload.

1351. The Commissioner of Police submits that any Kimberley wide alcohol restrictions should not reduce the current restrictions in Halls Creek and Fitzroy Crossing until a more successful alternative is found. On behalf of the Western Australia Police Force he also draws attention to the practicalities of policing in the Kimberley, where police officers are required to traverse long distances in their policing roles, which impacts upon their ability to enforce restrictions.

1352. The Department of Communities through its lawyer the SSO, expresses its support for communities that wish to introduce or strengthen restrictions on alcohol supply and consumption. They note that there are already Kimberley wide alcohol restrictions, and recognise that more work could be done to harmonise those restrictions, but (consistent with the Commissioner of Police's views) without watering down currently effective restrictions in towns such as Fitzroy Crossing and Halls Creek.

1353. The Director of Liquor Licensing, Department of Local Government, Sport and Cultural Industries through his lawyer the SSO, informs me that he may consider a recommendation for Kimberley-wide restrictions following consultation with key stakeholders and in accordance with s 64(1C) of the Liquor Control Act.

1354. The Director of Liquor Licensing cautions that liquor restrictions are unlikely, on their own, to result in effective long term changes to drinking habits, but recognises that supply reduction strategies are a strategy that works in the context of reducing alcohol related harm.[873]

1355. The ALS endorses the submission that alcohol restrictions are one option to assist in keeping children safe. However they submit that any restriction needs to be made in consultation with the local community and be community driven.

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[873] Exhibit 1.3 Tab 14.

Recommendation 8:

That there be restrictions on the purchase of take away alcohol across the entire Kimberley Region, but that such restrictions be formulated after there has been consultation with key stakeholders, including affected local Aboriginal communities.

Recommendation 9 – Banned Drinker register

1356. There are currently legislative provisions available to prevent individuals from attending licensed premises, thereby denying those individuals access to alcohol.

1357. Section 115 of the Liquor Control Act permits an authorised person (i.e. a licensee or police officer) to preclude entry onto licensed premises of a person who is known to be disorderly or quarrelsome or been convicted of an offence of violence where the penalty for the offences exceeds three years imprisonment.

1358. The Court was informed that this section was used by Kimberley police in an operation over the Easter period in 2017 with considerable success though it was very labour intensive and would be difficult to conduct on a regular basis. Superintendent Adams reported that during those Easter holidays in 2017, Kimberley police engaged 8,200 people at the front door of Kimberley liquor stores and prevented entry to 1,240 people who had a recent history of alcohol-related harm/disorder. There was a concurrent and significant decrease in alcohol related violence reported to police, a significant reduction in presentations at hospitals for alcohol related injury, and significant reductions in individuals dealt with by Aboriginal patrols.[874]

1359. The other legislative provisions denying entry of individuals into licensed premises are Prohibition Orders under s 152 of the Liquor Control Act and Prohibitive Behaviour Orders under ss 5 and 6 of the *Prohibited Behaviours Orders Act* 2010. However, as identified by Superintendent Adams, these provisions do not have the capacity

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[874] Exhibit 1.8, Tab 59, p.19.

to appropriately address the alcohol-related issues experienced by police in the Kimberley Region.[875]

1360. Western Australia does not have a Banned Drinker Register though such a register was re-introduced by the Northern Territory government, effective from 1 September 2017.[876]

1361. As of 1 September 2017 all persons wishing to purchase take away alcohol from outlets in the Northern Territory are required to show photo identification. This will enable those outlets to identify people who are banned from purchasing take away alcohol.

1362. The Northern Territory Banned Drinker Registrar will make decisions as to whether to issue a Banned Drinker Order on an individual and place that person onto the register. That decision can be made if requested by authorised persons, family members, carers or through self-referral. A range of therapeutic support options are in place for those people who are on the register to enable them to seek any help and support to address their alcohol abuse. If a person completes a recommended therapeutic support program their ban can be reduced if it is for six months or more.[877]

1363. Though the purpose of the Banned Drinker Register in the Northern Territory is to tackle crime and anti-social behaviour it also aims to reduce health-related harm associated with alcohol misuse by encouraging and supporting people to access help. It is designed to offer therapeutic support rather than punishing people who have a drinking problem.[878]

1364. Professor Ted Wilkes, whose evidence is referred to previously, was aware of a process regarding a "*ban*" in the Northern Territory and expressed the view that "*regardless of colour or race*" if you are not a safe drinker you should be held to account, either by being prevented from drinking, or to be barred for a period of time:

> "*….if you have a record, a bad record, in relation to drinking, then I think that you leave yourself open to be banned from the local outlets and from drinking alcohol in your particular area, at least for a period of time, and then, give it another chance at*

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[875] Ibid.

[876] A previous banned drinkers register was in place from 2011 to 2012 in the Northern Territory.

[877] health.nt.gov.au/professionals/alcohol-and-other-drugs-professionals/banned/drinker/register and the *Alcohol Harm Reduction Act NT (2017).*

[878] A previous banned drinkers register was in place from 2011 to 2012 in the Northern Territoryhealth.nt.gov.au/professionals/alcohol-and-other-drugs-health-professionals/banned/drinker/register.

a later date. And if you – as most of us believe, three chances and you're out."[879]

1365. Professor Marcia Langton, Foundation Chair of Australian Indigenous Studies at the University of Melbourne, is an Aboriginal woman, descended from the Yiman and Bidjara people in Queensland. Professor Langton was familiar with the Banned Drinker Register in the Northern Territory, recalling that it had the effect of taking out of the alcohol economy about 2,900 high risk drinkers due to their antisocial behaviour. Professor Langton highly recommends such a scheme as a very good way of limiting the harmful impact of the high risk drinkers.[880]

1366. Superintendent Adams informed the Inquest that Kimberley Police see the introduction of a Banned Drinker Register that is aligned to the provisions of s 115 of the Liquor Control Act as being a more effective and efficient way of achieving the positive results experienced during the police operations at Easter 2017, referred to above. In his experience: "*The Banned Drinker is the one that there has been quite universal acceptance. There has been very few people that argue that targeting the problem drinkers isn't a valid way of going forward.*"[881]

1367. Superintendent Adams suggested there should be a community conversation around what types of harm should be targeted if a Banned Drinker Register is introduced. He also cautioned that multiple responses are needed to reduce alcohol supply and demand, and that the Banned Drinker Register is one such response. The Superintendent perceives a benefit in an approach that targets the individuals that represent the most risk of harm. In conversations that he has had widely across the Kimberley, one concern is that the existing restrictions impact upon people who do not have a drinking problem.[882]

1368. The Director of Liquor Licensing through his lawyer the SSO notes that this is not provided for in the Liquor Control Act and that it is not part of the Director's function to provide therapeutic support.

1369. The Commissioner of Police through his lawyer the SSO, expresses the Western Australia Police Force's support for an assessment of the feasibility of introducing a Banned Drinker Register that is modelled on therapeutic support, whilst remaining cognisant that the

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[879] ts 150.
[880] ts 1954.
[881] ts 1840.
[882] ts 1864.

wholesale introduction of such a scheme would be costly and involve a long lead time.

1370. The Commissioner of Police therefore sounds a note of caution to the effect that any work to assess or implement a Banned Drinker Register does not impede the introduction of other measures to curb the supply of liquor to problematic individuals at the point of sale. The Commissioner informs the court that the Western Australia Police Force is actively pursuing measures to target the supply of alcohol to those drinkers whose consumption has a significantly disproportionate impact on vulnerable children and the wider community.

1371. The ALS informs the Court that they are instructed to oppose a recommendation for the introduction of a Banned Drinker Register unless extensive consultation is undertaken with the wider Aboriginal community in the Kimberley Region. They are concerned that, if it is not community driven, it could have the result of targeting Aboriginal persons.

Recommendation 9:

That the Western Australian Government considers and/or assesses the feasibility of a Banned Drinker Register that is modelled on therapeutic support for those who are placed on it. If the matter progresses to an assessment, that consideration be given to community consultation.

Recommendation 10 – Regulating "sly grogging"

1372. The Inquest heard evidence from police officers relating to the difficulty in establishing that defendants charged under s 109 of the Liquor Control Act with possession of alcohol for the purpose of sale were actually carrying the alcohol for that purpose i.e. *"sly grogging"* allegations.[883]

1373. A solution put forward to overcome that difficulty was to have the onus of proof reversed so that a defendant would need to establish a lawful reason to be carrying the alcohol. It is noted that the ALS in

[883] ts 1235 and 1236.

its submissions opposes a change that would have the effect of reversing the onus of proof.[884]

1374. The Director of Liquor Licensing through his lawyer the SSO refers me to the *Liquor Control Amendment Act* 2018 that has inserted a new s 109A (Offence to carry liquor in excess of prescribed quantity in prescribed area of State). This amendment is addressed to the driver of the vehicle, who is taken to be the person who carries the liquor, and makes it an offence for such a driver to, in a prescribed area of the State, carry a kind of liquor in a quantity that exceeds the quantity prescribed for that kind of liquor. A range of statutory defences are outlined.

1375. The Director of Liquor Licensing submits, and I accept that this amendment, coupled with appropriate regulations, will achieve a similar outcome to the outcome of proposed Recommendation 10, without alteration of the onus of proof.

1376. The Commissioner of Police through his lawyer the SSO expresses his support of legislative amendment that would overcome the difficulties of charging under the provisions of s 109 of the Liquor Control Act. Nonetheless he acknowledges that despite any legislative change, a change in behaviour is required to have any lasting effect.

1377. In light of the progression of the legislative amendment it is unnecessary for me to specifically make a recommendation regarding the regulation of *"sly grogging"* save to highlight the importance of resourcing the police in order to enforce it.

Recommendation 10:

That in light of the passage of the Liquor Control Amendment Act 2018 relating to the proscription on "sly grogging", that police be properly resourced to enforce it.

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[884] ts 1235.

Recommendation 11 – Diversionary patrols

1378. The State Government established a number of patrols in response to the recommendations of the 1992 Royal Commission into Aboriginal Deaths in Custody. These patrols were established with the intention of diverting at risk Aboriginal people who were generally intoxicated from unnecessary contact with the criminal justice and health systems by picking them up and taking them to a *"safe place"*. The number of these patrols has increased over time and in the 2016/17 financial year the Department of Aboriginal Affairs had funded 14 such patrols in Western Australia.[885]

1379. These patrols were funded through service agreements with the locally based Aboriginal Corporation or similar entity in each location. The Broome Kullari patrol was established in 1992 and was the first night patrol to commence operations within the State. The Milliya Rumurra Aboriginal Corporation reports that young people are now coming more under the focus of these patrols.

1380. Though the most publically visible role of these patrols is transporting intoxicated people from potentially dangerous situations to safe places such as their homes, or a refuge or sobering up facility, another role is the referral of people to appropriate agencies for support and follow-up

1381. Not only are patrols providing services on the *"front line",* they are also operated by Aboriginal people. It therefore offers one of the best ways of engaging and providing information to those who most need it. From secured funding the Kullari patrol in Broome has been able to develop additional diversionary services

1382. By way of example the Kullari patrol has a pilot program that takes groups of at risk Aboriginal people on day long fishing and picnic trips. This provides the patrol employees the opportunity to talk further with clients about their needs and provide information about introductions to the diversionary programs. This particular patrol wishes to extend its diversionary programs into other activities regularly held that would have attendees eating and drinking healthily.

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[885] These patrols operate in Perth, Kununurra, Wyndham, Halls Creek, Broome, Derby, Roebourne, Port Hedland, Laverton, Kalgoorlie, Meekatharra, Carnarvon, Geraldton and Mullewa.

1383. Counsel Assisting submits to me that using the services of these patrols would greatly assist the rehabilitation of those in the Kimberley Region who have issues with alcohol abuse.

1384. The Department of Communities through its lawyer the SSO, expresses its support for this recommendation and informs me that it is already implementing it by funding five patrols in the Kimberley in Broome, Derby, Halls Creek, Kununurra and Wyndham. Through the Regional Reform Unit (within the Department of Communities) they are preparing a business case seeking longer-term funding for patrols at various locations throughout the State.

1385. The business case proposes to reduce the provision of safe transport and divert those resources into assisting identified client issues, building stakeholder relationships and implementing effective intervention and diversionary programs. The proposal is for consultation and co-design with patrols in each location.

1386. The ALS supports the recommendation, drawing attention to the patent risk of serious harm to children who have a street presence or who are walking the streets late at night. They point to the evidence of Mr Geddes of the Department of Communities agreeing that such children are a high priority for that department.

Recommendation 11:

That there be recurrent, or more long-term funding to the various town based patrols in the Kimberley for the provision of diversionary services to those who are abusing alcohol.

Recommendation 12 – Family advocates

1387. The Education and Health Standing Committee's "*Learnings from the Message Stick*" report referred to recommendations having been made, over a period of more than 15 years, about the need for better service integration within and between the Western Australian Government, Commonwealth Government and non-government service providers. According to the Committee: "*The delivery of integrated services for Aboriginal people is severely lacking, resulting*

in significant levels of duplication leading to confusing and inconsistent services for Aboriginal people."[886]

1388. For example, when the Education and Health Standing Committee sourced "*review templates*" for the Roebourne review they received them from 18 Western Australian government agencies, nine Commonwealth government agencies, two local government authorities, 65 non-government organisations and Aboriginal corporations, and eight resource companies. Overall 452 review templates were returned.[887]

1389. I endorse the comments of the Education and Health Standing Committee to the effect that the extent of this review for one group of communities gives some indication of the prohibitive challenges of undertaking a full review of all services provided to remote Aboriginal communities in Western Australia.[888]

1390. A review of all of the services provided to remote Aboriginal communities in the Kimberley Region is outside the scope of the Inquest. Having regard to the present lack of integration of services, the Inquest explored options for helping families.

1391. In her evidence before the Inquest Professor Pat Dudgeon suggested that struggling families would be assisted by a "*family advocate*". A family advocate could help the families to find their way through the myriad of services on offer, and to identify the most appropriate ones.

1392. Such a person could assist the family in a variety of areas such as financial management, contact with the criminal justice system, assistance with alcohol and drug issues, access to health services and assistance in having children attend school. Essentially it would involve such a person being connected with the family and assisting the family with access to service providers.[889]

1393. The ALS support Professor Dudgeon's proposal, noting her suggestion that it be offered in a positive, supported manner, giving advice in a non-judgemental way.[890]

1394. Ms Brenda Garstone, the manager of the Yura Yungi Medical Service based in Halls Creek, gave evidence at the Inquest about her previous employment as a "*Strong Family Co-ordinator*" at the Department of Child Protection and Family Support. Her description

[886] Exhibit 1.1, Tab 2.
[887] Ibid.
[888] Ibid.
[889] ts 82; ts 92 to 93.
[890] ts 83.

of that role was not dissimilar to that of the family advocate as described by Professor Dudgeon.[891]

1395. Ms Garstone's strongly held view was that it was a position that was very successful, but that it had now been abolished.[892]

1396. At his appearance before the Inquest, Mr Grahame Searle, the then interim Director-General of the Department of Communities (now Director General) was asked for his views about the role played by a family consultant or family advocate who is engaged by government who can assist families in getting the services they require. Mr Searle compared such a role to that used by the Disabilities Services Commission of Local Area Co-ordinators who have assisted dysfunctional families.[893]

1397. At the Inquest Mr Searle was supportive of such a role as proposed by Professor Dudgeon and said it was something the Department of Communities is considering implementing with the intention that it first be introduced in the Kimberley Region.[894]

1398. WACHS through its lawyer the SSO, submits to me that a family advocate could produce some benefit, however that it would need to be implemented in consultation with local service providers to ensure there is no duplication of services. If the role is properly structured, I do not share their concern about a family advocate becoming an additional barrier between service providers and service receivers.

1399. The Chief Psychiatrist through his lawyer the SSO, whilst acknowledging some utility, submits to me that it could also contribute to the system being disjointed or fragmented. To minimise this risk, he submits that assistance must come from within existing structures, and intercalate with existing therapeutic models.

1400. The Department of Communities through its lawyer the SSO, supports this recommendation, but like the WACHS and the Chief Psychiatrist, considers it best implemented as part of its service delivery, in the form of a method of individualised engagement or case management, to assist people to identify the supports and services they need, and help them connect with those services.

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[891] ts 1463-1464.
[892] ts 1465.
[893] ts 1751.
[894] ts 1761 and 1762.

1401. The recommendation is therefore addressed to the Department of Communities.

Recommendation 12:

That there be the appointment of Local Area Co-ordinators or local Family Advocates in the Kimberley Region who can assist families in need of accessing service providers and that all efforts be made to have such roles filled by an Aboriginal person.

Recommendation 13 – Short term accommodation in East Kimberley

1402. Overcrowding in houses has been a systemic problem for the Aboriginal community for some considerable time. The notion that an Aboriginal person's house should be made available to that person's extended family stems from longstanding cultural obligations. These were highlighted in evidence by Professor Dudgeon.[895]

1403. Overcrowding creates significant problems for children. It is not an environment conducive to regular sleep patterns or to study. It also risks providing opportunities for abuse of children.

1404. There was also evidence before the Inquest of the transient nature of some Aboriginal families. The reasons for that are as wide and varied as attending family funerals, connecting with family, accessing medical services, or accessing locations where alcohol is more readily available.

1405. Counsel Assisting submits to me that a proposal that may alleviate overcrowding caused by the influx of visitors to the larger town sites would be the building of hostels specifically designed for short stay accommodation.

1406. There are currently two short stay facilities for Aboriginal people in the Kimberley Region. One is a 54 bed facility in Derby managed by

[895] ts 83; ts 1471.

