CITATION: *Inquest into the death of Kunmanara Forbes* [2009] NTMC 024

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Coronial
FILE NO(s):	A0085/2006
DELIVERED ON:	4 June 2009
DELIVERED AT:	Darwin
HEARING DATE(s):	22 – 24 April 2009 in Alice Springs
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Hanging of young person – petrol sniffing – sexual abuse – remote communities - effectiveness of FACS and other government intervention – police delay in coronial investigation

REPRESENTATION:

Counsel:

Assisting: Ms Helen Roberts
For Commissioner of Police: Mr John Stirk
For NT Department of Health and Families: Mr Kelvin Currie

Solicitors:

For Commissioner of Police: Mr Tom Svikart
For NT Department of Health and Families: Ms Sylvia Cecchin

Judgment category classification:	B
Judgement ID number:	[2009] NTMC 024
Number of paragraphs:	55
Number of pages:	22

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No.

In the matter of an Inquest into the death of

Kunmanara Forbes

ON 15 December 2006
AT Mutitjulu in the Northern Territory

FINDINGS

(Delivered in Darwin 4 June 2009)

Mr Greg Cavanagh SM:

INTRODUCTION

1. Kunmanara Forbes had just turned 15 when she died in Mutitjulu in 2006. Due to the sensitive nature of the circumstances leading up to her death, I ordered that her name not be published in media reports of the inquest or these findings. Her full name appears in the formal part of these findings as is required by the *Coroners Act*, but otherwise she will be referred to as Kunmanara, a traditional name for female Aboriginal persons who have passed away from Mutitjulu and surrounding areas.

2. On 15 December 2006 Kunmanara Forbes was found deceased by family members and a nurse in bushland surrounding the Mutitjulu community in Central Australia. She had apparently hung herself using an electrical cord. There is evidence, later referred to, which satisfies me to the required standard that she took her own life. Her death was therefore reportable to the Coroner as it was an *unexpected* and *unnatural* death.

3. The circumstances of her death were investigated on my behalf by members of the NT police, which is the practice in respect of all deaths reported to the Coroner. The time taken for the investigation to be completed to the

required standard was over 2 years, an unacceptable delay which has impacted upon my findings in this matter. I return to this issue later.

4. Pursuant to my discretion under s15 of the *Coroners Act*, I decided to hold a public inquest into the death of Kunmanara Forbes. There were a number of circumstances which led me to exercise that discretion. In the 6 months prior to her death (and at some earlier times also) Kunmanara Forbes was the subject of attention and interest by both NT Police and the NT Department of Family and Children's Services (FACS) as the possible victim of sexual abuse. The purpose of holding this inquest was to inquire further into actions taken by both of those agencies, but primarily FACS, in the period leading up to the death; to consider whether her death could have been prevented by further or different action; and to hear evidence of any relevant policy changes that have taken place in the period since Kunmanara Forbes' death.

5. Counsel assisting me at this inquest was Ms Helen Roberts. Mr Stirk sought and was granted leave to appear on behalf of the Commissioner of Police. Mr Currie sought and was granted leave to appear on behalf of the Department of Health and Families. Ms Katrina Jingo, the mother of Kumanara Forbes, was made aware of the inquest proceedings through direct contact with Detective Butcher. She has provided 3 statements as part of the investigation and she speaks English well. She attended court on Day 2 of the inquest and had a conference with Detective Butcher and Ms Helen Roberts. The purpose and nature of the proceedings were explained to her. She indicated that she understood but did not wish to come into Court and listen to any of the evidence as she would find it distressing.

6. A comprehensive brief of evidence was submitted to my Office by Detective Sergeant Butcher, containing approximately 60 witness statements (Exhibit 2). A number of files in the deceased's name were seized from medical clinics, police, FACS and ADSCA and tendered in evidence (Exhibit 3). I

also received in evidence a statement with a number of annexures from Detective Senior Sergeant Lauren Hill, a lengthy report with a number of annexures from Ms Jenny Scott, Executive Director of NT FACS, and a statement from Assistant Commissioner McAdie. The inquest was assisted by having access to files provided to my counsel assisting by NPY Women's Council (although those files were not tendered in evidence).