Mercycare, which began operating in late 2014, to provide accommodation to Aboriginal persons who visit the reginal centre.[896]

1407. Another short stay facility has recently been opened in Broome (providing between 80 and 100 beds of short term (less than 28 days) accommodation for Aboriginal people visiting Broome. It is also managed by Mercycare.[897]

1408. There have been *"some early discussions"* by the relevant section of the Department of Communities for the building of such facilities in the East Kimberley. Mr Lonsdale, Director of Client Services North, and Aboriginal Housing, Department of Communities (whose evidence is referred to previously) stated that there is an interest in this area, but that it would be: "*....subject to a demonstrated need and a business case.*"[898]

1409. Counsel Assisting submits to me that the need for such facilities in the East Kimberley are just as pressing as the need for them in the West Kimberley.

1410. The ALS support this recommendation and highlight the need for such accommodation to be culturally appropriate.

1411. The Department of Communities through its lawyer the SSO, supports this recommendation in principle subject to demonstrated demand and the availability of capital and recurrent funding for such a facility in Kununurra. They also point to the existence of hostels for secondary students and renal dialysis patients in Kununurra.

Recommendation 13:

That there be consideration of the funding for, and assessment of the feasibility of, the construction of culturally appropriate short term accommodation in Kununurra for Aboriginal persons visiting the East Kimberley Region.

[896] Exhibit 1.6, Volume 6, Tab 54; ts 1799.
[897] Exhibit 1.6, Volume 6, Tab 54.
[898] ts 1799.

Recommendation 14 – Transitional Housing Program

1412. Site visits by the Inquest to some Aboriginal communities showed the sub-standard state of housing for some Aboriginal families.

1413. The Department of Premier and Cabinet through its lawyer the SSO, submits to me that, rather than simply building more houses to meet the demand, it is preferable for Government strategies to focus on reducing the demand for social housing.

1414. The Transitional Housing Program was launched in Kununurra by the Housing Authority in September 2012 with an initial number of 40 transitional houses. The concept came from the Wunan Foundation and it was aimed at providing the opportunity for Aboriginal persons to create a better life for themselves.[899]

1415. To be eligible for the Transitional Housing Program participants must identify as being Aboriginal, be living in the locality for a minimum of 12 months, be part-time or full-time employed or engaged in full-time paid training, ensure school aged children in the household attend school regularly, commit to a Residential Tenancy Agreement, pay their required security bond payment, commit to ongoing mentoring and engagement with support services and meet transitional housing eligibility requirements.[900]

1416. It is intended that participants would develop independence and have the opportunity to take a significant step towards achieving home ownership. Transitional houses are designed to meet the needs of singles, couples and family groups.[901]

1417. Evidence from Mr Ian Trust at the Inquest was very supportive of this program. Mr Trust is a Giga man from the East Kimberley/Halls Creek area. He has held numerous leadership positions that include being the executive director on One Arm Corporation (an Aboriginal Development Corporation), the Chair of the West Australian Aboriginal Advisory Council, the Deputy Chair of the Kimberley Development Commission, and a board member of the East Kimberley Empowered Communities Organisation.[902]

1418. Mr Trust noted that the children of families in the transitional housing had a school attendance of 80% or more, and that there were rules as to the number of people who could be living in the house. Occupants

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[899] ts 1755; ts 1364.
[900] www.housing.wa.gov.au/transitionalhousing
[901] www.housing.wa.gov.au/transitionalhousing
[902] ts 1359.

who have the capacity and desire to do so, can then move into home ownership by purchasing the transitional house, or another in the community.[903]

1419. At the Inquest Dr Stephanie Trust, principal general practitioner at Kununurra Medical, posited that the rules around occupancy in transitional housing may also assist in minimising overcrowding arising from cultural expectations of visiting relatives.[904]

1420. Records reflect that among the participants in transitional housing in Kununurra, school attendance increased to 97% (Kimberley average being about 60%).[905]

1421. Since 2012 the Transitional Housing Project has extended to Broome, Derby and Halls Creek.[906]

1422. I am informed that the Department of Communities has supported and continues to expand the Transitional Housing Program with funding from the North West Aboriginal Housing Fund.

Recommendation 14:

That the Transitional Housing Project be continued in Broome, Derby, Halls Creek and Kununurra and be extended to other town sites in the Kimberley.

Recommendation 15 – Public housing and income threshold

1423. The Inquest heard evidence regarding the circumstances of a hypothetical family who may be in a dwelling that is classified as public housing but whose income then exceeds the eligibility criteria, requiring them to relocate.[907]

1424. This obviously may give rise to a disincentive to obtain (or remain in) employment, particularly in areas where housing is in short supply

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903 ts 1364.
904 ts 1338; ts 1354.
905 ts 1755 to 1756; ts 1364 to 1365; Exhibit 1.6, Tab 54.
906 Ts 1755.
907 ts 1807.

such as Halls Creek. It may lead to a family choosing between an increased income, or remaining in the public housing.

1425. Mr Peter Lonsdale, the Department of Communities' Director of Client Services North and Aboriginal Housing, in his evidence before the Inquest acknowledged this dilemma. One option is to move the house into a different program regime which would permit such a family to stay. Yet how viable that option would be *"depends on the land supply and our flexibility to replace an asset with another asset"* which he said would be *"a challenge."* He acknowledged that there may not be sufficient Transitional Housing Project houses in the area.[908]

1426. There should be no disincentives for Aboriginal persons to remain employed, yet such a situation may develop if there is a risk the person and their family are no longer eligible to remain in their house because their income has exceeded the Transitional Housing eligibility criteria.

1427. The Department of Communities through its lawyer the SSO expresses its support for this recommendation and informs me that it is already implementing it in practice by applying some flexibility in its decision making with over income tenants in the Kimberley by undertaking a holistic assessment of the tenant's personal, social and economic circumstances before making a decision on the tenant's ongoing eligibility.

1428. The Department of Communities also informs me that it allows for a timeframe of 12 months to two years to work with the family to relocate, and also acknowledges the additional challenges with respect to the availability of housing in Halls Creek.

1429. The Department of Communities outlines the steps it is currently undertaking to address these concerns:

a. They are looking at more flexible options to move people through the housing continuum to private rental accommodation and access home ownership;

b. They are building 15 transitional houses in Halls Creek;

c. On occasion, they will allow people to stay in the existing houses and pay a market rent.[909]

1430. There was ample evidence at the Inquest concerning the limited accommodation options and limited employment opportunities for

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[908] ts 1976; ts 1807-1808.

[909] Ex 1.6, Tab 54; ts 1779.

Aboriginal people living in the Kimberley. There were also concerns expressed about the need for stable housing.

Recommendation 15:

That Aboriginal persons living in the Kimberley Region in public and/or transitional housing are not disadvantaged regarding accommodation in the event of their household exceeding the income threshold for eligibility.

Recommendation 16 – Expansion of Yiriman Project

1431. The Yiriman Project first started in 2000 in a West Kimberley community called Jarlmadangah Burru, 120 kilometres from Derby. Elders from the Kimberley Aboriginal Law and Cultural Centre ("KALACC") saw problems that young Aboriginal people were experiencing and grounded a response to those problems in the law and culture of the language groups of the West Kimberley. The Yiriman Project is a non-incorporated body that has administrative support provided to it by KALACC which is incorporated. The Yiriman Project currently has 15 to 20 Elders actively involved who are all cultural advisors to KALAAC.[910]

1432. Mr Joe Brown (Yiriman Boss, governance group of the Yiriman Project) and Mr Scott Herring (Men's co-ordinator, Yiriman Project) produced a report for the coroner and gave evidence at the Inquest.

1433. The Yiriman Project takes its name from a cultural site in the West Kimberley called Yiriman. Its primary aim has been to support young Aboriginal persons from remote communities connected culturally and linguistically within Nyikina, Mangala, Walmajarri and Karajarri traditional land and language groups. The objective has been to equip them with the skills and resilience to cope with contemporary society, while imparting in them a strength to move away from activities involving self-harm and substance abuse.[911]

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[910] ts 1987 and 1988; Exhibit 1.9, Tab 63.
[911] Exhibit 1.9, Tab 63.

1434. The Yiriman Project is now based in Fitzroy Crossing and also works with the Bunuba and Gooniyandi groups.[912]

1435. The Yiriman Project has programs for Aboriginal boys and girls and young men and women (as well as families) which involves taking them out on country, where Elders engage the participants to reconnect with their country, culture and family. It involves telling stories about language, growing up on country and in culture, and the history of the Aboriginal people from the language groups.[913]

1436. The Elders teach young persons about cultural protocols: "....*things like how to approach a jila (water hole) safely in a culture way, about sacred sites, skin group relationships, who is related to who, people's roles and responsibilities to each other and how to be good men and women.*"[914]

1437. It is not a formal suicide prevention project or diversionary project, rather:

> *"The program is about recognising that when young Aboriginal people have a strong connection to country and culture, there is less risk of that person suffering from self-harm, mental problems and getting into trouble with the law. It is about recognising connection to culture as a protection against those things."*[915]

1438. The Yiriman Project supports the concept of "*upstream solutions*", described by Mr Scott Herring, the Yiriman Project's Men's Co-ordinator, in his evidence before the Inquest as follows:

> *"... we're really looking at working with the community, with the population, to strengthen people prior to them running into problems."*[916]

1439. The authors of the report informed the Court: "*We have had kids who have been out on country with Yiriman tell us that after being out on country they felt alive for the first time.*" Young people are taken out on country that has specific cultural significance to them, their family and their ancestors. At the Inquest the authors demonstrated a keen willingness to work collaboratively with drug and alcohol personnel,

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912 Ibid.
913 Ibid.
914 Ibid.
915 Exhibit 1.9, Volume 9, Tab 63.
916 ts 1994.

highlighting more work that could be done to assist children in this area.[917]

1440. The Yiriman Project is presently funded by the State and Federal Governments. The Court is informed that the State Government has commenced funding recently, as of May 2017, with the former Department of Corrective Services funding the Yiriman Youth Diversion Program's on-country activities. This component of the funding is to support young people in the Fitzroy Valley at risk of involvement in the criminal justice system. Previously much of the funding had come federally and with philanthropic and corporate funding.[918]

1441. The State Government's funding is through the Youth Justice Innovation Fund, and was administered by the Youth Justice Board (now dissolved) to trial community based initiatives to reduce reoffending and the overrepresentation of young people in custody. The Board had a special interest in programs designed for young Aboriginal people and aimed to build organisational capacity amongst emerging Aboriginal service providers. The Yiriman Project is one of seven grant agreements.[919]

1442. The Court is also informed that the funding for staff salaries is provided through the WA Primary Health Alliance funding from the Commonwealth Government, while funding for on country activities comes from the Western Australian Department of Corrective Services.

1443. Mr Brown and Mr Herring reported that in a number of forums, the Yiriman Project has been independently evaluated and assessed as being a successful program that can reduce the prospect of young Aboriginal persons committing suicide. They referred to positive evaluations by the following:

a. The 2012 Reconciliation Australia National Governance Award;

b. The Productivity Commission's 2014 Report *"Overcoming Indigenous Disadvantage – Key Indicators"*, citing Yiriman as a model of Indigenous governance that works;

c. The reference in the Aboriginal and Torres Strait Islander Suicide Prevention and Evaluation Project Report as an example of a project that reduces the prospect of a young

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[917] Ibid; ts 2008 to 2009.
[918] ts 1988 and 1989; Exhibit 1.9, Volume 9, Tab 63.
[919] Exhibit 1.5, Tab 55.

person committing suicide by diverting young people's behaviours away from drugs and alcohol and towards healing and connection to culture; and

d. The positive comments in the Western Australian Parliament's Education and Health Standing Committee's 2016 report "*Learnings from the Message Stick*", referring to it as a well-known example of a community-owned program embedded in local culture.[920]

1444. In the experience of Mr Brown and Mr Herring, one of the reasons that the Yiriman Project has been so successful is because of the strong cultural governance of the project. They would like to see other communities in Western Australia be able to establish projects like Yiriman, where Elders from those communities take at risk young people out on country and back to culture. They explain that it would be for those people and language groups to identify sites of cultural significance to them, where they could take young people out on country and teach then the ways of their old people.[921]

1445. Counsel Assisting submits to me that at present the Yiriman Project is only operating in a small part of the Kimberley Region amongst a limited number of Aboriginal language groups. Although those Elders who operate the Yiriman Project are very willing to expand its design to other regions and communities, the evidence of Mr Herring was as follows:

> *"Our position is really, really clear, that before we can extend the Yiriman Project, we need to make sure that the Yiriman Project is – is properly resourced."* [922]

1446. Ms Garstone, the manager of the Yura Yungi Medical Service based in Halls Creek, whose evidence is referred to previously, testified as to the importance of "*on country*" healing programs:

> "*I think we really need to work more from a therapeutic level to go out into the community, go out on country. We – we need to, you know, get – get our families to reconnect with their culture, their identity, re-establish themselves, get them to feel better about who they are. At the moment, a lot of them don't feel good about themselves and I've observed in other – other places whereby culture has really strengthened an individual and they've had a new burst of life when they've actually been*

[920] Exhibit 1,9, Volume 9, Tab 63.
[921] Ibid.
[922] ts 1995.

able to showcase their culture, their identity, they live their language, do their cultural practices, do their dancing."[923]

1447. At the Inquest Ms Skeen, whose evidence is referred to previously, made the insightful observation regarding the benefits of focussing upon cultural healing through on country programs before the situation becomes dire for a young person:

> "*And so I think we should focus more on that – you know, focus on the health and wellbeing of young people, continue to go on on-country trips and learn about our language and culture and who we are instead of waiting until we realise that there's a cohort of young people that are really, really disengaged, and, oh, we need to bring them back on country.*"[924]

1448. Dr Trust, principal general practitioner at Kununurra Medical, is a Kidja woman, and she has worked in the health services for over 30 years. In her experience, a large number of people with mental health problems can be treated in a General Practice setting. In this regard, she considers that early support is important and that treatment does not always have to be from mental health specialists.[925]

1449. In Dr Trust's opinion, back to country mental health support services are lacking. She draws attention to the importance of "*going out bush and fishing*" as an example of activities that may form part of cultural healing. In her view, her community needs more culturally appropriate mental health support services.[926]

1450. I accept the submission by ALS that the Yiriman Project is an ideal model for the "*primordial*", "*selective*" and "*indicated*" interventions as outlined in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project report (ATSISPEP report) referred to above under the heading "*Aboriginal Suicide*" and that it could be easily duplicated for Aboriginal people across Western Australia.

1451. The WACHS through its lawyer the SSO, expresses its support of a holistic approach to healthcare, but note that they are not in a position to compare the Yiriman Project against other projects with regards to efficacy and cost effectiveness. They also submit that without a local lead, the Yiriman Project may not be viable in new areas.

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923 ts 1476.
924 ts 576.
925 Exhibit 1.4, Tab 42.
926 Ibid.

1452. In general terms, the Chief Psychiatrist through his lawyer the SSO, outlines his support of "*upstream strategies to build cultural resilience*." He has not investigated the Yiriman Project therefore cannot specifically comment on it. He submits that this funding decision would be best dealt with by the Mental Health Commission.

1453. The Department of Justice through its lawyer the SSO informs me that it is committed to ensuring that it only funds programs that have been comprehensively evaluated. Therefore its support for this recommendation is dependent on the outcome of the evaluation conducted as part of the Youth Justice Services Evaluation Framework for funded programs that measures the impacts and effectiveness for the outcome for young people and applies to all their programs. The first acquittal report for the Yiriman Youth Diversion Program was due in 2018 and is not a public document. This evaluation will inform the Department of Justice's future funding decisions regarding the project.[927]

1454. The Department of Justice notes that it is one of the funding sources for the Yiriman Project, and future funding may be affected by the transition of some of the Youth Justice Service functions to the Department of Communities through the Machinery of Government changes.

1455. The Department of Communities through its lawyer the SSO sounds a note of caution over recommending a specific program that may work well in one place but be unsuitable or not work elsewhere in the Kimberley.

1456. At the Inquest Ms Lucy Gunn, executive director of Department of Planning, Lands and Heritage, recalled an instance of where the Yiriman Project was offered to an Aboriginal community, and they elected not to proceed with it, due to it being linked with a particular language group.[928]

1457. The ALS draws to my attention the evidence concerning the difficulties experienced by the Yiriman Project in securing ongoing funding (that is, funding for consecutive periods of more than one or two years). At the Inquest, in connection with the lack of longer term funding commitments, Mr Herring stated: "*So we're constantly in a battle to ensure that we can continue.*" I accept Mr Herring's evidence that in his experience, people across the Kimberley are calling out for a

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[927] Exhibit 1.6, Tab 55; ts 1925.
[928] ts 1567; ts 1575.

project like the Yiriman Project, and that the Elders from the relevant communities need to be empowered to run such a program.[929]

1458. I also take account of the ALS submission addressing the potential difficulties that a "*grass-roots*" Aboriginal organisation might have in collating the qualitative and quantitative data to satisfy funding guidelines from government departments.

Recommendation 16:

That the Yiriman Project or a model akin to the Yiriman Project be extended across the Kimberley, and that consideration be given to the following matters in connection with the extension:

a. **That the Western Australian government through its various health and justice branches should explore opportunities for the implementation of models akin to the Yiriman Project in other remote parts of Western Australia with priority given to those areas with high rates of Aboriginal youth suicide.**

b. **That funding providers for the Yiriman Project and other programs akin to the Yiriman Project should acknowledge the need for key performance indicators that are flexible and reflect the difficulty such organisations have in providing quantitative and qualitative data on the success of individual interventions with at-risk clients.**

c. **That the Western Australian government should consider guaranteed funding for the Yiriman Project on a longer term basis, whether through funding provided by the Department for Corrective Services for diversionary programs, through ATSIPEP funding, or through funding co-ordinated through the Mental Health Commission.**

Recommendation 17 – Consultation with Aboriginal communities

[929] ts 1995 to 1996.

1459. There were repeated calls by Aboriginal witnesses who gave evidence at the Inquest for consultation with the Aboriginal communities by Government and/or service providers. That need is self-evident. History has shown that "*solutions*" imposed on Aboriginal persons without consultation have not been successful.

1460. At the Inquest, I explored the question of consultation from the perspective of gaining an understanding who ought to be consulted from within the Aboriginal communities.

1461. Community consultation would depend on the issue to be addressed and the significance of it to the relevant Aboriginal community.

1462. Having regard to the number of Aboriginal communities in the Kimberley Region, it may not be efficient or realistic to consult with every community. Nevertheless their needs and concerns ought to be recognised and this could be achieved by consultation with representative bodies throughout the Region.

1463. Counsel Assisting submits to me that the following entities are those that could be consulted:

a. Kimberley Land Council;
b. Kimberley Aboriginal Law and Cultural Centre;
c. Aboriginal Advisory Council;
d. Aarnja (a Kimberley Aboriginal membership organisation with representation across the region);
e. Indigenous Specific Social and Emotional Well Being (SEWB) Services;
f. Prescribed Aboriginal body corporates: such entities ought to be engaged as they are the traditional owners recognised under the Native Title Law;
g. Kimberley Aboriginal Young Leaders Committee: this committee comprises of nine young Aboriginal persons from across the Kimberley Region ranging in ages from 18 to 35.[930]

1464. Counsel Assisting particularly notes the importance of consulting with representatives of the age group ranging from 18 to 35 years, because their experiences and knowledge growing up as young people in the Kimberley would be invaluable.

1465. Professor Dudgeon and Professor Wilkes were asked for their opinions on which entities ought to be consulted in order for the views of Aboriginal persons to be sought and provided, when consideration is

[930] ts 565-566.

being given to initiatives that affect Aboriginal persons. I am assisted by their opinions, that include a number of the above entities, and that by way of addition include the Kimberley Aboriginal Medical Service and the Kimberley Language Resource Centre.[931]

1466. Organisations such as those referred to in this finding ought to be considered for consultation: Nyamba Buru Yawuru Ltd, Nindilingarri Cultural Health Services and Marniwaratikura Womens' Resource Centre

1467. The ALS submits to me that it ought to be part of any consultation process, as should the Aboriginal Family Law Services and the relevant Aboriginal Medical Services.

1468. The Chief Psychiatrist through his lawyer the SSO, submits to me that known evidence-based strategies should be used for addressing Aboriginal suicide, and that these already involve local engagement. He refers to the need to build long-term relationships between government agency staff and local Aboriginal community members. He sounds a note of caution about identifying appropriate representatives on an ongoing basis, and would not like to see it become a *tick-box* exercise.

1469. The WACHS recognises the importance of consultation and through its lawyers the SSO, expresses its support for this recommendation. Like Counsel Assisting, the WACHS does not endorse specific people or entities to be consulted as this would vary depending on the subject matter that the consultation relates to. I accept that qualification.

1470. The WACHS also supports the principle of co-design in creating strategies for Aboriginal health, being strategies designed through Government and Aboriginal communities working together.

Recommendation 17:

That the Government and its service providers continue to ensure that the strategies for addressing Aboriginal suicide be implemented in consultation with appropriate representatives from the Aboriginal community, that the representatives which are appropriate to consult are identified on an ongoing basis, and that such representatives be provided with an

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931 Exhibit 1.1, Tab 1B

opportunity for involvement in the co-design of such strategies.

Recommendation 18 – Visually recorded statements from domestic violence victims

1471. The evidence established that the home environments of almost all of the children and young persons whose deaths have been investigated in this Inquest were marred by incidents of domestic violence.

1472. The statistical evidence received at the Inquest establishes that domestic violence within the Aboriginal population in the Kimberley Region remains high. The impact upon children witnessing such violence by their parents or caregivers can be devastating. The evidence given at the Inquest from members of the Western Australia Police Force indicates that it is difficult to initially have victims of domestic violence report the offending and, if they do, often they become reluctant to maintain their complaint through to an eventual trial.[932]

1473. At the Inquest Ms Pitt-Lancaster, who manages the Shelter in Kununurra and whose evidence is referred to previously, was questioned about factors that would encourage affected women to report assaults upon them. She has a long and extensive history of helping women. In evidence she outlined the following suggested improvements:

a. Mandated accountability for the perpetrator, with the example of a requirement to attend a 10-week anger management course, in order to be held accountable for the conduct;

b. A type of cohabitation restraining order with the aim of keeping a woman safe whilst she and her partner continue to live in the relationship, with the example of conditions stipulating no alcohol consumption, and if he breaches that, not returning to the home until 12 hours after his last drink;

c. Acknowledging that some women are fearful of making a witness statement alleging an assault for a range of factors,

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[932] ts 1263-1285.

including the fear that their children may be removed from them;

d. Acknowledging the need for ongoing counselling, support and safe places for women while they go through the court process.[933]

1474. Counsel Assisting submits to me that one legislative provision that would increase the prospects of complaints of domestic violence being reported and then maintained would be the allowing of visually recorded statements taken from victims of domestic violence to be admitted as all or part of their evidence-in-chief during a defended hearing for such charges or associated restraining order applications. This would dispense with the need for a written statement to be taken from the complainant as such a statement would be replaced by their recorded statement.

1475. This measure has been in place in New South Wales since 1 June 2015 through the *Criminal Procedure Amendment (Domestic Violence Complainants) Act 2014 (NSW).*

1476. The purpose of this legislation was to introduce the following assistance for alleged victims of domestic violence:

a. Reducing the trauma of them having to tell their story in front of the alleged offenders;
b. Reducing the difficulty in remembering details of incidents at a later court date as the recording will be played before any additional oral evidence is given by the complainant;
c. An increased ability of the complainant to give an accurate account of what happened at the time of the incident as the recording must be made as soon as practicable after the offence has allegedly been committed;
d. Bringing the complainant's appearance and experience at the time of the alleged crime into the court room;
e. Reducing or preventing intimidation towards the complaint to change their evidence;
f. Increasing the likelihood of early pleas of guilty;
g. Saving victim's time when they are giving a statement.[934]

1477. The Court is informed that the recording can be done using either dedicated video equipment or even police officer's own smart phones. The defendant's legal representative still has the opportunity of cross-examining the complainant at any trial.

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[933] ts 1433 to 1434.
[934] www.police.nsw.gov.au/dvec-external-summary.pdf

1478. The Department of Justice through its lawyer the SSO, outlines its support for measures being introduced that are aimed at increasing the prospects of complaints of domestic violence being reported and maintained. The Department of Justice refers to other Australian jurisdictions, including but not limited to New South Wales, that have implemented or announced similar changes. They also refer to the New South Wales Bureau of Crime Statistics and Research that publicly released an evaluation on 27 October 2017 of the 2015 NSW Domestic Violence Evidence-in-Chief (DVEC) reforms, that found amongst other things: "*….no evidence to indicate that DVEC has had a significant impact on the probability of a guilty plea or the time to finalisation for matters resulting in a guilty plea.*"[935]

1479. Whilst these reforms will no doubt continue to be evaluated, it is the alleviation of the stress upon the alleged victim that warrants my consideration. There may be a range of other factors that affected the New South Wales conviction rate. I accept that the alleged victim may still need to attend court for cross examination, but as with all vulnerable witnesses, removing the need to re-tell events in court as part of evidence-in-chief is an improvement.

1480. The Department of Justice confirms that it would be responsible for instructing on the amendments to legislation should these reforms be implemented. They refer me to the current State Government's election commitment to giving family violence victims automatic access to "*special witness status*" and making it easier and less traumatic for victims to obtain violence restraining orders by allowing victims to give their evidence by pre-recorded video evidence in confirmation hearings. They refer to a project, commencing in the near future, to assess the legislative and resourcing implications of this commitment and express their support for a recommendation that measures be introduced aimed at increasing the prospects of complaints of domestic violence being reported and maintained.

Recommendation 18:

That measures be introduced aimed at increasing the prospects of complaints of domestic violence being reported and maintained; and

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[935] ts 1267

As part of such measures, that the State Government consider introducing legislation allowing for visually recorded statements taken from victims of domestic violence to be admitted as evidence-in-chief at a court hearing

Recommendation 19 – Training for service providers on effects of trauma and FASD

1481. At the Inquest, a range of service providers readily acknowledged the importance of culturally relevant training for staff who deal, on a regular basis, with Aboriginal persons. Such training is important for those service providers involved in the areas of education, health, mental health, child protection and police who have regular contact with Aboriginal persons.

1482. The evidence at the Inquest established the importance of involving Aboriginal persons in the design and delivery of this training.

1483. Counsel Assisting submits to me that any training, if not already doing so, ought to include (i) the effect of trauma, particularly intergenerational trauma and (ii) FASD.

1484. The effects of FASD and its prevalence in the Aboriginal community is still a relatively recent phenomenon. Its devastating impact on the executive functioning of sufferers is an important matter for service providers to consider when dealing with those afflicted with FASD. Though its symptoms may be sufficiently known to those working in the health sectors, it is vitally important that other service providers as outlined above receive appropriate training in regards to FASD and its symptoms, particularly cognitive impairment.

1485. The WACHS through its lawyer the SSO acknowledges the critical importance of Aboriginal cultural competence training, including issues such as trauma and FASD, and submit to me that they already make the relevant training available to staff.

1486. The WACHS refer to the mandatory Aboriginal Cultural eLearning online training across the West Australian heath system aimed at supporting staff in the development and provision of culturally secure health services, and its alignment with the WA Aboriginal Health and

Wellbeing Framework 2015 – 2030. It has a high level of Kimberly staff compliance.[936]

1487. The WACHS' monthly regional training available to all new staff includes *"Kimberley Cultural Awareness"*, a one hour cultural introduction delivered by the Regional Aboriginal Health Consultant. Staff are also encouraged to attend cultural awareness programs provided by local Aboriginal organisations and providers. The newly appointed Regional Aboriginal Health Consultant is engaging with these providers to progress participation of WACHS Kimberley staff.[937]

1488. The WACHS draws my attention to the Statewide Specialist Aboriginal Mental Health Service (SSAMHS) where Aboriginal mental health workers are part of a mainstream multidisciplinary mental health team, assisting with providing a culturally secure mental health service. The SSAMHS reports to the Mental Health Commission on the number of cross cultural training sessions, on a six monthly basis.[938]

1489. The WACHS though its lawyer the SSO submits that the Aboriginal Mental Health Model of Care fits with the ATSISPEP general recommendations and implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

1490. They submit that the Kimberley Mental Health and Drug Service (KMHDS)has taken significant steps to implement the recommendations from the 2016 ATSISPEP report including that:

a. 22% of KMHDS staff are of Aboriginal or Torres Strait Islander descent;
b. Approximately 67% of staff have completed cultural competency training; and
c. Staff are supported to attend *"trauma informed care"* workshops which are held regularly in West Kimberley.

1491. The Chief Psychiatrist through his lawyer the SSO, notes that culturally relevant training is already occurring but agrees with, and supports, a greater emphasis on FASD and "*Trauma Specific Care.*"

1492. The Department of Justice through its lawyer the SSO, outlines the steps it has taken towards ensuring that its employees who have contact with Aboriginal persons have cultural awareness training

[936] Exhibit 1.6, Tab 57.
[937] Ibid.
[938] Ibid.

including in relation to dealing with Aboriginal persons who may be affected by trauma and/or FASD, as follows:

a. A Working with Diversity program which is provided to all Youth Custodial Officers during Entry Level Training Programs. It is also available to other staff in the Department of Justice on a voluntary basis;

b. A Youth Justice Officers Professional Development Program includes a two-hour Mental Health information session and a two hour presentation regarding FASD.

c. A presentation entitled "*Foetal Alcohol Spectrum Disorder - an introduction to working with FASD clients in Youth Justice*" has been developed by Department of Justice's Youth Justice Psychological Services and presented to approximately 50 departmental staff in the metropolitan area.[939]

1493. The Department of Education through its lawyer the SSO, expresses its support for its school education staff receiving ongoing culturally relevant training, and training on the effect of trauma and FASD on students, and points to the extensive evidence of the impact of FASD in the area of education.[940]

1494. The Department of Education draws attention to the following evidence that reflects upon its efforts to understand the impact of FASD on the learning capabilities of a number of children attending Kimberley schools:

a. School psychologists supported by specialist teachers look at FASD and a number of other disabilities which have a spectrum of behaviours from a perspective of behavioural analysis and address those behaviours and coach and support teachers to develop particular strategies to respond to those behaviours;[941]

b. Mr Mark Adkins, former Lead School Psychologist for the Kimberley Education region explained that schools are able to make contextual adjustments and adopt practices to maximise engagement opportunities;[942]

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[939] Exhibit 1.6, Tab 55; Exhibit 1.6, Tab 55.17; Exhibit 1.9, Tabs 63C and 63D;

[940] Exhibit 1.5, Tab 50; Exhibit 1.3, Tab 19; Exhibit 1.4, Tab 48; Exhibit 1.5, Tab 50C; ts 1610-11; ts 670.

[941] ts 670; ts 1610.

[942] Ex 1.4, Tab 44.

c. The "*Students at Educational Risk*" policy requires schools to develop individual education plans for students whose academic, social and/or emotional attributes are a barrier to engagement with the content and standards defined in the WA Curriculum;[943]

d. Cultural proficiency in service delivery has been worked on by the School Psychology Service and Aboriginal Education Teams in the Kimberley; it is ongoing work for all staff, and Aboriginal Islander Education Officers, Education Assistants and Attendance Officers also provide ongoing training and support to education staff during induction, in classrooms and during home visits, for them to understand local community contexts.[944]

1495. The Department of Education outlines the present funding that may be applied to support students with disabilities and/or additional learning needs:

a. An education adjustment allocation is provided to schools for students in the bottom 10% of the NAPLAN assessment, in order to flexibly implement programs and learning support for these students;[945]

b. An individual disability allocation may be provided for students who are assessed as eligible based on eight categories of disability (including for example global development delay);[946]

c. Assistance for students with complex needs may be provided through the "*Schools of Special Educational Needs*" which provides support through teams of teachers; an example is the Behaviour and Engagement program, which provides educational support and services for students with extreme, complex and challenging behaviours - they can typically be children who have experienced a lot of trauma.[947]

1496. The Commissioner of Police through his lawyer the SSO, informs me that recently the University of Notre Dame was contracted to undertake an independent review of the Western Australia Police

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[943] Exhibit 1.5, Tab 50.

[944] ts 673 and 686; Exhibit 1.4, Tab 40.

[945] ts 1409; Exhibit 1.5, Tab 50.

[946] Exhibit 1.5, Tab 50.

[947] Exhibit 1.5, Tab 50; Exhibit 1.3, Tab 17; ts 511

Force training curriculum and policies pertaining to police engagement with Aboriginal people. The aim is to guide the transition of current training beyond mere cultural awareness towards a more comprehensive program of Aboriginal cultural training, both at the entry level and through a staff member's career.

1497. The Commissioner of Police informs me that the Western Australia Police Force is also supportive of further awareness in the area of FASD and trauma for police officers interacting with Aboriginal people. He informs me that the Western Australia Police Force is keen to work with experts in this field to identify components of this increased awareness that will be included in inductions, policy, process and procedures.

1498. The Commissioner of Police refers to the evidence of Superintendent Allan Adams, in charge of the Kimberley District Office, who drew attention to the importance of focussing on the vulnerability of the particular individual when engaging with that person in an investigative process. That may be a vulnerability relating to FASD, language and/or education.[948]

Recommendation 19:

That cultural competency training given to service providers who interact with Aboriginal persons is co-designed with Aboriginal persons and delivered in a culturally relevant manner with emphasis on the effect of intergenerational trauma and FASD, and on the importance of cultural wellbeing, and that all service providers be required to be trained and that it be funded.

Further, wherever possible, that cultural competency training be delivered by involving local Aboriginal people.

[948] Ts 1885.

Recommendation 20 – Training in suicide intervention and prevention

1499. The deaths of the 13 children and young persons the subject of this Inquest were all preventable.

1500. Given the prevalence of self-harm by Aboriginal children and young persons, it is important that service providers in the specific areas of child protection and education be aware, as far as possible, of any signs that a child or young person might be contemplating suicide. It is therefore important that child protection workers and teachers receive training in the area of first aid mental health, applied suicide intervention skills and gatekeeper suicide prevention.

1501. The Department of Justice through its lawyer the SSO, informs me that it is supportive of a recommendation for training in suicide intervention and prevention for its youth justice officers, Juvenile Justice Team Coordinators, Bail Coordinators, psychologists, teachers, Aboriginal Welfare Officers and custodial officers.