7. At the inquest I heard oral evidence from the following witnesses: Detective Sergeant Carmen Butcher, Dr Rob Roseby, Kenny Presley, Nicole Sutterby, Detective Sergeant Lauren Hill, Senior Constable Michael Deutrom, Susan Carlyle, Lance Carmichael, Jenny Scott, Craig Wotherspoon and Assistant Commissioner Mark McAdie.

8. Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

9. Section 34(2) of the Act operates to extend my function as follows:

> "A Coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

10. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

"(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

Formal Findings

11. Pursuant to section 34 of the *Coroner's Act* ("the Act"), I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the deceased person was Veronica (aka Veronic) Forbes born 10 November 1991. The deceased resided primarily at Mutitjulu community in the Northern Territory of Australia.

(ii) The time and place of death was Mutitjulu community between 9:30am and 4:30pm on 15 December 2006

(iii) The cause of death was hanging (self inflicted).

(iv) Particulars required to register the death:

1. The deceased was Veronica Forbes.

2. The deceased was of Aboriginal descent.

3. The cause of death was reported to the Coroner.

4. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton on 20 December 2006.

5. The deceased's mother is Katrina Nabaltjari Jingo and his father is Kevin Forbes.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

12. Kunmanara Forbes was born on 10 November 1991 in Alice Springs to Katrina Jingo and Kevin Forbes (now deceased). She usually lived at Mutitjulu community with her mother. However, as is not unusual for Aboriginal people in Central Australia, she moved around a lot, particularly during the last year of her life. During 2006 she lived, variously, at Areyonga, Ernabella, 5 Mile Outstation (near Hermannsberg/Ntaria), Nyrripi, Alice Springs town camps, and Mutitjulu. Records of NT government schools and the relevant college at Yulara have been searched and it appears from those searches (and consistently with her itinerant lifestyle) that she did not attend school at all during 2006 when she was 14.

13. For about a month prior to her death she had been living in Mutitjulu. On the morning of 15 December 2006 she had an argument with her mother over cigarettes or money for cigarettes. It led to a physical fight although neither was injured. She was seen running into bushland holding an electrical cord. Some attempts were made by family to look for her before they contacted police, several hours later. Later that day she was found by family members hanging from a tree by the power cord. Nurses were on the scene very shortly afterwards but they found no signs of life. A post-mortem examination was carried out by Dr Sinton on 20 December 2006, and the cause of death found to be hanging. A toxicology report records that no drugs were detected in a body cavity fluid test. A small alcohol reading was detected but as this was in body cavity fluid (rather than a blood test) it is not necessarily indicative of alcohol consumption prior to death.

14. The police investigation into the immediate circumstances of her death has satisfied me that no other person was involved in her death. In light of the evidence of an earlier suicide attempt by the same means (hanging),

statements made by Kunmanara Forbes to others in the period leading up to her death to the effect that she wanted to hurt herself or kill herself, and the manner of her death, I find that she intentionally caused her own death.

15. The chronology of the deceased's involvement with NT government and non-government agencies relevantly commences in 2003. She was the subject of a Child Concern Report from the NPY Women's Council to FACS on 30 May 2003, and a further similar report on 3 July 2003. The hard copy of the May referral was found on an NPY Women's Council file relating to the deceased's mother and was tendered as Exhibit 6. It did not form part of the hard copy FACS file produced to the Coroner and was not, apparently, part of the material available to the caseworker Susan Carlyle when she first received a referral about Kunmanara Forbes in October 2005 (Transcript Carlyle p74). It was, however, available on computerised FACS records (Statement Jenny Scott, and Transcript Wotherspoon p108).