1502. The Department of Justice also refers to its Youth Custodial Officer Entry Level Training Program that includes two days training in Youth Mental Health First Aid (which is delivered by accredited trainers from Mental Health First Aid Australia) and its two day Gatekeeper Suicide Prevention Course (for the purpose of assisting participants to develop a range of skills and knowledge to improve their ability and confidence to work with people at risk of suicide, including being able to understand and identify self- harm). They inform me that this program also includes sessions on the Youth At Risk Management System, which records risk management strategies and plans for young people in custody at risk of self-harm or suicide.[949]

1503. The Department of Communities through its lawyer the SSO, expresses its support for this recommendation and informs me that it is already implementing it, referring to the following:

a. Its two day Gatekeeper Suicide Prevention Course delivered by the Mental Health Commission, for the purpose of assisting participants to develop an understanding of suicide and self-harming behaviour and to provide an

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[949] Exhibit 1.9, Tabs 68E, 68F and 68G.

understanding of the link between mental disorders and suicidal behaviours); and

b. Its two day intensive Suicide Prevention Workshop run by Indigenous Psychological Services (IPS) for the purpose of developing a greater understanding of:

   i. Why an Aboriginal specific Suicide Prevention program is necessary;
   ii. Cultural learning styles and their impact on engagement, counselling and intervention strategies;
   iii. Research findings, statistics and myths; and
   iv. Suicide Risk Assessment, prevention, postvention and unique factors impacting Aboriginal individuals.[950]

1504. The Department of Education through its lawyer the SSO, acknowledges that schools play a role in recognising warning signs (near term indicators that a suicidal attempt or student self-harm may be imminent). They point to the following initiatives:

a. They are currently conducting training in Kimberley schools, to assist school staff, school leaders, teachers and student support staff to understand the elements of self-harm and suicide intervention and prevention;

b. They have developed guidelines, namely the "*School response and planning Guidelines for students with Suicidal Behaviour and Non-suicidal Self Injury*" with the aim of supporting schools in recognising and responding to student disclosures by undertaking a risk assessment;[951]

c. Risk assessments are conducted by the school psychologist with the consent of the student and the parents or carers, with a particular focus on "*safety planning*" for students referred by teachers and other education staff; following that, the schools create a Risk Management Plan for the students, in consultation with key people who have a role in the child's safety; [952]

d. They have, through the School Psychology Service, coordinated the delivery of Gatekeeper Suicide Prevention training, a required training program for all school

[950] Exhibit 7, Tab 58.
[951] Exhibit 1.5, Tab 50.
[952] ts 687 and 690-691; Exhibit 1.4, Tab 44.

psychologists, that can also be undertaken by student service coordinators and deputies;[953]

e. They provide a Gatekeeper State-wide Coordinator for this program to all government, Catholic and Independent schools under the Mental Health Commission funded Schools Suicide Response and Prevention Project.[954]

1505. With respect to the Kimberley Region specifically, the Department of Education points to the following efforts to assist with support for students at risk of self-harm, and with suicide intervention and prevention:

a. They support flexibility within the government schools to manage their professional learning to meet the needs of their school community, such as conducting Gatekeeper Suicide Prevention training for staff, as well as mental health first aid training, and providing wrap around services to children who are identified as having suicidal ideations;[955]

b. The School Psychology Service supports programs to strengthen protective factors for students, such as health and wellbeing, social and emotional competencies and emotional regulation, connection to, and strengthening connections with, culture;[956]

c. Since 2008 they have increased the number of school psychologists in the Kimberley and have moved to deploy school psychologists closer to schools;

d. Since 2010, school psychologists have been based in Derby, Fitzroy Crossing and Halls Creek to lessen the amount of travel time and make the resources more immediately available to teachers and students in schools. [957]

1506. It is to be borne in mind that the School Psychology Service is not a primary clinical health service, and does not deliver acute clinical mental health care. Its role is to support schools in understanding and managing students presenting with behavioural difficulties, complex needs and or school readiness issues. School psychologists

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[953] Exhibit 1.5, Tab 50; ts 679 – 687.

[954] Exhibit 1.5, Tab 50.

[955] ts 525 – 534; ts 650.

[956] ts 670; Exhibit 1.5, Tab 50.

[957] ts 671 – 694.

will refer to clinical health services where appropriate for students with mental health problems and psychological distress.[958]

Recommendation 20:

That Department of Communities' child protection workers and school teaching staff (in the public and private sectors) who have regular contact with Aboriginal children receive appropriate training in suicide intervention and prevention, and that such training be provided at appropriately regular intervals.

Recommendation 21 – Employment of Aboriginal persons

1507. The evidence before the Inquest frequently pointed to the importance of service providers in the Kimberley Region having some staff who are of an Aboriginal background Though there are Aboriginal persons fulfilling assistant roles in education, health and police, there is a relative absence of Aboriginal persons in more senior roles.

1508. Whilst assistant positions are very important it is also highly desirable that Aboriginal persons be employed in more senior positions and in greater numbers within service providers who regularly have contact with the Aboriginal community in the Kimberley Region. At the times of the deaths there was no Aboriginal psychiatrist working in the Kimberley Region.[959]

1509. In order to generate more employment opportunities for Aboriginal persons in the area of education, health (including mental health), child protection and police, it may be necessary to introduce bridging courses to assist prospective employees.

1510. The Department of Health through its lawyer the SSO, informs me that it is working towards the Public Sector Commission's 3.2% Aboriginal employment target for the WA Health system and

[958] Exhibit 1.5, Tab 50.

[959] ts 1627.

accordingly has set an annual goal to increase the total number of Aboriginal employees by 100 each year.

1511. The Department of Health draws my attention to a pilot program approved by its Director General for the application by Health Service Providers (including WACHS) of section 51 of the *Equal Opportunity Act* 1984 (WA) to their advertising and recruitment strategies to create flexibility and support for Aboriginal people to gain employment.

1512. The Chief Psychiatrist noted the numerous training events run through the Department of Health's Institute for Health Leadership which have included Aboriginal participants from both country and metropolitan areas. Dr Chapman also explained that in the SSAMHS one of the key performance indicators was to assist recruited Aboriginal staff into training and to help support them in training in order to obtain qualifications and experience to create career pathways.[960]

1513. The WACHS recognises the benefits of increasing the number of Aboriginal employees across all areas and levels, both to Aboriginal clients of a health service, and as providing an opportunity to build the cultural capacity of non-Aboriginal employees. They point to their Aboriginal Employment Strategy and their recruitment of Regional Aboriginal Health Consultants to form part of Regional Executive Teams. This role was filled in the Kimberley Region in February 2017, with the aim of developing partnerships and community capacity building, and on creating a workplace culture and environment that attracts and retains Aboriginal people.[961]

1514. The WACHS points to its Aboriginal Entry Level Employment Program supporting traineeships, cadetships and apprenticeships, and its Aboriginal Mentorship Program *"Your Footsteps; Our Future"* with a substantial number of staff having completed the training to become a mentor.

1515. The Court is informed that as at 1 July 2017 WACHS exceeded the State Government's Aboriginal employment target of 3.2%, employing a total of 410 Aboriginal employees which equates to 4.3% of the total WACHS workforce. As at I July 2017, WACHS Kimberley employed 146 Aboriginal people which equates to 12.6% of the WACHS Kimberley workforce. Within the KMHDS the proportion of Aboriginal staff is greater than 20% which is the highest proportion of Aboriginal staff in any Western Australian health entity.[962]

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[960] Exhibit 1.5, Tab 51A; ts 1137.
[961] Exhibit 1.6, Tab 57; Exhibit 1.3, Tab 22.
[962] ts 1735; Exhibit 1.6, Tab 57.

1516. The Chief Psychiatrist refers to the growth in numbers of specialist Aboriginal Mental Health Workers across the WACHS, and specifically notes that 26 staff out of 120 in the KMHDS are Aboriginal. He refers to flexible work arrangements and gender considerations in place to improve recruitment and retention of Aboriginal staff. Through his lawyer the SSO, he submits that Kimberley is already leading Western Australia with the employment of Aboriginal persons.[963]

1517. The Department of Education through its lawyer the SSO, submits to me that it is implementing this recommendation as far as is possible, given the accessibility of tertiary teaching qualifications, and recognition of prior learning, and points to the following evidence:

a. Aboriginal persons are employed in various capacities in all schools in the Kimberley Region, including as Principals, teachers, education assistants, and Aboriginal Islander Education Officers (who are typically recruited from local communities as cultural liaison experts to provide input and leadership);[964]

b. In most of the remote community schools there is an Aboriginal Islander Education Officer allocated to each classroom, sometimes more, and the government has indicated that they will be allocating additional Aboriginal Islander Education Officers to schools (Mr Dedman, former Principal of Halls Creek District High School reported that when he was there, they had 14 Aboriginal Islander Education Officers, all local Aboriginal persons, for a school of 400 students);[965]

c. At a regional level they have an Aboriginal Education Team, made up of all Aboriginal staff, including the Manager of Aboriginal Education and three Aboriginal coordinators, including one based in Kununurra for the East Kimberley. The team has responsibility for supporting Aboriginal Islander Education Officers in schools at both a professional and emotional level;[966]

d. Aboriginal Islander Education Officers are able to train whilst in the classroom to obtain their Certificate III in Education Support;[967]

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[963] Exhibit. 1.5, Tab 51A.
[964] ts 693; ts 441; 1817/17.
[965] ts 673; Exhibit 1.4, Tab 40.
[966] ts 1407.
[967] ts 512; Exhibit 1.3, Tab 19.

e. The Aboriginal Education Team and the School Psychology Service have collaborated to support Aboriginal employment in the Department of Education through the Community Leadership Program, that is focused on developing and maintaining the leadership of Aboriginal staff in schools.[968]

1518. The Department of Education refers to the following challenges regarding the recruitment of Aboriginal teachers:

a. Whilst they encourage Aboriginal Islander Education Officers to become teachers, unfortunately it can be challenging for Aboriginal Islander Education Officers to leave their communities to undertake University studies elsewhere;

b. The availability of options for achieving tertiary qualifications in the Kimberley Region is limited by distance and the number of tertiary institutions offering distance education in teaching or recognition of prior learning articulating into teaching qualifications required for teacher registration. [969]

1519. The Commissioner of Police through his lawyer the SSO draws my attention to the evidence of Superintendent Allan Adams who informed the Court, at the Inquest, that the Kimberley Police District employed 11 individuals who identified as Indigenous (four sworn police officers, four Community Relations Officers, two Aboriginal Police Liaison Officers and one cleaner). As at March 2017, the Western Australia Police Force employed 95 male and female Aboriginal police officers in this State.[970]

1520. The Commissioner of Police outlines the steps being taken in support of an increase in the numbers of Aboriginal police officers:

a. In 2016, an Aboriginal Cadet Program commenced, with the aim of enabling Aboriginal applicants to become more competitive in the Western Australia Police Force recruitment process, and it includes mentorship and a West Coast TAFE course to increase literacy and preparation for the recruitment process;

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[968] Ibid.

[969] ts 693.

[970] Exhibit 1.8, Tab 59.

b. If this recently commenced program is successful, they would look at expanding the program to regional placements;

c. They have taken a number of measures to increase the diversity of Police Officers, in particular by modifying the recruitment and selection process to be more inclusive of applicants from Aboriginal and Culturally and Linguistically Diverse backgrounds.[971]

1521. The Commissioner of Police also draws attention to the challenges for the Western Australia Police Force in increasing the numbers of Aboriginal Police Officers; some of them are as follows:

a. Past efforts to provide a pathway for Aboriginal Police Liaison Officers to become sworn officers have not met with much success, and some Aboriginal Police Liaison Officers have outlined a level of: "*uncomfortableness around some of the expectations of a police officer*" in discussions with Superintendent Allan Adams.[972]

b. There can be challenges for Aboriginal persons taking a policing role in their own community;

c. If the Aboriginal Cadet Program is expanded to the vast Kimberley Region, there are a number of issues to be resolved, including management of the scheme in remote locations and the availability of educational components of the program.

1522. The Commissioner of Police also notes the evidence regarding the highly valued role of the Community Relations Officers who have an important role to play in policing the Kimberley Region by enhancing police relations with Aboriginal communities. [973]

Recommendation 21:

That efforts continue to be made to employ Aboriginal persons in health (including mental health), education, child protection and police and, where necessary or desirable, that consideration be given to introducing bridging courses and cadet programs and/or locally accessible training courses to

[971] Ibid.
[972] ts 1866.
[973] Exhibit 1.8,Tab 59; ts 1246.

assist prospective employees to obtain the necessary qualifications.

Recommendation 22 – Cashless debit card

1523. I heard evidence concerning the Cashless Debit Card, an area that is not without controversy, because of the number of deceased children and young persons the subject of this Inquest who had been diagnosed with failure to thrive in their infancy, and a range of other illnesses exacerbated by poor living conditions, and also because of the number of children and young persons whose home environments were marred by unabated alcohol abuse and domestic violence.

1524. KCLS submit to me that the Cashless Debit Card is a form of compulsory income management and refer to its introduction in trial sites in Kununurra and Wyndham in April 2016. Participants are issued with a debit card which cannot be used to buy alcohol or gambling products (with the exception of lottery tickets). Eighty percent of a trial participants income support payment is placed on a restricted account linked to the card. The result is that only 20% of that income support payment may be withdrawn in cash.

1525. The cashless debit card has been trialled in respect of all working-age people living in the trial sites who obtain income support payments. It includes persons living on disability, parenting, carers, unemployed and youth allowance payments. People on the aged pension, a veteran's payment or who earn a wage are excluded from the trial, but can volunteer to take part in the trial. The Inquest heard that some Aboriginal people refer to it as the "*White Card.*"[974]

1526. Failure to thrive is a term often used to describe inadequate weight gain in infants and children. It has largely been replaced by the term *"poor growth"*. This diagnosis generally describes a child whose current weight, or rate of weight gain is significantly below that expected of similar children of the same age and sex. Nutrition is the main driver for a child's growth but medical, and psychosocial problems can also play a part. In some cases, inadequate nutrition can be associated with caregiver neglect or child abuse.[975]

1527. Failure to thrive can have both short and long term effects on the developing child. It can interrupt the immune response, increasing

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[974] Exhibit 1.4, Tab 32.

[975] The Royal Children's Hospital, Melbourne, Australia, Clinical Practice Guideline on Poor Growth, [Internet; 04/01/2019], https://www.rch.org.au/clinical guide

the risk of severe infection and infant mortality. Prolonged failure to thrive may cause ongoing growth deficits, delay in cognitive and psychomotor development, diminished physical activity and development, behavioural problems and learning disabilities.[976]

1528. The Inquest heard evidence from Aboriginal witnesses who support the cashless debit card and those who did not support it.

1529. Whilst it is not seen as a panacea, some of the evidence given in support of the Cashless Debit Card is as follows:

> *"I supported it because I think the things that we were doing to try and … bring about social and economic change in the East Kimberley hasn't really worked. When you look at the Closing the Gap sort of figures each year from the … Federal Government, very few of those gaps have been closing, so it had to do something sort of different to what we have done in the past…"*[977]

> and

> *"… I have been in Aboriginal Affairs for over 40 years. I haven't seen anything that has really sort of started to bring about some level of change. … but I think that the cashless debit card still offers the best chance we have of actually trying to bring about sort of societal change in the East Kimberley."*[978]

> and

> *"I think that the reason why the Government should consider this in using it as the new way of delivering social service benefits is because the system that we've had in place for the last 50 years has guaranteed failure. The reason why we are sitting here today is because of that system. For us to go back to a system that is guaranteed failure would be absolute ludicracy so that's why I don't support sort of going back and, you know, let's build on what we've got here now and actually improve it."*[979]

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[976] Black RE, Allen LH, Bhutta ZA, Caulfield LE, De Onis M, Ezzati M, et al. Maternal and Child undernutrition: global and regional exposures and health consequences. Lancet. 2008;371(9608):243-60
Brewster D, Nelson C, Couzos S. Failure to thrive [Aboriginal children]. In: Couzos S, Murray R, editors. Aboriginal Primary Health Care: An Evidence-based Approach. 3rd Ed. South Melbourne, Vic: Oxford University Press; 2008 p. 265-97
[977] ts 1359 and 1360.
[978] ts 1360.
[979] ts 1362.

1530. Dr Elise Klein, whose evidence is referred to previously, is a lecturer in Development Studies at the University of Melbourne. Dr Klein has led a research project into the Cashless Debit Card, based upon 13 months of field based research in the Kimberley Region, leading her to express her concern about it having a disempowering effect:

> *"I think that the research that we've done finds that the card has been, overall, quite disempowering for people. So it is made – well, first of all, it is targeted – everybody on welfare except if you're getting an age pension or Veterans' Affairs. So that's a lot of people. And so the compulsory nature of the card has been perplexing but also quite disempowering for people. Because the discourse underpinning the card is very much one of if you're on the card or the card is introduced for people with behavioural problems or with alcohol problems. And so that's a very, sort of, broad-brush kind of statement for people – for very vulnerable people who are finding – or are on – receiving benefits from the State because they are vulnerable."*[980]

1531. The Department of Communities through its lawyer the SSO, whilst acknowledging that it is a Commonwealth program, expresses its support for the extension of the cashless debit card program in locations that request it.

1532. The ALS draws attention to Ms Klein's evidence and submits to me that a compulsory, as opposed to voluntary regime of income management in the East Kimberley represents a significant disempowerment of Aboriginal people. The KCLS also express their reservations regarding compulsory income management and submit that it ought not be imposed without the consent of the individual.

1533. An evaluation of the Cashless Debit Card trial is outside the scope of the Inquest as is any recommendation that suggests a compulsion. The following recommendation is made, to be considered in parallel with, and not in substitution of, any relevant trial or program already in place, or planned.

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[980] ts 1004.

Recommendation 22

That consideration be given to extending an offer of a voluntary cashless debit card program to include the entire Kimberley Region.

Recommendation 23 – Video-conferencing for mental health assessments

1534. For the majority of the 13 deaths the Inquest investigated, the children and young persons had not been given a mental health assessment. It is therefore not known whether these children and young persons had mental health conditions that may have responded to treatment using either conventional medical treatment or traditional cultural healing methods, or a combination of both.

1535. The Chief Psychiatrist for Western Australia, gave evidence at the Inquest that:

> *"For those individuals who are in the system, and who are known or who are referred to the mental health services, being able to assess them in a timely way in a way that meets their access needs is really an important principle."*[981]

1536. An improvement has been made in the access to treatment for children and young persons living in the Kimberley Region with the appointment of Dr Paul Simons to the position of Child and Adolescent Mental Health Psychiatrist. That appointment took place in January 2017 and as Dr Gibson noted: *"That was long overdue."*[982]

1537. Nevertheless, given the size of the Kimberley Region and the pressing need for psychiatric services to be available to Aboriginal children and young persons in the region, it is likely to be a significant workload for just one person.

1538. The difficulty in arranging an urgent mental health assessment was highlighted by the circumstances of the child referred to in Case 5. One potential solution for facilitating a more immediate mental health

[981] ts 1624.
[982] ts 1624.

assessment would be for a video conferencing session between the patient and the mental health clinician.