16. Nicole Sutterby is a registered nurse who commenced employment as a substance abuse worker in the Mutitjulu community in September 2005. She had prior experience with young people and addiction issues in Victoria, and she had spent 12 months as a nurse at Wadeye in the Northern Territory. Kunmanara Forbes became one of her clients with respect to petrol sniffing. Ms Sutterby gave evidence that she became concerned that Kunmanara Forbes had been subject to sexual abuse: specifically, that she was engaging in sexual behaviour with adult men of the community at a 'petrol sniffing house'. No complaints or admissions about this were made to Ms Sutterby by the deceased herself. Nevertheless, Ms Sutterby spoke to the mother and grandmother of Kunmanara Forbes about it, along with the mother of one of the suspected abusers. It was agreed that efforts would be made between the older women to keep the teenager away from the house. Ms Sutterby also reported her concerns to FACS and police in late October 2005. The deceased was at that time almost 14 years old. (It should be noted that Ms Sutterby gave evidence that she kept notes of dealings with her clients, and

that they were stored at the Health Clinic, but separately from the medical files. I accept that she did so).

17. Police at Yulara referred the matter to FACS, and so FACS received two reports relating to the same concerns at about 25 October 2005. The Child Concern Report was to the effect that Kunmanara Forbes was a 'long term petrol sniffer' and it was thought she was selling sex to get petrol from two adult men (who were named in the report). At this time Ms Carlyle, on behalf of FACS, made an assessment to the level of Child Concern, and two weeks later on 15 November 2005 she visited Mutitjulu to complete a "Full danger assessment and plan".

18. During that visit she spoke with an Aboriginal Health Worker who gave the opinion that the reports of sniffing and sexual abuse were true. At the same visit Ms Sutterby told Ms Carlyle (and this was confirmed by Ms Sutterby in her evidence at this inquest) that she had seen an improvement in Kunmanara's self-esteem and presentation over the past couple of weeks. It seems these improvements were attributed to intensive efforts that had been made with her by Ms Sutterby, and, it appears, a youth worker then employed at Mutitjulu (whose statement is part of Exhibit 2) to engage her in positive activities rather than sniffing petrol. Further conversations with a school teacher, with Kunmanara's grandmother Judy Trigger and some observations of Kunmanara herself satisfied Ms Carlyle that there had been some improvement and that she was, by FACS criteria "conditionally safe".

19. Ms Carlyle's case notes refer to the need for Kunmanara to attend at the Health Clinic for 'sexual health screening', and a verbal assurance by the Aboriginal Health Worker that this would be attended to. The reason this was thought important was obviously related to the above concerns about sexual abuse.

20. In fact, by November 2005, according to the Mutitjulu health clinic notes, Kunmanara had already tested positive to both Chlamydia and gonorrhoea, a

matter which Ms Carlyle agreed would have been relevant to her risk assessment (Transcript p 80). She did not look at Kunmanara's medical notes when she visited in November 2005 to conduct her risk assessment, but rather relied on anecdotal information given to her verbally by the Aboriginal Health Worker already referred to. Ms Carlyle had no clear recollection of the reason why she did not see the notes on that visit, although she assumed based on other experience visiting Mutitjulu that it was because clinic staff did not have time to show them to her.

21. It is clear that the medical records contained information highly relevant to any risk assessment being carried out by a FACS caseworker. In this particular case, those records indicated that Kunmanara had been sexually active, having tested positive to two sexually transmitted diseases at the age of 13 years. Further, there was an entry concerning an allegation she made that she had been beaten by her brother. This particular event was described to Ms Carlyle, by family members, as "traditional punishment" for petrol sniffing. The version (supported by injuries) contained in the medical notes was 'significantly different' from that (Transcript p82). Similarly, this information was relevant to the assessment that FACS was there to carry out in relation to Kunmanara Forbes' family situation and safety.

22. Ms Carlyle was asked a number of questions about her reliance upon verbal assurances rather than insisting upon seeing the medical records. At p 82:

Q *What do you think about that [the assurance that sexual health screening would be carried out] now that you know that [the health worker] has told you there was going to be screening but in fact there'd already been diagnosis of sexually transmitted infections, the information about which appeared on the medical file that you weren't shown. Does that make any difference to how you now view that assurance?*

A Obviously, in hindsight, of course it does. I mean, but the reality at the time is the clinic was incredibly chaotic and it was often difficult to get

information out of any of the staff there at that time. They were short staffed and I had to rely on another worker's verbal assurance that she would follow through.

23. I heard other evidence which suggested both directly and indirectly that there were problems with the efficient operation of the Mutitjulu Health Clinic at the relevant time. The notes made by Ms Sutterby were not able to be found by police. She gave evidence that she was discouraged by the clinic director from reporting her concerns about Kunmanara to FACS, unless "the family agreed". Shortly after this, Ms Sutterby's employment was terminated much earlier than her contract had originally intended. There was very high staff turnover at the clinic in 2005 and 2006. I could not take this issue any further at this inquest because of the substantial delay in any of these matters of fact being investigated by police. For example, Ms Sutterby's notes, made in late 2005, were not searched for until October 2008. In those circumstances, I can draw no conclusions whatsoever from the fact that they could not be located. Witnesses were not asked to recall important conversations or events on this subject until Detective Butcher took over the investigation of this matter 18 months after the death. The question of why Ms Carlyle did not see the important medical notes in November 2005 is but one example of those events. The reason for the termination of Ms Sutterby's employment is another such example. In those circumstances, no reliable findings of fact about any role played by the Clinic or its staff in the relevant events can be made and I do not propose to attempt to do so.

24. However, I think it can fairly be said that there were at least, "governance issues" plaguing the Mutitjulu community in 2005 and 2006. So much clearly emerged from evidence given (and my own observations) at my previous inquest into the deaths of two Mutitjulu men from petrol sniffing, held in 2005 which sat for one day at Mutitjulu itself. It is a matter of public record that the Australian government appointed an administrator to the

Mutitjulu Community Aboriginal Corporation in mid 2006, although that appointment was challenged through the Federal Court, ultimately successfully, on administrative law grounds. In addition, the ABC screened a Lateline program in June 2006 which aired allegations that there was a "sex for petrol" trade going on in the Mutitjulu community. The joint police and FACS taskforce, referred to as Operation Prell, was set up to investigate those and related allegations, and it must be assumed that both the investigation itself, and the intense publicity, had some effects upon community members.

25. I return to the timeline of events with respect to Kunmanara Forbes and her involvement with FACS. After the November 2005 visit and risk assessment, she was assessed as "safe", but the file kept open. The significant events of 2006 were as follows.

26. In January 2006 Ms Carlyle contacted the Mutitjulu Health Clinic to check on the sexual health screening and was told it had not yet occurred. This information, apparently provided verbally by whomever it was that answered the phone, was misleading in that it did not disclose the fact that a diagnosis of STIs had already been made in relation to Kunmanara.

27. Kenny Presley was employed as an Aboriginal community welfare worker with Alice Springs FACS between 2005 and April 2008. In early May 2006, he was travelling to Hermannsberg to visit a number of his own clients, and he was requested to check on Ms Carlyle's client, Kunmanara Forbes. Ms Carlyle had received some information that Kunmanara was staying at 5 Mile outstation (near Hermannsberg). When he arrived Kunmanara was not there but her mother Katrina Jingo was there. Mr Presley had never met either Ms Jingo or her daughter. He was told a number of things by Katrina Jingo which he recorded in the Case Notes. In summary, he was told that Kunmanara Forbes was not sniffing petrol if and when she stayed at 5 Mile outstation but that she often 'ran away' to Hermannsburg (where the

inference was that she was sniffing petrol) contrary to the wishes of her mother. Ms Carlyle accepted based on this information (which she conceded was limited) that Kunmanara Forbes was at that time "still within the family unit" in terms of care. In June a number of people advised Ms Carlyle that Kunmanara was living between town camps in Alice Springs. She received conflicting information about Kunmanara's health and petrol sniffing. Despite some visits to Alice Springs hospital (where relatives were staying) and a couple of addresses in Alice Springs, Ms Carlyle did not locate Kunmanara.