1539. The Chief Psychiatrist noted that the *Mental Health Act 2014* (WA) provides for the use of video-conferencing to make assessments under that legislation.[983]

1540. The Chief Psychiatrist gave in principle support to a service that would provide 24 hour access to a consultant psychiatrist via video-conferencing to remote regions. Though the infrastructure is available in the Kimberley, the Chief Psychiatrist's evidence was that these sessions are available only during normal office hours, and it is the provision of an after-hours service of this facility that requires expansion.[984]

1541. Counsel Assisting submits that video-conferencing with a consultant psychiatrist on a 24 hour basis for the Kimberley Region should be implemented as a matter of priority. Furthermore, video-conferencing should also be utilised when a mental health clinician in the Kimberley Region is unable to personally see or visit any individual who urgently requires an assessment.

1542. The Department of Health and the WACHS through their lawyer the SSO, support the use of video-conferencing for mental health assessments. They inform me that assessment by video-conference is already being provided across the Kimberley Region by the on-call Kimberley psychiatrist, including after hours. They endorse the Chief Psychiatrist's views concerning the potential challenges for a remote family to engage, and the potential successes, such as subspecialist input from Perth for a child in a remote Kimberley area.[985]

1543. The Department of Health and the WACHS inform me that they are committed to improving *"telehealth"* systems and point to their WA Telehealth Strategy and Implementation Framework 2017 – 2022 which is being finalised, with the aim of fully embedding telehealth as an enabler of safe, quality, accessible and sustainable healthcare services for all Western Australians.[986]

1544. The Chief Psychiatrist through his lawyer the SSO, reiterates his strong support for this recommendation, though noting that the

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[983] ts 1622.
[984] ts 1623.
[985] Exhibit 1.6, Tab 57; ts 624.
[986] Exhibit 1.6, Tab 57.

majority of persons who suicide across the state, country and world are not linked with mental health services.

1545. The Department of Justice through its lawyer the SSO, informs me that it would see this recommendation as being also beneficial in terms of providing health services to prisoners, having regard to the Director General's responsibility under section 95A(1) of the *Prisons Act* 1981.

1546. The ALS, whilst supportive of the recommendation submits that there be consultations with local Aboriginal communities regarding the teleconferencing and refers to the importance of face to face consultations.

1547. Self-evidently, a face-to-face consultation is always preferable, because of the better quality of engagement for the patient, who is able to experience the contact without the separation of a video screen. However, realistically this is not always achievable especially in the more remote areas, and around the clock. The use of video-conferencing in such circumstances supports the provision of healthcare services where there are practical impediments to a face-to-face consultation, such as timing, or distance.

Recommendation 23:

That the use of video-conferencing for mental health assessments be expanded throughout the Kimberley Region, including an after-hours service.

Recommendation 24 – Traditional cultural healing and mental health

1548. At the Inquest there was extensive evidence given about the benefits of traditional cultural healing methods for Aboriginal people. I have addressed this issue throughout this finding, and in particular under the heading *"Cultural continuity and cultural healing".*

1549. The Chief Psychiatrist gave evidence as to the mental health issues that are particular to Aboriginal people. He stated:

> *"… whilst Indigenous people get a range of mental illnesses that are very similar to other cultural groups, they have particular vulnerabilities which mean that often managing*

those is complex and challenging, and preventing those is equally complex and challenging."[987]

1550. One of the eight *"Standards for Clinical Care"* adopted by the Chief Psychiatrist is titled *"Aboriginal Practice"*. This practice is designed to ensure that mainstream service providers engage in culturally appropriate care. One of the purposes is to improve mental health outcomes for Aboriginal people with mental illness by defining standards for: "*Delivering mental health services that take into account the cultural and social diversity of Aboriginal people with mental illness and meeting their needs and those of their carers and community throughout all phases of care.*" It is expected that mental health services and providers will work collaboratively and in partnership with Aboriginal people with mental illnesses and their carers.[988]

1551. At the Inquest the Chief Psychiatrist acknowledged that there can be a collaborating and working together of western styled treatment and culturally appropriate traditional treatment. In that regard the Inquest heard evidence during its visit to the Nyamba Buru Yawuru Centre in Broome about the Yawuru concept of Liyan which relates to the interconnectedness for Aboriginal people between the self, the wider community and the land.

1552. The Liyan has been variously described as the spirit, the sixth sense, intuition, or heart feeling and has been referred to throughout this finding.

1553. The Nyamba Buru Yawuru Centre was at the time in the process of obtaining funding for a cultural healing centre to be built at its premises. Mr Peter Yu, the Chief Executive Officer of Nyamba Buru Yawuru Centre was also of the view that cultural healing can work in conjunction with more conventional western styled treatments.[989]

1554. Counsel Assisting submits to me that there is considerable merit in encouraging a two-pronged treatment program for Aboriginal persons (particularly children and young persons) who have suicidal ideation. The two systems can work together and treatment programs can include the patient reconnecting with their culture and their land as espoused by the concept of Mabu Liyan.

1555. The Department and Health and the WACHS through their lawyer the SSO, recognise that there can be collaboration in the sphere of mental health between Western style scientific treatment and culturally

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[987] ts 1628.
[988] Exhibit 1.5, Volume 5, Tab 51A.
[989] ts 1630; Exhibit 15A.

appropriate traditional Aboriginal treatment and point to section 189 of the *Mental Health Act 2014* (WA):

> *"Provision of treatment to patients of Aboriginal or Torres Strait Islander descent*
>
> *To the extent that it is practicable and appropriate to do so, treatment provided to a patient who is of Aboriginal or Torres Strait Islander descent must be provided in collaboration with ——*
>
> *(a) Aboriginal or Torres Strait Islander mental health workers; and*
> *(b) significant members of the patient's community, including elders and traditional healers."*

1556. The WACHS draws attention to Dr Simons' evidence to the effect that traditional cultural practices may not have a positive impact upon every Aboriginal person, and that self-evidently, Aboriginal persons are individuals and their level of engagement with culture varies widely. The Department of Health holds the position that it should not be compulsory. The Chief Psychiatrist has a similar view.[990]

1557. The WACHS submits, and the Deparment of Health and Chief Psychiatrist agree, that it is not the appropriate body to provide traditional Aboriginal treatment, nor is it in a position to provide oversight and maintenance of standards of care in that domain. Nor can the Chief Psychiatrist perform an oversight role for traditional Aboriginal treatments. WACHS point to Dr Cleland's evidence:

> *"I don't think it's practical or appropriate for a government organisation to be providing cultural healing services, but ...referring on to those services where they are available ...is appropriate."* [991]

1558. Mental Health Services (as defined in section 4 of the *Mental Health Act* 2014 (WA)) including those within the WACHS, have collaborative relationships with many outside services, both medical and non-medical. The WACHS informs me that this can include traditional Aboriginal healers chosen by Aboriginal patients, and that they endeavour to work collaboratively and respectfully with those traditional healers. The Chief Psychiatrist submits that it is important

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[990] Exhibit 1.4, Tab 40.
[991] ts 623.

that treatment decisions be made by individual clinicians and patients with regard to the individual circumstances.[992]

Recommendation 24:

That mental health treatment plans for Aboriginal persons offer the option of the inclusion of traditional cultural healing, and where that option is accepted, that all efforts be made to work collaboratively for the benefit of the patient.

Recommendation 25 – Development of cultural healing projects

1559. Counsel Assisting submits to me that cultural healing projects as proposed by the Nyamba Buru Yawuru Centre with the intended construction of its cultural healing centre are to be encouraged and, where necessary, funded by Government. The evidence points to these measures as being an integral part of reducing Aboriginal deaths by suicide.

1560. My attention is drawn to the conclusion made by the authors in "*Rising Indigenous suicide rates in Kimberley and implications for suicide prevention*":

> *"In spite of significant increases in resourcing of the health sector in the Kimberley region and various suicide prevention programs, deaths by suicide continue to increase. The risk factors for Indigenous suicide in our study are very broad and suggest that efforts must be made at improving the social and wellbeing of the community at large rather than focus on traditional methods of delivering psychiatric services to distressed individuals on a one-on-one basis. This needs to be done in partnership with the community through a shared process of discovering what works rather than implementing Western-based notions of mental health treatment models. Education and awareness of suicide being 'everyone's business', rather than that of mental health services, needs to continue. There is also a need to better understand cultural*

[992] Exhibit 1.6, Tab 57 Appendix 2; ts 1702-1703, 1737; ts 903; www.nmahsmh.health.wa.gov.au/services/statewide_simhs.cfm.

aspects of Indigenous suicide and augment community-led ways of improving this blight, which is ever on the increase. This constitutes an enormous challenge for all service providers." [993]

1561. The Department of Health and the WACHS through their lawyer the SSO inform me that they are supportive of cultural healing projects in circumstances where they are community led. They are unable to comment on whether funding the Nyamba Buru Yawuru Centre is the most appropriate use of government resources. The Chief Psychiatrist holds similar views and submits that funding decisions like this are best dealt with by the Mental Health Commission.

1562. The Department of Health and the WACHS query the meaning of "*Western-based notions of mental health treatment models.*" Further, the Chief Psychiatrist through his lawyer the SSO, expresses his concern and submits that the scientific approach to "*discovering what works*" and "*treatment*" is to be endorsed.

1563. For the purpose of this finding *"Western-based"* mental health treatment models may be taken to mean the mental health treatment model that is offered by the Department of Health. This can be contrasted with the notion of cultural healing that can operate to improve mental wellbeing, and support and complement Western-based mental health treatment.

1564. In the *"Learnings from the message stick"* report, the Education and Health Standing Committee referred to the work of the Canadian researcher Michael Chandler, who proposes that individualistic approaches to suicide prevention are mistaken, and that Indigenous suicide is instead required to be *"communally treated with 'cultural medicines' prescribed and acted upon by whole cultural communities."* This communal approach is necessary as damage inflicted on Indigenous groups of *"peoples is collective, rather than personal, and multiplicative, rather than simply additive."*[994]

1565. The availability of cultural healing programs in the Kimberley Region is critical to the emotional and cultural wellbeing of Aboriginal communities in the Kimberley Region, that in turn supports Aboriginal mental health.

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[993] Campbell A, Chapman M, McHugh C, Sng A, Balaratnasingam: *Australasian Psychiatry* 2016 Volume 24(6) 561-564.

[994] Exhibit 1.1, Tab 2; Chandler, MJ and Dunlop, W.L 'Cultural wounds require cultural medicines'

Recommendation 25:

That there be funding by Government for the development of cultural healing projects in the Kimberley Region such as the one being developed by the Nyamba Buru Yawuru Centre in Broome.

Recommendation 26 – Trauma informed care and treatment

1566. Associated with the above two recommendations is the need for mental health service providers to have a specific plan for the Kimberley Region for the treatment of Aboriginal people who live in communities that have been traumatised.

1567. At the Inquest there was extensive evidence given about the causes and consequences of ongoing trauma endured by Aboriginal communities. I have addressed this issue throughout this finding and in particular under the heading *"Intergenerational Trauma"*.

1568. As stated by Professor Judy Atkinson:

> *"Trauma-informed services and trauma-specific care are important for those unable, or still working, to heal trauma. Although there are a growing number of early childhood programs specifically aimed at Indigenous children, most do not originate from trauma-informed service or incorporate trauma-specific care. …*
>
> *Further trauma-informed service and trauma-specific care interventions will be strengthened by action at the policy level. All Government and non-Government agencies need to ensure their policy frameworks are trauma-informed."*[995]

1569. The Department of Health and WACHS through their lawyers the SSO inform me that they are supportive of services being trauma informed. They submit that trauma specific services however are services comprising therapeutic care directed specifically to addressing trauma to aid the healing and recovery of victims/survivors of trauma, and that there is no single way to provide trauma specific care. They point to the possibility of contributions to treatment from a diverse range of sources such as Indigenous culture,

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[995] Exhibit 1.1, Volume 1, Tab 3.

neurodevelopmental science, ecological approaches (which consider all systems that negatively affect a given child's situation) and even physical activity.[996]

1570. The Department of Health and WACHS submit that there are already a range of services in pace trying to decrease the impact of trauma and point to Dr Simon's evidence concerning the roles of the justice system, mental health and drug and alcohol systems, remote area nurses, child health nurses, paediatric and mental health services, child protection services and education systems. Dr Simons points to multiagency meetings that provide support in understanding and appropriately responding to young people. For example the Child and Adolescent Mental Health Service and the WACHS adolescent psychiatrists proactively provide education to a range of services involved with young people.[997]

1571. The Department of Health and the WACHS submit that further systematic research is needed to determine whether, and on what basis, trauma-informed services and trauma-specific care practices appropriately tackle childhood trauma.[998]

1572. The Chief Psychiatrist through his lawyer the SSO, expresses his support for the recommendation, but submits that these services provided to children and young persons in the Kimberley Region ought to operate in a "*trauma-informed model.*" I have accepted this, in the context of this recommendation.

1573. The Department of Justice through its lawyer the SSO, expresses its in principle support for this recommendation, within the context of its policy frameworks and services for young people in the justice system. They inform me that they are working towards a trauma informed delivery of its services to Aboriginal children and young people in the community and in detention. Their Youth Justice Psychological Services provides trauma-informed counselling that is offence-specific.

1574. The Department of Justice recognises and understands that many young people in the justice system have experienced multiple traumas and that rehabilitation and care will need to address the trauma's causes and symptoms. As an example they point to their

[996] Exhibit 1.1 Tab 3.
[997] Exhibit 1.4, Tab 40.
[998] Exhibit 1.1, Tab 3.

current Professional Development Program which includes a model on trauma informed practice.[999]

1575. The Department of Communities through its lawyer the SSO, supports this recommendation, and informs me that it aims to provide trauma specific response for each child's individual needs based on known individual history. This is despite often not having a full account of the specific trauma(s) a child has suffered. Trauma specific means that treatment goals for any referral to a practitioner addresses the named traumas of the child. They inform me that only practitioners who work from a trauma informed framework with adequate cultural competency are contracted by the Department of Communities. They also inform me that whilst some treatments are individual others at times need to be systemic addressing wider issues that affect every child in an area. They provide as examples cases of drug use, depression and suicide, being three areas in which practitioners work with children individually, in groups and with carers to address what are systemic problems that interact and influence each other.

1576. The Department of Communities also informs me that Out of Home Care provided by it or its partner agencies in the Kimberley Region is Trauma Informed and that all Departmental Residential Care homes operate under the Sanctuary Model. The Sanctuary Model is a framework to build safe communities within the care context that helps children heal from trauma.[1000]

Recommendation 26:

That the care or treatment that is provided by service providers to Aboriginal children and young persons in the Kimberley region operate in a trauma informed model, and that service providers take account of the need for trauma-specific care where possible.

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[999] Exhibit 1.9, Tab 68D.

[1000] Exhibit 1.3, Tab 24.

Recommendation 27 – Holistic approach to alcohol, drugs and mental health

1577. The evidence at the Inquest established that a number of the children and young persons whose deaths were investigated were abusing alcohol and/or taking illicit drugs. A number may also have had undiagnosed mental health conditions.

1578. At the Inquest Chief Psychiatrist Dr Gibson acknowledged that mental health clinicians: *"don't necessarily do co-morbidity i.e. drug and alcohol and mental health as well* [as] *we could"*. In his experience it can be difficult for clinicians to maintain skills concerning the identification and treatment of mental health conditions, together with skills concerning the types of treatment required for drug and alcohol abuse.[1001]

1579. Dr Gibson gave evidence about the introduction of an approach that operates more holistically:

> *"a process where people that are coming into positions within services are given an understanding right from the outset that this is [a] situation where they are expected to have – maintain a skill set around co-morbidity, working with drugs and alcohol".*[1002]

1580. There is considerable merit in having such a system that identifies the importance of *"co-morbidity services"* and the need for individual staff who are equally skilled in mental health and drug and alcohol issues.[1003]

1581. It would be beneficial both economically and to the patient if the one health professional was able to address these three areas which clearly interconnect and overlap for those Aboriginal persons requiring treatment.

1582. The WACHS through its lawyer the SSO acknowledges the co-morbidity of alcohol, drugs and mental health issues. However, they submit that clinicians with speciality knowledge in all of these areas are rare and that it is not practical for health service clinicians to be equally and highly skilled in all three issues. They point to the

[1001] ts 1634.
[1002] ts 1636.
[1003] ts 1666.

evidence of the Chief Psychiatrist: *"...it's hard to maintain a skill set across both areas."*[1004]

1583. They also point to the Chief Psychiatrist's evidence to the effect that the Kimberley was one of the first areas to have a merged mental health and drug service. Whilst the WACHS considers that the more realistic goal is for clinicians to have access to training in these areas, I take account of the Chief Psychiatrist's view:

> *"….people always talk about you just train them up. Well, that – that doesn't work because you can offer the training. People turn up to the training, you know. I think it's – it's about actually having positions – mental health positions where the job description does actually expect the person to have an approach to – to comorbidity, that it's not just a – you know, a – a second thought as the person is there that, you know, they might have to deal with this. It's a case that they're actually recruiting to that. The difficulty, of course, is for the Kimberley that they often don't have a wide pool of clinicians from which they actually recruit so they have to do the work within their service to try and bring that together."*[1005]

1584. From the perspective of continual improvement, the Chief Psychiatrist considers that more needs to be done to have clinicians engaged with managing co-morbidity as a whole. Through his lawyer the SSO, he submits that all clinicians should have a base knowledge of alcohol and other drugs issues, as well as mental health issues, but that treating these issues can be a specialised field.[1006]

1585. In the *"Learnings from the message stick"* report the Education and Health Standing Committee referred to Aboriginal suicide as less likely to be a consequence of mental illness or depression, and that it can better be categorised as a *"reactive emotional response"* to life circumstances, and alcohol and drug abuse.[1007]

1586. Various statistics are produced that indicate that most Aboriginal persons who suicide have not been diagnosed with a mental health condition. This may be because they did not in fact have a mental health condition. It may also be because, realistically, they had no access to mental health services.

[1004] ts 1634.

[1005] ts 1634

[1006] ts 1634 to 1635.