28. On 6 July 2006, police located Kunmanara Forbes at a town camp in Alice Springs and brought her to the police station with her mother for an interview by the Operation Prell investigators. Ms Carlyle was assisting the Operation Prell and between late June and July, she travelled to a number of remote communities with police for the purpose of the investigations. On 6 July 2006, FACS in Alice Springs advised the interviewing police that they had "no one available" to attend the joint Taskforce interview with Kunmanara Forbes. By unfortunate coincidence, Ms Carlyle was travelling to Mutitjulu that day in connection with Operation Prell. After the interview, police reported back to FACS that although she had disclosed no matters of a criminal nature, they still had concerns about Kunmanara. That is contemporaneously recorded on the PROMIS system but does not appear on the FACS file. Ms Carlyle was not aware of it at the time (Transcript p88). This lack of coordination and communication appears on a number of occasions in the history of this matter. The unavailability of any FACS representative to attend a "joint" interview with a client about whom they apparently had ongoing concerns clearly highlights the staffing problems within FACS in Alice Springs in 2005 and 2006 about which I heard evidence.

29. In the early hours of 5 August 2006 Kunmanara Forbes was taken to Nyrripi Health Clinic by extended family reporting that she had attempted suicide by

hanging. She was seen by Nurse Christina Whap. Her presentation was consistent with what was reported. Nurse Whap consulted with the District Medical Officer, Dr Arcus. The preferred option was for Kunmanara to travel to Alice Springs to be seen at the hospital. She refused to do this. Had the DMO insisted, Kunmanara would have been sedated for air transport, an option which carries its own risks. It was decided, after ongoing consultation, that the family would take her to Yuendumu (where they had already planned on travelling for the sports weekend) and she could be seen by a doctor at the Clinic there. This was a sensible option in all of the circumstances, which were carefully considered by the health professionals involved. Kunmanara was driven to Yuendumu where she was taken to the Clinic by relatives. However, Yuendumu Clinic had no notes recording a visit and the GP on duty could not recall a visit. It is unknown whether she waited to be seen. Again, this is a factual matter which was not investigated by police until Detective Butcher took over carriage of the file, and it is really now too difficult to reliably resolve. Nothing further occurred in relation to this serious incident.

30. On 5 September 2006 Ms Carlyle went to Mutitjulu but at that time Kunmanara Forbes was not there. Enquiries led Ms Carlyle to speak to Gilbert Forbes, a grandfather of Kunmanara, at Hermannsberg on 24 October 2006. He told her that Kunmanara had been sent to live with his sister in law in Ernabella because she had been "running around being cheeky and sniffing petrol". Ms Carlyle later spoke to the sister in law who confirmed Kunmanara had been with her for some period, but had now 'run away' back to Mutitjulu.

31. Further, Mr Forbes told Ms Carlyle about the Nyrripi suicide attempt. In relation to the suicide attempt, Ms Carlyle's evidence was that when she returned to Alice Springs she telephoned Nyrrripi Clinic but spoke to a very busy person who could not give her any information. This is not recorded in the case notes but I accept it occurred. Nevertheless, further efforts could

have been made. Ms Carlyle said that referral to Mental Health services so far down the track (3 months after the incident) would have been pointless (Transcript p97), but Craig Wotherspoon, the Manager of Alice Springs FACS said that further information should have been pursued, and that the Mental Health Referral should have been made regardless of the delay (Transcript p112).

32. On 31 October 2006 a psychologist employed with the Central Australian Mental Health Service, Mr Lance Carmichael, was in Mutitjulu and spoke to Kunmanara Forbes. In evidence, he said he had been asked by one of the health workers to speak with her about her school attendance (or lack thereof). He had a short conversation with a teenage girl whom he assumed was Kunmanara Forbes at a house in Mutitjulu. He was not given, nor did he seek, any background information about Kunmanara. She was 'difficult' to talk to which he did not find surprising in the circumstances. By way of follow up, Mr Carmichael spoke with an employee of the school. Neither Mutitjulu Clinic nor FACS was made aware of this contact. Despite Mr Carmichael's evidence to the contrary, I do not find that this conversation constituted a mental health consultation. It was an unfortunate missed opportunity.

33. On 20 November 2006 the Mutitjulu Clinic File records a diagnosis of syphilis in relation to Kunmanara Forbes. She was given antibiotic treatment and the central database (notifiable diseases) was advised. There is no evidence of communication with FACS.