[1007] Elliott-Farrelly, T., 'Australian Aboriginal Suicide: The Need for an Aboriginal Suicidology', Australian e-Journal for the Advancement of Mental Health, vol. 3, no. 3, 2004

Recommendation 27:

That all health service clinicians in the Kimberley Region have the necessary skills to screen for and facilitate care for patients with alcohol, drugs and mental health issues;

Further, that all health service clinicians in the Kimberley Region have access to training in the assessment and management of alcohol, drugs and mental health issues.

Recommendation 28 – Mental health facility in East Kimberley

1587. The building of an inpatient mental health facility in the Kimberley was one the former State Coroner's recommendations from the 2008 Kimberley Inquest. The Mental Health Unit Mabu Liyan at the Broome Regional Hospital was subsequently built and was opened in 2012. It is a 13 bed inpatient mental health unit with two secure beds. There are Aboriginal mental health workers in-reaching into the Mabu Liyan Mental Health Unit. In 2016, 127 of the 203 inpatient mental health admissions into the Mabu Liyan Mental Health Unit were Aboriginal patients.[1008]

1588. Of the 13 deaths that this Inquest investigated ten occurred in the East Kimberley Region. The question therefore arises as to whether an additional mental health unit should be built at a hospital campus in this part of the Kimberley Region as well.[1009]

1589. At the Inquest the Chief Psychiatrist was of the view that there was not the necessary value in having an in-patient unit in the East Kimberley Region and *"that more focus should be spent on improving and supporting the community aspect of care there."*[1010]

1590. Notwithstanding the Chief Psychiatrist's opinion expressed at the Inquest on this topic, Counsel Assisting submits to me that a mental health unit should be built in the East Kimberley. It may be that this facility is not simply confined to the treatment of mental health issues, but also those related to areas of drug and alcohol addiction, particularly amongst children and young persons within the

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[1008] Exhibit 1.5, Tab 51A.
[1009] Most logically, that would be as part of the Kununurra District Hospital.
[1010] ts 1631.

Aboriginal community. Such a facility would also acknowledge the co-morbidity of services that Dr Gibson had referred to in another part of his evidence.

1591. In his evidence Dr Chapman pointed to the State-wide Specialist Aboriginal Mental Health Service that now operates in partnership with the Kimberley Mental Health and Drug Service. Whilst in his opinion no amount of unfettered escalation of resources will be sufficient to meet the needs of the population, and he notes the improvements, as a mental health and drug professional, he believes they are still under-resourced.[1011]

1592. Ms Petina Pitt-Lancaster, manager of the Gawooleng Yawoodeng Aboriginal Corporation Women's Shelter in Kununurra (the Shelter), whose evidence is referred to previously, told the Inquest that one of the greatest challenges for her service is linking mothers and their children to specialist clinical help due to the limited psychological services in Kununurra.[1012]

1593. The Shelter managed by Ms Pitt-Lancaster provides diverse programs and support to women and children who are escaping family and domestic violence, and they embed lore and cultural considerations into all aspects of their decision making. In her report to the coroner she outlined that one of their common difficulties is trying to engage external clinical help for children in the Shelter. The staff in the Shelter have basic training as counsellors, but they do not have specialised clinical skills.[1013]

1594. In Ms Pitt-Lancaster's experience, the child psychologist who comes to Kununurra every six weeks is inevitably working with children who are in the care of the Department of Communities (formerly the Department of Child Protection and Family Support) as a priority, with the result that children who are with their mothers in the Shelter do not have access to a psychologist.[1014]

1595. The WACHS through its lawyer the SSO submits to me that the expense involved in establishing such a facility in the East Kimberley would produce better outcomes if used elsewhere. The WACHS cited the evidence of the Chief Psychiatrist, who opined that the more important focus is to improve the community treatment aspect of care, and the evidence of Ms Smith, who outlined the hub and spoke

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[1011] ts 1135.
[1012] Exhibit 1.4, Tab 45.
[1013] Ibid.
[1014] Ibid.

system, with Broome being the hub where a lot of the resources are focussed.[1015]

1596. The WACHS points to the expense of establishing and operating an acute inpatient unit in Kununurra, and the difficulty of attracting skilled and/or locum staff to that area.

1597. The WACHS draws attention to the evidence of Dr Chapman who informed the Court that despite the enormous resources consumed to set up the Mental Health Unit (Mabu Liyan) at the Broome Regional Hospital, it did have the advantage of reducing the Kimberley patient transfers to Perth to a "*tiny trickle.*" This is supported by information that reflects that in 2012, 56 mental health patients were transferred from the Kimberley to Perth. In 2013, the calendar year after opening, seven patients were transferred. In 2016, 18 patients were transferred.[1016]

1598. The WACHS submits to me that this shows the objective has been achieved, and there is therefore much less need for a facility in the East Kimberley in 2018 than there was for a facility in the Kimberley in 2008.

1599. The Chief Psychiatrist through his lawyer the SSO, submits that there would undoubtedly be difficulties in securing staff for an inpatient facility in the East Kimberley, and does not support an inpatient facility. In his view this will not necessarily bring people together, strengthen communities or build trust and relationships.

1600. The ALS submits to me that there is considerable merit in providing mental health treatment to Aboriginal people in locations close to their country, family and support networks.

1601. I have carefully considered the WACHS and Chief Psychiatrist's submissions regarding a proposal for a mental health facility in the East Kimberley and the particular concerns they have expressed. However, on balance I have determined to recommend such a facility or at least, that there be a feasibility study undertaken.

1602. The circumstances outlined under the headings *"Home environment"* in respect of the deaths occurring in the East Kimberly are too serious, and it would be naive to imagine that they represent isolated instances. They reflect upon the serious alcohol and drug abuse problems, which often go hand in hand with mental health conditions. The fact that mental health illnesses were not diagnosed should not

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[1015] ts 1631; ts 1731
[1016] ts 1135

be taken to mean that there were no persons with mental health illnesses.

1603. It is known that Aboriginal communities are diverse, and value their connection to country. One facility for the entire Kimberley Region, located in Broome is not sufficient.

Recommendation 28:

That a facility be built in the East Kimberley Region which incorporates the co-morbid treatment of mental health, alcohol and drug abuse problems, or alternatively that a feasibility study be undertaken with a view to considering the need for, and impact of, such a facility.

Recommendation 29 – Preventative strategies for new parents

1604. At the Inquest the Regional Director of WACHS Ms Rebecca Smith (whose evidence is also referred to previously) testified that current youth mental health and substance abuse services in the Kimberley are available for children aged 14 to 17 years old, but that WACHS are not funded to provide these services to younger children.[1017]

1605. Ms Smith emphasised the importance of the first three years of a child's life and stated that, in order to appropriately address youth mental health and substance abuse, provision of services must begin at the peri-natal stage: "*resources need to start pre-conception or at conception.*" She talked about the importance of "*the first thousand days*" and the need for services around making a woman and the unborn child safe and healthy.[1018]

1606. The evidence highlighted the importance of addressing peri-natal and infant mental health issues, so as to seek to prevent the dysfunctionality that can lead to future substance abuse problems. The Chief Psychiatrist acknowledged that the National Mental Health Commission's review of its services in Australia talks about: "*….having greater focus on the upstream to actually do the*

[1017] ts 1680 to 1681.
[1018] Ibid.

preventative work and no more is that relevant than in the Kimberley."[1019]

1607. In evidence, the Chief Psychiatrist supported an emphasis on treatment at the peri-natal stage with an emphasis on mental health issues. He believed that could be done through liaising and working with obstetric services so that it does not just become a stand-alone service.[1020]

1608. The Department of Health and the WACHS through their lawyer the SSO, support this recommendation and note that peri-natal mental health screening is already routinely undertaken as part of antenatal and postnatal care.

1609. The Chief Psychiatrist through his lawyer the SSO, supports the recommendation and submits that reference also be made to the role of the WA Peri-natal Mental Health Unit. I have accepted that.

Recommendation 29:

That peri-natal and infant care by health service providers in the Kimberley Region incorporates the treatment of mental health issues and that those clinicians be made aware of the role and resources developed by the WA Peri-natal Mental Health Unit.

Recommendation 30 – Recreational facilities

1610. It emerged from evidence heard at the Inquest that there is a lack of activities for children and young persons to engage in during the evening and school holidays and that many unsupervised children *"roam the streets"* during these times.

1611. At the Inquest Senior Sergeant Stefano Principe, officer in charge of Kununurra Police Station gave his perspective, in connection with children between the ages of approximately eight and 15 years, and also explained that this can be seasonal:

[1019] ts 1636 and 1637.
[1020] ts 1637.

"….sometimes at night you could see up to 50 children roaming the streets, you know, attending the shopping centre, sometimes the 24-hour BP service station, they hang around there. So wherever there's lights or a bit of entertainment, they tend to just walk around. There are – there are sometimes issues with vandalism because of boredom. But they're avoiding, generally, going home." [1021]

1612. The ALS also refers me to this evidence of Senior Sergeant Principe and further the evidence of Senior Sergeant Peter Jenal, officer in charge of the Halls Creek Police Station, to a similar effect, namely that in their opinions the children are bored, avoiding going home or do not have a safe environment to return to.[1022]

1613. Both officers in charge referred to a lack of after-hours activities for children to engage in and that despite school holiday programs for children, it is clear that more could be done. [1023]

1614. Few town sites (and even fewer Aboriginal communities) have a facility where children and young persons are able to meet and/or engage in activities, such as a youth centre, or recreational centre.[1024]

1615. Anecdotal evidence indicates that where such facilities are available, young persons are less likely to engage in antisocial behaviour. Such facilities could also serve as the first step for troubled youth to seek help.

1616. From its visits to Aboriginal communities, it became apparent to the Court that such facilities either do not exist, or that they had fallen into disrepair and were no longer in use.

1617. Counsel Assisting submits to me that development of these facilities in the Kimberley Region would alleviate the boredom and reduce the antisocial and criminal activity that seems to follow as a consequence.

1618. The Department of Communities through its lawyer the SSO, expresses its strong support for youth and community-led youth initiatives. They submit that better use of existing facilities and public spaces may often be preferable to constructing new facilities, and they note that there are a range of existing facilities across the

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[1021] ts 1452.
[1022] Ibid.
[1023] ts 1242 to 1244.
[1024] Senior Sergeant Peter Jenal testified that no such facility exited in Halls Creek.

Kimberley Region. They also note that these and any additional facilities require both capital and operational funding.

1619. The ALS supports this recommendation, and highlights the importance of consultation with local Aboriginal communities in the course of the development of programs or facilities.

1620. It is clear to me that the development or refurbishment of facilities for young persons can serve a range of objectives, from providing structured and enjoyable activities, a meeting place for arranging on-country programs, a support network, a safe space, somewhere to meet new friends, and a place for a troubled young person to feel comfortable to ask for help.

Recommendation 30:

That the development or refurbishment of facilities for young persons to meet and engage in activities be undertaken in the Kimberley Region, in consultation with local Aboriginal communities.

Recommendation 31 – Mental health clinician for Halls Creek

1621. The Halls Creek community has a high percentage of Aboriginal residents and a history of difficulties relating to poor health, domestic violence, alcohol abuse, criminal offending and low school attendance.

1622. A number of positive measures have been taken within the community for improvement in these areas but unfortunately problems still remain.

1623. At the Inquest the Chief Psychiatrist acknowledged that more resources into mental health in the Kimberley, and particularly the East Kimberley, are required.[1025]

1624. The officer in charge of the Halls Creek Police Station, Senior Sergeant Jenal, outlined the difficulty for persons in Halls Creek who require mental health assessments and/or treatment. Unfortunately

[1025] ts 1632.

they have to rely on services from external providers. He was of the view that the present system of mental health clinicians travelling once a month from Kununurra to Halls Creek was inadequate, particularly when the need was urgent.[1026]

1625. Another complicating factor identified by Senior Sergeant Jenal concerned delays in this monthly service when the visits are cancelled due to the clinician being on leave (for example being unwell), also stating: "….*there is a disparity between the time that people need assistance to when they actually get it.*"[1027]

1626. As recounted by Senior Sergeant Jenal, when there is an incident of self-harm in Halls Creek, the police will usually take the person to the local hospital and referrals are made for further assessment of the patient in Derby, Kununurra or Broome. He was of the view that: *"there needs to be somebody in town here in Halls Creek that can deal with it at that time or the next day."*[1028]

1627. Comparatively speaking Halls Creek's population of approximately 1,500 is not a small town. Only Broome, Kununurra and Derby have populations greater than 2,000 in the Kimberley Region.

1628. The WACHS through its lawyer the SSO draws my attention to the evidence concerning outreach services (including mental health services) provided by Kimberley Mental Health and Drug Service to Halls Creek. They also point to the Halls Creek Aboriginal Medical Service providing primary healthcare, and to the WACHS hospital in Halls Creek that deals with acute psychiatric emergencies.[1029]

1629. Whilst acknowledging that additional mental health services in the Kimberley Region would be of value, the WACHS submits that specifying Halls Creek is too specific. They draw my attention to other areas which would also be assisted with additional resources.

1630. The WACHS also points to the difficulty of attracting and retaining adequately trained clinicians to live in remote areas, including the cost of wage incentives, and the difficulty of housing a clinician. Their preference is for multiple clinicians with different specialties being available to provide care, by way of outreach services to a number of areas using the hub and spoke model.

1631. The Chief Psychiatrist through his lawyer the SSO, submits that it will be hard to get permanent staff to stay in that location, and that

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[1026] ts 1448.
[1027] ts 1448.
[1028] ts 1449.
[1029] ts 1674 to 1678.

it is preferable to increase the visiting capacity of multiple clinicians with different specialties to multiple locations, rather than permanently basing one individual in a specific location.

1632. I accept there are difficulties in attracting and retaining mental health clinicians in locations such as Halls Creek, but monthly visits, which can themselves be cancelled, cannot adequately cater for the needs of this community. The risk is that a person may develop a more acute psychiatric condition that could have been more appropriately managed with earlier intervention from a mental health clinician. It is not enough to say that the person can then be hospitalised.

Recommendation 31:

That there be a mental health clinician permanently based in Halls Creek, or alternatively, that there be an increase in the visiting capacity of mental health clinicians for Halls Creek.

Recommendation 32 – Expansion of "Adopt-a-Cop"

1633. The ALS draws attention to the sad history of governmental and policing policies that have led to a culture amongst some Aboriginal communities of fear and distrust of the police.

1634. At the Inquest I heard evidence of initiatives in Halls Creek that are aimed at building positive relations between police and community members.

1635. One of these initiatives is the Adopt-A-Cop Program undertaken by the Halls Creek Police in conjunction with the Halls Creek District High School (that caters for Kindergarten to Year 12 students).

1636. The evidence of Senior Sergeant Jenal was that the prior experience of the police attempting to engage with 15 or 16 year olds was not working. It was then decided by the Halls Creek police to look at attempting to engage with younger children of a primary and lower high school age.[1030]

[1030] ts 1452.

1637. This program has involved police officers entering the classroom and engaging with children through the Adopt-a-Cop program. Activities include having the children look at and try out police vehicles' lights and sirens in an educational setting. The aim is to de-mystify, and to reduce an automatic fear response towards police, which in time can develop into an aggressive response. As stated by Senior Sergeant Jenal:

> *"So it's about getting in and showing the children that we're not there to basically lock everybody up. We're there as their friends and they can come and speak to us at any time."* [1031]

1638. It is apparent that this program has extended to other areas of the Kimberley, including Wyndham.[1032]

1639. Counsel Assisting submits to me that the program should be extended to other major town sites throughout the Kimberley Region.

1640. The Commissioner of Police through his lawyer the SSO expresses the Western Australia Police Force's support for police stations and multi-functional police facilities in the Kimberley Region undertaking activities similar to the Adopt-A-Cop program in Halls Creek.

1641. The Commissioner of Police draws attention to evidence given at the Inquest of other initiatives undertaken by police officers in towns and remote communities in the Kimberley in engaging with Aboriginal children in a proactive way to improve the community's relationship with the Western Australia Police Force, in the nature of community events referred to earlier in this finding.[1033]

1642. The Commissioner of Police also outlines the Western Australia Police Force's initiatives specifically in the area of engaging recidivist juvenile offenders, given that the issue of cautions has proven to be of limited effectiveness:

a. The Kimberley District has six Youth Crime Intervention Officers with two located in each of Broome, Derby and Kununurra and two planned to be introduced in Fitzroy Crossing by mid-2018;

b. The Western Australia Police Service is exploring how the Kimberley Youth Crime Intervention Officers may be utilised to run programs that engage younger children from

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[1031] ts 1452.
[1032] ts 1452.
[1033] Exhibit 1.3, Tab 23; Exhibit 1.4 Tabs 28, 37 and 46.

dysfunctional backgrounds to provide guidance to those children around the ramifications of continued offending;

c. The Youth Crime Intervention Officers work extensively with youth orientated service providers and local government.[1034]

1643. Realistically, the experience of the Western Australia Police Force has been that even through such activities, they can only play a limited role in the lives of young people and that they struggle to have a lasting impact on children who continue to return to dysfunctional households/environments.

1644. The ALS supports this recommendation highlighting the benefits of a good rapport between police and local Aboriginal children, especially in small communities. They also point to the importance of developing such programs in consultation with the Aboriginal communities.

Recommendation 32:

That police stations in the Kimberley Region consider undertaking activities similar to the "Adopt-A-Cop" program in Halls Creek, ensuring these programs are developed in consultation with senior members of the Aboriginal community and that those police efforts be supported.

Recommendation 33 – Expansion of Elders' Reference Group

1645. There are a great many Aboriginal persons in the Kimberley region who are dedicated to improving the wellbeing of their people. Aboriginal Elders have an important role in preserving traditional knowledge and passing that knowledge on in accordance with cultural practices. They are also able to offer guidance and advice to community members at a broader level. Unfortunately, there is a view that the traditional respect towards Elders is waning.[1035]

[1034] Exhibit 1.8, Tab 59

[1035] Exhibit15A.

1646. A program such as the Yiriman Project is one way of reintroducing that respect. Another example is the creation of the Elder's Reference Group in Halls Creek, and evidence was given about the work of this group at the Inquest.