34. On 6 December 2006 Susan Carlyle formally referred Kunmanara Forbes for assessment under the *Volatile Substance Abuse Act.* She explained in evidence that her decision to do so was borne of frustration. At transcript 93:

I hadn't been able to locate the young person, I hadn't been able to engage with her. Our resources were completely stretched. We now had the capacity

to be able to make referrals to the VSA so it seemed like the appropriate thing to be doing that if this young person obviously needed a service the referral needed to be made.

35. On 7 and 8 December 2006 Kenny Presley was in Mutitjulu. He was again asked to see Kunmanara Forbes. Kunmanara was reluctant to engage him but claimed she had not sniffed for 'two weeks'. Mr Presley observed that she looked very thin and sickly and that she was losing hair. Her appearance caused him great concern, and he noted that it was also causing her concern, in that "it was a shame job for a young girl" to have hair loss (Transcript p 39). (Indeed the alopecia is noticeable in the autopsy photographs.) Mr Presley told Kunmanara and her mother about the referral to the Volatile Substance nurse.

36. In late 2006 the process for referrals under the VSA had some problems; it took a long time for approval to be given, and there had been some difficulties with approval of particular treatment centres. Indeed there was no appropriate facility for adolescent girls in Central Australia to go for residential treatment. However, I heard consistent evidence that the situation has now changed and is operating much more effectively. In any event, there was insufficient time for this issue to arise for Kunmanara Forbes, as she died on 15 December 2006.

37. Dr Rob Roseby is the head of the Department of Paediatrics at Alice Springs hospital and has held that position for over five years. He agreed to review the medical notes and relevant parts of the coronial brief in order to assist this inquest. In his expert opinion, there were clearly a number of protective concerns in relation to the deceased for a couple of years before her death, which were not limited to the actual suicide attempt in August 2006. He gave an opinion as follows (Transcript p28):

... she was itinerant, she had no one looking over her to pick up on whether things were going okay or not going okay and when things were falling

down, as they so obviously were. There was no family around, no consistent family member taking responsibility for this girl to help to set her on the right track and to make sure that she had the appropriate assessments and the help that would come from those assessments. So all of that's missing. And she had a whole lot of physical and behavioural concerns that would have or should have raised her case to a higher level basically ...

...there are two agencies that if they were involved should have, could have and should have picked up the severity of this case and severity of risk in this case and done something more about it. The first is Family and Children's Services and the second is Remote Mental Health Service.

(Transcript p 30)

...when I was reading through the file knowing the outcome as we do, it was almost like seeing a horror movie where you know what's going to happen at the end and you just want someone to ask the particular questions or

Q All the flags were there and no one – no institution or no one in particular picked up how serious it was? A No one put it all together. I think that people did pick up that there were some serious things here, some serious things there, but no one actually brought the case together.

38. Given the lack of effective involvement of Remote Area Mental Health (discussed above) it was Dr Roseby's view that FACS had a responsibility to "pull the case together" (Transcript p31-32). Although Ms Scott gave a somewhat qualified assent to this proposition (Transcript p122-123), the contrary was not put to either Dr Roseby in questioning nor me in submissions by counsel for FACS. I find that in all the circumstances FACS was the appropriate organisation to organise a case conference and should have done so in relation to the deceased, so that the disparate pieces of information about her physical and mental health, wellbeing, and whereabouts which were in the hands of different organisations could be

brought together at a time when she was still alive, and a plan made to assist her.

39. There is evidence before me there now exists an ongoing joint Taskforce (jointly between NT Police and NT Families and Children) established to respond to reports of child abuse in the Southern Region of the Northern Territory. The officers from each organisation are actually physically located in the same offices in Alice Springs. It is intended that the Taskforce provide a coordinated response and simultaneously investigate both criminal and safety aspects of the matters reported to it. Detective Sergeant Butcher gave evidence that the taskforce has been operating effectively over the last five or six months and is currently operating well. Similar comments were made by representatives from FACS. Ms Scott also gave evidence of improved protocols between FACS and NGOs including NPY Women's Council in relation to the sharing of information. Due to these changes in particular, I do not propose to make any formal recommendations which are applicable to FACS (now NT Families and Children) in this case.

40. Ms Scott also gave evidence about an information sharing scheme between remote Clinics and NT Health whereby all of a particular patient's health information can be stored on a central database and accessible to all health professionals who may deal with the patient. It has obvious advantages in Central Australia where it is common for people to move around a lot. However, my understanding is that this scheme requires both the consent of the patient, and the active cooperation of the particular Clinic or health professional, and so it is limited in that way. I could not say with any confidence that the availability of such a scheme would have made a material difference to the information flow to and from the Mutitjulu Health Clinic in this particular case. I am not aware whether the Mutitjulu Health Clinic even now is one of the remote clinics which cooperates with the Scheme.

41. Dr Roseby told the inquest that despite the very high risk adolescent population in the Northern Territory, we are the only jurisdiction in Australia without a specifically targeted adolescent health service. In his view this is a "huge gap" (Transcript p29). The purpose of such a service would be continuing education of other health professionals about adolescent health issues, the building up of expertise in the area of adolescent health, and a raised profile for the significant issues in the area. Dr Roseby has made this submission to the Health Department on another occasion and he believed it was "well received". He is hopeful that adolescent health will progress in the Northern Territory.

42. The evidence of Dr Roseby on this topic in the context of this case commended itself to me. Counsel for the Department of Health did not seek to dissuade me from this view and I propose to make a recommendation to this effect.

Police involvement with the deceased during her life

43. I have had the benefit of a comprehensive statement compiled by Senior Sergeant Lauren Hill, reviewing and commenting upon all recorded interactions between police and Kunmanara Forbes during her life. I was assisted by her very thorough analysis. She made some criticisms, primarily relating to the content or adequacy of PROMIS entries, none of which I need to comment upon further as I do not find they had any direct impact in this matter.

44. I heard evidence from Senior Constable Michael Deutrom who was stationed at Yulara during 2005 and up until July 2006, and then stationed at the (then new) Mutitjulu police station between July 2007 and December 2007. He gave evidence that petrol sniffing was a significant problem in Mutitjulu during the period he served at Yulara. When he returned after an absence of one year, this time to Mutitjulu, petrol sniffing had reduced so that it was either non-existent or not at all visible. Senior Constable Deutrom, who is

very familiar with Mutitjulu, attributes this dramatic change to the substitution of Opal fuel for petrol at Yulara.

45. Sergeant Dooley-McDonnell was one of the two police officers who interviewed Kunmanara Forbes on 6 July 2006 as part of Operation Prell. She is an experienced investigator in the area of child abuse and sexual offences. The interview was conducted with the assistance of an interpreter, and was professional and appropriate. Kunmanara Forbes disclosed no offences against her, indeed she disclosed no explanation as to how she may have contracted the sexually transmitted infections, which were specifically referred to by police later in the interview. Sergeant Dooley-McDonnell was not surprised by this lack of disclosure. In her experience, factors including community or cultural shame, lack of support systems, and adolescence itself all contribute to a difficulty for investigators in obtaining disclosures even when the surrounding circumstances strongly suggest there have been offences committed.

46. After the interview police remained concerned about Kunmanara's circumstances and safety and made a referral to FACS.

Delay in Coronial Investigation

47. As earlier stated in these findings, the elapsed time between the death and the submission of a final coronial investigation brief to my office was more than 2 years. Assistant Commissioner Mark McAdie made an unqualified apology for this delay, and appeared at the inquest to answer questions put to him about it.

48. The investigation was originally allocated to the then Sergeant in Charge of the Yulara police station (who has now left NT police and was not called to give evidence at this inquest). He carried out some investigations, and arranged for the seizure of some medical and other records, but did not pursue a number of issues including obtaining statements from FACS

workers, clinic workers etc. He submitted a file to his supervisor in Alice Springs approximately one year after the death, but the file was not deemed completed to a suitable standard at that time.