1647. Aboriginal Elders from the Halls Creek Region work with police to conduct night time patrols and speak to children who are on the streets: "*they go to the children.*" These Elders are provided with torches, shirts and hats so they are readily identifiable to police and they also have walkie-talkies to communicate with police, and call upon them if needed.[1036]

1648. These Elders are both men and women and though it is voluntary work, arrangements have now been made for it to be part of the Community Development Program (CDP) and so they can receive payment for their work. At the Inquest Senior Sergeant Jenal explained that when these arrangements are finalised, and where the Elders have performed the 25 hours per week by walking around and engaging with the community and the children, they will be able to receive payment for it.[1037]

1649. Ms Lisa Fowkes, research scholar, Centre for Aboriginal Economic Policy Research, Australian National University prepared a report for the coroner regarding remote employment programs. Ms Fowkes outlined that the CDP is the main program of job related assistance for unemployed people in remote areas of Australia. All people on income support who have participation requirements and who live in the CDP service areas (of which there are five in the Kimberley) must participate in the program as a condition of receiving income support.[1038]

1650. There are approximately 3,500 participants in the CDP program, and over 95% of participants are Aboriginal people. From 1 July 2015, unemployed job seekers aged from 18 to 49 years who have been assessed as having full-time work capacity have been required to work for 25 hours per week, scheduled over five days per week.

1651. The above is outlined within the context of explaining the background to this recommendation. An evaluation of the CDP program, and a comparison with its predecessor, the CDEP program, is outside the scope of the Inquest.

1652. Senior Sergeant Jenal (officer in charge of the Halls Creek Police Station) gave evidence of the success of the Elders Reference Group

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[1036] ts 1453.
[1037] ts 1454.
[1038] Exhibit 1.9, Tab 64.

in Halls Creek. This group was re-commenced by an Elder in the community and is supported by the Halls Creek Police.

1653. Senior Sergeant Jenal acknowledged that its success was connected to the community ownership of the group: "*it was their own people dealing with their own issues which worked out really well.*" He was of the view that this was an initiative that could work in other towns in the Kimberley and that it was: *"about having the right people on board and about people wanting to do it as well."*[1039]

1654. Counsel Assisting submits to me that, based upon the evidence at the Inquest there would undoubtedly be Aboriginal Elders and persons throughout the Kimberley Region who would be prepared to assist in a program such as this, particularly if it could be part of their CDP work.

1655. The Commissioner of Police through his lawyer the SSO, expresses the support for the Western Australia Police Force developing closer ties with Traditional Owners similar to the Halls Creek Elders Reference Group in towns and remote communities in the Kimberley.

1656. The Commissioner of Police informs me that the current work with Aboriginal Elders Groups is being developed in some local areas. The intent in this early development is to introduce these reference groups as key advisory forums for Police leaders in some predominantly Aboriginal communities.

1657. The ALS supports this recommendation but only in the context of the extension of the Elders Reference Group.

Recommendation 33:

That the Elders Reference Group presently in operation in Halls Creek be extended to other Kimberley town sites and that this work be CDP recognised, and that current police efforts continue and be supported.

[1039] ts 1453 - 1454.

Recommendation 34 – Alcohol and drug rehabilitation for children and young persons

1658. The evidence before the Inquest established that in many of the Kimberley town sites, there are no rehabilitation centres to treat persons for drug and alcohol issues. Even more concerning, within the context of this Inquest, there are no rehabilitation services that specifically cater for children and young persons. A number of children and young persons who died by suicide were consuming alcohol to excess, and taking illicit drugs.

1659. The ALS draws my attention to the evidence of the Team Leader of the Youth Justice Prevention and Diversion Team for the East Kimberley region (whose evidence is referred to previously):

> "….*we had children as young as eight smoking gunja. We had kids as young as ten drinking alcohol.*"[1040]

1660. To hear service providers at the coal face describing children ten years or younger consuming alcohol and illicit drugs is a cause of great concern. These are not isolated cases. The harmful effects of this behaviour not just to the child but to the community are all too obvious.[1041]

1661. Dr Stephanie Trust, principal general practitioner at Kununurra Medical, whose evidence is referred to previously, reported her experience concerning mental health services in the Kimberley. In her role as a GP she treats mental health issues that come up every day. She has worked in health services for over 30 years. She notes there has been slight improvement in mental health services in the Kimberley in recent years, but is concerned that the services are still inadequate given the high levels of mental health issues in her community.[1042]

1662. Dr Trust sees a lot of young people who are wanting to get off amphetamines, marijuana, alcohol and other drugs. In her experience, the rehabilitation centres in Wyndham and Broome were not equipped to deal with the "*ice epidemic*" and in any event,

[1040] ts 1102.
[1041] Ibid.
[1042] Exhibit 1.4, Tab 42.

young people see them as being alcohol rehabilitation services and are reluctant to engage with them.[1043]

1663. Dr Trust believes there is a need for local rehabilitation services that cater to young people. She has a lot of young patients between the ages of 18 and 25 years that would like to avail themselves of rehabilitation services, but want those services to be close to home and tailored to young people.[1044]

1664. Sadly, Dr Trust sees a "*revolving door*" where people come back from the rehabilitation clinic to Kununurra, and have resumed drinking the week of their return. In her opinion there is a need for development of transitional services for when people come out of the rehabilitation clinic. She believes this would involve transitional housing so that people could follow a step down process to assist with implementing the strategies they have learned, with a view to reintegrating into the community.[1045]

1665. The importance of local rehabilitation services was also addressed by Ms Brenda Garstone, the manager of the Yura Yungi Medical Service based in Halls Creek, whose evidence is referred to previously. Ms Garstone testified that there are no such rehabilitation facilities in Halls Creek and that the nearest one is in Wyndham. In addressing the importance of having local facilities she said:

> "*And a lot of Aboriginal people – country do not like going to another person's country. They feel very isolated from their families and country and they don't feel comfortable going to another person's country.*"[1046]

1666. The WACHS through its lawyer the SSO, draws attention to the evidence of Ms Smith concerning the role of the regional Child and Adolescent Mental Health (CAMH) teams, where a child's treatment needs are considered "*urgent,*" namely if the child is immediately at risk. There are options that include having the child seen almost immediately by a CAMH worker, or if that person is unavailable, by immediate link to a child psychiatrist or psychiatry team by telehealth service, or by conveyance to the hospital emergency department. This may include an overnight stay unless through close examination, consultation and

[1043] Ibid.
[1044] Ibid.
[1045] Ibid.
[1046] ts 1477.

assessment, there is agreement that the child is safe to go home in the care of a responsible adult.[1047]

1667. The WACHS also draws attention to the evidence of Dr Chapman concerning the treatment and care provided by the Kimberley Mental Health and Drug Service. The WACHS outlines its preference for the locally based multi-disciplinary teams that are located in regional centres across the Kimberley in Kununurra, Halls Creek, Derby, Fitzroy Crossing and Broome. Outreach is provided by each of these teams to surrounding and remote areas. Clients may present directly (without referral) or with referrals from health professionals and from other relevant parties.[1048]

1668. The WACHS submits that this model with multi-disciplinary teams providing community services directly or by referral is the preferred model rather than services located in a single facility. They also submit that this current approach reflects the fact that most drug and alcohol treatment in Australia takes place in the community.

1669. The Chief Psychiatrist through his lawyer the SSO, also submits that most drug rehabilitation is done in the community rather than in an inpatient setting at a facility, because most people who need rehabilitation cannot go into inpatient settings for months at a time. Further the changes that rehabilitation seeks to bring about need to be embedded in the patient's real life and circumstances.

1670. I have taken account of the SSO submissions on this point. Unfortunately however, vulnerable children with drug and/or alcohol issues may not be successfully treated by a combination of outreach community care and emergency response. The scale of the problem is too big and their home and community environments may not be conducive to rehabilitation.

1671. Difficult as it may be to accept, there are many young children in the Kimberley Region who are addicted to illicit drugs, and who abuse alcohol. This behaviour carries with it severe risks to their physical and mental health. It makes them vulnerable to abuse

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[1047] ts 1733.
[1048] Exhibit 1.6, Tab 57; ts 1134.

and self-harming behaviour. It unquestionably increases the risk of suicide.

1672. The ALS supports the recommendation but cautions that, given the extreme youth of some of the Aboriginal children who might be in need of assistance from such rehabilitation centres, participation ought to be done on a collaborative basis with the child, the family or guardian and the Aboriginal community in which they live.

Recommendation 34:

That facilities be developed and funded in the Kimberley Region that specifically cater for the rehabilitation of children and young persons with addiction to drugs and/or alcohol, with step down processes. The development of these facilities should be informed by the principles of self-determination, cultural continuity and empowerment.

Recommendation 35 – Expansion of "Kindylink"

1673. The evidence at the Inquest established that the 13 children and young persons whose deaths have been investigated had poor school attendance rates, and as a consequence, poor academic outcomes. For some of them their level of disengagement was such that they displayed serious behavioural problems that presented as a risk to the health or safety of other students and/or teachers. The educational experiences of these children is not unique in the Kimberley Region.

1674. Despite extensive efforts being made by the Department of Education and certain sectors of the Aboriginal community, the school attendance rate of Aboriginal students remains low and, unsurprisingly, their academic performances overall are poor. It is trite to say that without a regular education and adequate performance, the prospects of a young person being gainfully employed diminishes significantly.

1675. In its report "*Learnings from the Message Stick*" the Education and Health Standing Committee referred to Aboriginal students consistently achieving poorer educational outcomes in terms of school attendance, engagement and achievement, and its

consequences namely reduced prospects for future employment. Citing Australian Bureau of Statistics figures, the Committee noted that:

> "*In June 2015, the national unemployment rate for Aboriginal people was 20.6 per cent compared to the general unemployment rate of 6.0 per cent.*"[1049]

1676. Even before employment becomes a consideration, it is to be borne in mind that when children disengage from school, they risk losing the benefit of an important protective and stabilising factor in their lives.

1677. The evidence before the Inquest indicated that it can be difficult convincing some parents of the benefits of their children regularly attending school and there are a range of factors that can drive this disengagement.

1678. Counsel assisting submits to me that any program that motivates a parent or caregiver to ensure a child attends school regularly should be considered. The Inquest heard evidence of the Kindylink Program for three year olds that was introduced in Halls Creek in 2015. This program centres on parents bringing their three year old children to classes that encourage and mentor them in the importance of reading to their children and teach them the importance of play-based learning activities.[1050]

1679. Mr Darryl Dedman (who from 2011 to 2016 taught and was then the Principal at the Halls Creek District High School) was very supportive of this program. Though he acknowledged that initially there was not enough discussion with the Aboriginal community, he was of the view that it was a program that was definitely worth pursuing: "*….we needed to ask the community how they would like it implemented and how they see it as being important.*"[1051]

1680. The Department of Communities and the Department of Education through their lawyer the SSO, support this recommendation.

1681. The Department of Education is presently delivering KindyLink in government schools in the Kimberley Region, but it is as part of a pilot. Specifically they inform me that in 2016 they implemented a three-year KindiLink pilot in 37 public schools including the following schools in the Kimberley Region: Broome Primary School, Cable Beach Primary School, Derby District High School, Fitzroy

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[1049] Exhibit 1.1, Tab 2.
[1050] ts 1488 and 1489.
[1051] ts 1489.

Valley District High School, Halls Creek District High School, Kalumburu remote community school, Kununurra District High School and La Grange Remote Community School.[1052]

1682. Mr Hale, Deputy Director General, Schools, outlines KindiLink's aims which are to engage Aboriginal parents with their child's education and to develop the relationship between the school, the family and the community from an early age. He does sound a note of caution, to the effect that KindiLink will only be successful if it has the cooperation of the parents.[1053]

1683. The ALS is supportive but draws my attention to the need for consultation with, and support from, the individual Aboriginal communities if the KindiLink program is to continue beyond the pilot. The Department of Education concurs with the need for consultation.

Recommendation 35:

That early education programs such as Kindylink be maintained for the Kimberley Region, with consideration for funding beyond the period of the pilot, and that programs be developed in consultation with the local Aboriginal communities.

Recommendation 36 – Re-engagement classrooms

1684. Following on from Recommendation 35, this recommendation also addresses school attendance rates.

1685. Another program which was introduced by Mr Dedman at the Halls Creek District High School concerned the initiation of a re-engagement classroom for years 3 and 4 in 2013. A teacher was assigned as a *"re-engagement teacher"* and the school focused on 12 students in these age brackets who had attendance rates of less than 10% and who were regularly being suspended. Within one year those 12 students had attendance levels of between 70% - 90% (with

[1052] Ex 1.5, Tab 50.
[1053] ts1592.

one achieving 100% attendance) and all had no further suspensions.[1054]

1686. This program was clearly a success but it was also highly intensive, requiring a committed teacher and the cooperation from the students' parents. An example of the dedication required by the teacher was that she would visit all of the children's parents at least two or three times a week, and also collect the children in the mornings and take them home at the end of the school day.[1055]

1687. The Halls Creek District High School not only had an appropriate teacher to take up this role, but it was also generously funded by the Department of Education. Counsel Assisting submits to me that such a program ought to be developed at other public schools throughout the Kimberley Region.

1688. The Department of Education through its lawyer the SSO, sounds a note of caution about this initiative and does not support it as an appropriate measure in all Kimberley primary schools. They point to the evidence concerning the needs and diversity of different communities, the complex reasons for student non-attendance, and the size and remoteness of some schools, meaning that staffing may not be viable.[1056]

1689. The Department of Education points to the evidence of the other options being explored and/or implemented in schools to reengage Aboriginal children with education:

a. Co-designing approaches to support better attendance with individual school communities;

b. Implementing culturally sensitive and culturally responsive curricula;

c. Attendance strategies implemented by special needs behaviour and engagement teachers;

d. Engagement programs such as Clontarf, Baroola Rangers, Girls Academy and Follow the Dream. [1057]

[1054] Exhibit 1.4, Volume 4, Tab 48; ts 1489 and 1490.
[1055] ts 1490.
[1056] Exhibit 1.5, Tab 50; ts 1591.
[1057] ts 1612; Ibid, p 1611 ts 531 – 532;

1690. When regard is had to the highly intensive role discharged by the re-engagement teacher referred to above, it is clear that significant funding is required to expand the initiative.

1691. The ALS are supportive of schools within the Kimberley Region being encouraged and resourced to introduce re-engagement classrooms at a primary school level.

1692. Unfortunately the scale of disengagement from school is severe, and whilst the efforts of the Department of Education referred to above are undeniably helpful, it is clear that it was the re-engagement teacher's efforts in meeting with the parents in their homes, that generated the trust and confidence, and the significant turn-around in attendance.

Recommendation 36:

That schools within the Kimberley Region be encouraged and resourced to introduce re-engagement classrooms at a primary school level.

Recommendation 37 – School vocational programs

1693. Most of the young persons whose deaths were investigated at the Inquest had been unable to complete their schooling, and had no realistic prospects of employment. Consideration ought to be given to the provision of alternative programs such as vocational programs.

1694. Those high school aged students who are unable or have difficulties in reading or writing will find it highly challenging to engage in classroom activities. At the Inquest Mr Dedman gave the following example:

> *"I think for the senior boys who have missed out the fundamentals – the shame of being in a classroom and not being able to read or to write well prevents them from engaging in activities that are going to improve their situation. However, when you engage them in collaborative, cooperative activities where they're all working together on a task to build, maintain*

> *– when they see a purpose in the activity that they're doing, then they are very hard workers."*[1058]

1695. An example of an alternative program that can operate to improve employment prospects is the trade training centre recently built at the Halls Creek District High School. As Mr Dedman explained:

> *"A Bushranger Program was introduced for boys in the senior grades with low attendance. We were looking to provide them with other non-academic trade skills. They worked on practical projects such as horticulture and road building. Despite often having to work outside in 35 degree heat, these students built retaining walls, poured cement and built a road. Their success in completing these projects generated a lot of pride for themselves and the school."* [1059]

1696. Research scholar Ms Fowkes, whose evidence is referred to previously and who prepared a report to the coroner on remote employment programs, also gave evidence about there being a large number of young people who disengage from school because there are not a lot of alternative education options for teenagers in high schools in the Kimberley Region.[1060]

1697. The Department of Education through its lawyer the SSO, expresses its support but notes that its ability to implement the recommendation will vary between high schools and communities, and draws attention to the following:

a. The number of Aboriginal students achieving Vocational Education and Training VET (VET) qualifications at Certificate II and higher since 2010 has grown significantly and is continuing to increase;

b. There are inevitable difficulties with access to VET courses in the Kimberley Region because of the smaller numbers of students and access to specialist input or specialist equipment.[1061]

1698. The Department of Education refers to Mr Hale's evidence concerning its efforts directed towards exploring better options for VET delivery particularly in regional and remote areas in

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[1058] ts 1490.
[1059] Exhibit 1.4, Volume 4, Tab 48.
[1060] ts 2079 to 2080.
[1061] Exhibit 1.5, Tab 50 ts 1588.

conjunction with the Department of Training and Workforce Development (this is at the early stages of development).[1062]

1699. The ALS is supportive of the recommendation that high schools in the Kimberley Region be provided with facilities that enable non-academic students to engage in vocational programs.

Recommendation 37:

That high schools in the Kimberley Region be provided with facilities that enable non-academic female and male students to engage in vocational programs.

Recommendation 38 – Aboriginal language classes in schools

1700. At the Inquest, numerous Aboriginal witnesses spoke of the importance of the teaching of Aboriginal languages at schools in the Kimberley Region. This can demonstrate that a school is culturally sensitive and culturally responsive to the Aboriginal community and gain the confidence and trust of parents of Aboriginal students.

1701. Ms Garstone, whose evidence is referred to previously, considered that Aboriginal people are caught between trying to reconnect with their culture and: "*trying to fit into the Western world*". On considering that both can be achieved, Ms Garstone opined:

> "*….it can be achieved by Aboriginal people learning their language and culture, being allowed to do that and supported to do that. Unfortunately, our language is – is becoming extinct and there are only a few traditional predominant speakers. However, there's that will for the younger generation to learn their language. We just need the means to do that.*"[1063]

1702. The importance of learning an Aboriginal language as part of supporting resilience and healing was also referred to by Ms Skeen, Ms Carter and Mr Nicholas Espie, who stated, in connection with being on country:

[1062] ts 1588.
[1063] ts 1469.

"….it's important in the sense that it's maintaining a balance between our culture – keeping in connection with that culture which does build, I believe, strong families. It's social, emotional wellbeing for us to be on country, to be involved in activities with family, with our culture to be able to explain cultural significance of places, or even the historical family connections to places on country."[1064]

1703. The Department of Education through its lawyer the SSO, expresses its support for this recommendation and refers to the evidence before the court that shows that a number of schools in the Kimberley are teaching Aboriginal languages:

a. Since 1998, the ongoing provision of the Aboriginal Languages Teacher Training Course has enabled Aboriginal language speakers to train to become Aboriginal language teachers; two Department of Education officers are responsible for training and support, and one of the is located in the Kimberley Education Regional Office;[1065]

b. In 2016 there were 10 languages taught in the Kimberley Education Region; the Principal of Derby District High School Mr Williams informed the court that there are plans to teach Nyigina at primary school level in Derby, and that when he was at Broome Primary School they taught Yawuru:

"….being in an Aboriginal community, it makes sense to teach Aboriginal language to students. When I was at Broome Primary, we …. taught Yawuru because we're on Yawuru land. We taught Yawuru to all children regardless of whether they're Aboriginal or not."[1066]

c. In 2016, there were 1336 students learning an Aboriginal language in the Kimberley Region, an increase from 1313 students in 2015.[1067]

1704. The Department of Education also refers to the importance of consultation with the individual communities before making a decision to teach an Aboriginal language in that community and if so, which language. They referred to the evidence that teaching an Aboriginal language could cause difficulties in some communities, for example in Halls Creek which has multiple language groups,

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1064 ts 2045; see also ts 576 and 936.
1065 Exhibit 1.5, Tab 50.
1066 ts 514.
1067 Exhibit 1.5, Tab 50.

meaning that it was hard to develop a language program without appearing biased.[1068]

1705. The ALS is supportive of the recommendation regarding the introduction or expansion of the teaching of Aboriginal languages at schools in the Kimberley Region.

Recommendation 38:

That the Department of Education introduce or continue to expand the teaching of Aboriginal languages in its Kimberley schools, in consultation with the local Aboriginal communities.

Recommendation 39 – Yiriman Project linked to schools

1706. As already outlined above the Yiriman Project that currently operates from Fitzroy Crossing has been a very successful program designed to assist troubled youth through connection with cultural and traditional knowledge, that is achieved by taking them out on country and engaging with Aboriginal Elders.

1707. A collaborative approach with schools would enable the identification of those troubled youths who could benefit from such a program. Counsel Assisting submits to me that the Department of Education could consider funding such students to enable them to participate in such a program.[1069]

1708. The Department of Education through its lawyer the SSO, expresses its in principle openness to exploring options, in consultation with local Aboriginal communities, to link with programs that support the re-engagement of Aboriginal students with the education system.

1709. The Department of Education has not considered a long term evaluation of the Yiriman Project to determine whether that particular programme may be supported by all Aboriginal communities within the Kimberley Region, whether it is able to

[1068] ts 1617; Exhibit 1.4, Tab 48.

[1069] This recommendation can only be achieved outside of the Fitzroy Valley region if funding is provided to expand the Yiriman Project to other parts of the Kimberley Region (see Recommendation 16).

deliver those re-engagement outcomes to a number of students or whether other programmes would be equally or better suited for that purpose.

1710. The ALS submits to me that the Yiriman Project has been a successful example of a community-owned program, and support the recommendation.

1711. The dual aim of this recommendation is to assist students who could benefit from an on-country program, and through that process, to also encourage a re-engagement with the education system.

Recommendation 39:

That the Yiriman Project or a model akin to the Yiriman Project be linked to schools within the Kimberley Region.

Recommendation 40 – Residential colleges for schools

1712. Under Part 6A of the School Education Act, the Minister may establish such student residential colleges as the Minister considers necessary to provide residential accommodation and related services for students whilst they attend, and participate in an educational program of a school.[1070]

1713. Within the context of this recommendation, a residential college is a stand-alone college that provides residential accommodation for children attending local high schools.

1714. Under Part 6A of the School Education Act, the Minister in considering whether to establish a student residential college for secondary school students, is to take into account of the social, cultural, lingual, economic or geographic factors that might affect access to school education for particular students.[1071]

1715. Students in student residential colleges are only students enrolled in a secondary school providing education to children in the eighth to thirteenth years of their compulsory education period. In the

[1070] Section 213B(1) of the School Education Act.
[1071] Section 213B(2) of the School Education Act.

Kimberley Region, the Department of Education currently manages Broome Residential College in accordance with the School Education Act.[1072]

1716. A number of witnesses who gave evidence before the Inquest were questioned regarding the desirability of the establishment of such facilities. There were witnesses who supported it and others who did not.

1717. The Broome Residential College is the only Department of Education student residential college in the Kimberley. There are two other student residential colleges, one operating in Kununurra (Kununurra Aboriginal Student Hostel) and the other in Fitzroy Crossing (Yiramalay School) that are not affiliated with the Department of Education.[1073]

1718. As at semester one 2017, the Broome Residential College had 102 student residents – 98 Indigenous and 4 non-Indigenous. By 27 June 2017 there were 83 – 80 Indigenous and 3 non-Indigenous residents. Student residents ranged in ages from 12 to 18 years and attended Broome Senior High School or St Mary's College, Broome.

1719. In her report to the coroner Emeritus Professor Judy Atkinson, whose evidence is referred to previously, addressed the importance of safe places for children to learn and further their education within the Kimberley Region. In her opinion such boarding schools should be trauma informed, with staff having trauma specific skills to help children heal. The curriculum in such schools should focus on cultural change and cultural continuity: "*so that young people understand that there is both change and continuity and that they are part of it.*"[1074]

1720. This perspective was also supported by a number of other witnesses at the Inquest, who highlighted the importance of residential colleges being culturally appropriate, involving "*wrap-around services*" and being developed in consultation with the local communities:

a. Mr Williams, principal of Derby District High School, whose evidence is referred to previously, highlighted the importance of a residential college being situated close to the child's family, having regard to Aboriginal persons' strong cultural identity; he considered that Broome Residential College "*works very, very well*" but cautioned against

[1072] Ex 1.5, Tab 50.
[1073] Exhibit 1.5, Tab 50; ts 706.
[1074] Exhibit 1.3, Tab 13.

assuming that it would work in all locations in the Kimberley;[1075]

b. Mr Neil Morison, head of the boarding school at Nhulunbuy High School in Arnhem Land in the Northern Territory, in a township of approximately 3,000 people, gave evidence about the success of their residential facility attached to the high school; they have 300 students at the high school, approximately 40% are Indigenous Yolngu students, and at the residential facility there is accommodation for 40 students; he spoke of the importance of consultation: "*Yolngu Elders of the area, so they've been with us on the whole journey from even the design and implementation of the building.*"[1076]

c. Ms Maureen Carter, CEO of the Nindilingarri Cultural Health Service in Fitzroy Crossing considered a residential college to be a short term solution; she cautioned against removing a child from their family and community and expressed a preference for more work being done to support and empower families and communities;[1077]

d. Ms Emily Carter, CEO of the Marninwarntikura Fitzroy Women's Centre, whose evidence is referred to previously, highlighted the importance of there being a choice regarding participation in a residential college;[1078]

e. Ms Tonii Skeen, whose evidence is referred to previously, provided a young person's perspective; whilst she did not attend Broome Residential College, she spoke highly of the contribution it can make to a young person's education and noted the importance of any such college being proximate to the child's family and community, on "*Kimberley soil*" so that the child can further his or her education whist continuing to have access to family and being able to go out on country.[1079]

1721. Counsel Assisting submits to me that there is considerable merit in extending residential colleges beyond Broome and Kununurra. The evidence regarding the plight of the number of the children and young persons whose deaths were investigated demonstrated a

[1075] ts 526 to 527.
[1076] ts 2091.
[1077] ts 938.
[1078] ts 742.
[1079] ts 577.

dysfunctional and traumatic existence. By age 12, most of them had very low school attendance rates.

1722. The existence of a residential college in close proximity to their families in a culturally appropriate environment with the necessary wrap around services would improve the wellbeing of children who witness domestic violence and alcohol abuse and who are subjected to overcrowding at home, neglect or abuse.

1723. Attendance at such a residential facility would have to be with the permission of the child's parents or caregivers, and the consent of the child.

1724. Remaining close to their family and on country would alleviate the home sickness experienced by those children who are currently sent to boarding school interstate or to other regions of Western Australia.

1725. The Department of Education through its lawyer the SSO submits to me that whilst it is open to expand student residential colleges, it does not support this recommendation in its current form as residential facilities operated by the Department for school aged students across the Kimberley would not necessarily be culturally or developmentally appropriate in all circumstances.

1726. However, the Department of Education sounds a note of caution by pointing out that its role in addressing disadvantage is primarily about the delivery of education, and not in providing residential facilities for the purpose of removing children from dysfunctional home environments. They draw attention to the following evidence:

a. Historical concerns;

b. The need to ensure that they retain their educational value;

c. That it could be seen as a punitive measure and thus must be done with the full support of the community;

d. That there must be an extensive consultation process;

e. That it could work in some places but not others because of the different people;

f. Each community having different needs and preferences around their secondary school aged children accessing educational programs in government and non-government schools;

g. If it involves primary school students, the prospect of the separation of young children from their families, which

could sever that primary relationship at a very young age.[1080]

1727. The Department of Education also submits that it is necessary to consider the future development of student residential colleges in the Kimberley Region within the context of, not only their statutory duties, but also the historical and cultural context and sensitivities for individual Kimberley communities on a case by case basis.

1728. The Department of Education draws attention to the evidence of Mr Neil Morison, head of the boarding school at Nhulunbuy High School in the Northern Territory. In Mr Morison's experience, it only worked out if the young person, not just the families, wanted to attend the boarding school.[1081]

1729. The Department of Education considers it essential to have the support and involvement of each local community when considering options to ensure there is community connection and cultural support. They would only consider further residential colleges with voluntary admission arrangements as currently apply.[1082]

1730. The Department of Education also suggests the option of exploring the potential for smaller residential housing that may resemble more of a group home closer to home than the Broome facilities.

1731. The Department of Education accepts that residential facilities may provide a routine for young people by creating consistency in the domestic environment, and informs me that it will continue to consult with Aboriginal communities to explore options for expanding the types of student residential colleges established under the School Education Act. In respect of the Broome Residential College, they ensure that consultation occurs, with the College Manager and associated school staff touring the Kimberley to speak with parents and students from remote communities every two years.[1083]

1732. The ALS submits to me that there may be a case for further residential colleges in the Kimberley Region, but submits that rigorous consultation with Aboriginal cultural groups in the

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[1080] ts 77;ts 387-388; ts 526; ts 661-662; ts 1584; ts1586/

[1081] ts 2098-2099.

[1082] *School Education (Student Residential Colleges) Regulations 2017* (WA), r 6.

[1083] Exhibit 1.5, Tab 50; ts 1586.

Kimberley Region ought to take place before embarking on it, and highlights the importance of such colleges being culturally appropriate.

1733. This is clearly a significant undertaking. My recommendation is made in the context of the difficult home environments endured by the children and young people whose deaths have been investigated at the Inquest, and the likely impact it had upon their schooling.

Recommendation 40:

That consideration be given to residential facilities being built for school aged students in the Kimberley Region, after consultation with local Aboriginal communities, and that any such colleges be co-designed and informed by the principles of self-determination, cultural continuity and empowerment.

Further that admission is voluntary, with the consent of the parents and/or caregivers, and the consent of the child.

Recommendation 41 – Remuneration for CEO's of Aboriginal Communities

1734. The Inquest heard that the CEOs from two Aboriginal communities that it visited were not paid for their work and were not being reimbursed for the expenses they personally incurred in undertaking the role of CEO of their respective communities.[1084]

1735. Ms Gunn of the Department of Planning, Lands and Heritage was of the view that this question of remuneration of such CEOs could be the joint responsibility of the State and Commonwealth Governments.

1736. The Department of Communities through its lawyer the SSO, submits to me that Aboriginal Communities employ their own CEO's and it is a matter for those communities as to what and how they pay their CEO's.

[1084] Exhibit 15A; Exhibit 15G.

1737. The role of CEO's of Aboriginal communities ought to be supported and encouraged. These people are making a huge personal committment to the wellbeing of their communities, and their efforts are to be commended. It ought not be expected that they continue to fulfil these roles without some form of remuneration, or at least reimbursement, where appropriate.

Recommendation 41:

That a policy be introduced that ensures those who appropriately act as CEOs of their Aboriginal communities are either remunerated for their efforts or, at the very least, reimbursed for expenses incurred in executing that role.

Recommendation 42 – Mutually agreed outcomes

1738. The Education and Health Standing Committee in its report: "*Learnings from the Message Stick*" addressed the importance of empowering Aboriginal communities and referred to the research undertaken by Chandler and Lalonde (also referred to previously in this finding) that was able to link empowerment within Indigenous communities in Canada with a very low, or zero youth suicide rate. The Committee referred to Professor Pat Dudgeon's research report for the Telethon Institute of Child Health Research: "*Hear our Voices*", that describes empowerment as a process of healing, and a process of "*decolonisation*", redressing the ongoing inequality experienced by Aboriginal persons.[1085]

1739. The Education and Health Standing Committee was alive to the need for the government to be prepared to share its power with Aboriginal communities in order to achieve true empowerment:

> "*Empowering Aboriginal communities requires Western Australian Government agencies to relinquish their power when setting and implementing policies for Aboriginal people and undertake a fundamental shift in the way government does business.*"[1086]

[1085] Exhibit 1.1, Tab 2.
[1086] Ibid.

1740. In his report to the coroner, Senator Patrick Dodson, whose report to the coroner is referred to previously, submitted that there is a need for structural reform that involves a devolution of power:

> "*If we are serious about giving effect to the notion of empowerment, we must move beyond mere consultation and give serious consideration to how we can incorporate the idea of free, prior and informed consent in policy and practice. I have long advocated an agreement making approach which results in the negotiation of mutually agreed outcomes. Whether one calls this a treaty, compact or regional agreement, it must include a mechanism to devolve sufficient power to enable local/regional agreed outcomes based on Indigenous people's aspirations and indicators for well-being. Importantly, it must set out the service delivery responsibilities for both the state and Aboriginal communities to achieve these targets.*"[1087]

1741. KCLS draw my attention to the right of Indigenous people to self-determination as recognised in Article 3 of the *United Nations Declaration on the Rights of Indigenous Peoples* (2007), which was endorsed by the Australian Government in 2009. Article 3 of the declaration states: "*Indigenous peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.*"

1742. The Department of Premier and Cabinet, through its lawyer the SSO, as outlined previously submits to me that the Western Australian Government seeks to adopt a new way of working together, by ensuring Aboriginal Western Australians have input into place-based policy formation, government priorities, commitments and practice. This includes Aboriginal engagement in co-identification of place-based priorities, future targets and overall indicators of positive change. They inform me that this represents a significant shift in policy and practice for government agencies and they properly anticipate that it will require time to nurture and embed in the public sector new ways of working with Aboriginal people and communities.

1743. This submission is well-received and the sentiments are to be commended. I have made this recommendation my final one, as it stands alone, but also, if the principles are introduced, they will

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[1087] Exhibit 1.3, Tab 18.

guide the implementation of many of the previous recommendations, if that course is chosen.

Recommendation 42:

I recommend that:

- **The principles of self-determination and empowerment be given emphasis in initiatives, policies and programs relating to Aboriginal people in Western Australia and that the Western Australian Government introduce measures to enable Aboriginal people and organisations to be involved in setting and formulating policy that affects their communities;**

- **That in developing such measures, consideration be given to negotiating mutually agreed outcomes, with service delivery responsibilities as between the Western Australian Government and Aboriginal people and organisations; and**

- **The Western Australian Government develop a state-wide Aboriginal cultural policy that recognises the importance of cultural continuity and cultural security to the wellbeing of Aboriginal people in this State.**

CONCLUSION

1744. The situation in the Kimberley Region is dire and children and young persons have continued to die by suicide, despite the valiant efforts of service providers, despite the increased Governmental funding, despite a better understanding of the importance of being culturally competent, and despite the numerous initiatives being implemented to avoid these preventable deaths.

1745. The considerable services already being provided to the region are not enough. They are still being provided from the perspective of mainstream services, that are adapted in an endeavour to fit into a culturally relevant paradigm. It may be time to consider whether the services themselves need to be co-designed in a completely different way, that recognises at a foundational level, the need for a more collective and inclusive approach towards cultural healing for Aboriginal communities.

1746. If the cultural healing is able to occur at the community level, underpinned by the principles of self-determination and empowerment, there is a prospect of the benefits of this healing being passed on to children and young persons, through stronger, safer, more resilient communities, and families.

1747. If this course is chosen it will require significant commitment of funding and a preparedness to engage with the Aboriginal communities to co-design the services. It will also require both short and long term perspectives to be taken of the factors that give rise to the unacceptable levels of poverty within the region, and that generate the social determinants of ill health.

1748. Whilst the stated aim of giving people the incentives to bring themselves out of poverty (through better health services, education and employment prospects) is very sound, some consideration needs to be given to those people who are presently beyond being able to take advantage of those incentives.

1749. It is my hope that more resilient communities and families will mitigate the types of pre-existing vulnerabilities that were evident in the children and young persons whose deaths have been investigated by this Inquest.

R V C FOGLIANI
STATE CORONER
7 February 2019