49. The location of the file (from a police administrative point of view) is unclear during the next several months but at one stage it was recorded on the PROMIS system as being with the Coronial Investigation Unit. A/Commissioner McAdie appropriately conceded that one of the major contributors to the delay in completion of this file was a lack of clarity, at times about who was in charge of the file and who was responsible for its timely completion (Transcript p134). In May 2008, Detective Butcher was temporarily transferred from Investigations Alice Springs to Yulara, to relieve as the Officer in Charge at Yulara (the previous officer in charge referred to, having by then taken long service leave). She was allocated the coronial investigation file as one of her tasks. She commenced the investigations while in Yulara and continued them upon her return to Alice Springs in about September 2008. Detective Butcher first submitted the file to her supervisor, Senior Sergeant Lauren Hill in November 2008. The file was returned to her, with S/Sgt Hill directing some further investigations to be carried out. The file was again submitted by Detective Butcher in early January 2009 and was delivered to my Office by S/Sgt Hill at the end of that same month. The coronial brief ultimately received was of a high standard. My counsel-assisting, Ms Roberts, has received all of the assistance and cooperation she has requested from both officers in preparation for the inquest.

50. Detective Butcher agreed in evidence that there were forensic disadvantages arising from having to commence an investigation some 18 months after the death had occurred and Assistant Commissioner McAdie also appropriately agreed that there are obvious problems associated with such a delay. He did not seek to assign blame to any particular individual but acknowledged that the responsibility lies with police management.

51. Assistant Commissioner McAdie gave evidence that the Coronial Investigation Unit in Alice Springs had changed its role in recent years, from a primarily administrative Unit, to a Unit with investigative, oversight, and liaison functions. Certainly the latter is how the Coronial Investigation Unit in Darwin operates under the supervision of Sergeant Anne Lade, and it does so very effectively. The Unit has a number of functions in addition to members attending deaths, carrying out investigations into some of those deaths, and coordinating a large number of administrative functions pursuant to the *Coroners Act* on behalf of the Coroner. One of the additional and important functions of the Unit is to offer advice to police members conducting investigations from other areas as to particular requirements of the Coroner; another is to review files when submitted as to their quality; and another is to carry out further investigations in particular matters of a specialist or complex nature. It was my understanding that the addition of a second member to the CIU in Alice Springs in early 2007, with an altered job description, was specifically directed towards this change in role, and intended to establish a structure which would operate in a similar way to the Coronial Investigation Unit in Darwin.

52. However, my Office has continued to experience significant delays with the submission of files from the Alice Springs region, and continues to receive files which are not of sufficient quality at the time of their first submission. Even at the time of this inquest, there were about 30 files from the Southern Command which were over six months old (that is, six months had elapsed from date of death with no file submitted). That is a significant proportion of matters, given that Southern Command has approximately 70-80 reportable deaths to investigate annually. (There was even an outstanding file from September 2006, which is not a case of any particular complexity justifying a lengthy delay).

53. Assistant Commissioner Commissioner McAdie's evidence was that in most cases, with some exceptions for unusually complex matters, a coronial

investigation should be completed between 6 weeks and 6 months after the date of death. This is a realistic and appropriate expectation, but it is not being met in a substantial number of cases, and this is unsatisfactory. Delays in coronial investigations are not only distressing and frustrating for family members and other persons and organisations involved with the deceased, but they compromise the accuracy, reliability and effectiveness of the investigation itself. In this particular case there were a number of factual matters which I could not resolve due to the delays. A/Commissioner McAdie acknowledged that it is a police management responsibility to ensure that appropriate timelines and standards are adhered to. As I indicated to counsel for police at the outset of the inquest, I propose to make specific recommendations in respect of this issue and I do so below.

Recommendations

54. For the reasons that appear above in these findings, I make the following recommendations pursuant to s35(2) of the *Coroners Act*.

(i) I recommend that the Police Commissioner ensure that the Coronial Investigation Unit in Alice Springs is appropriately staffed and resourced in order that the members of that Unit are able to, and do, exercise investigative, oversight and liaison functions in relation to deaths reported to the Coroner in the Southern Command in a similar way to the operation of the Coronial Investigation Unit in Darwin.

(ii) I recommend that the Police Commissioner put specific strategies in place to ensure that reportable deaths are investigated by police officers in the Northern Territory in a timely way, with the expectation being that a coronial investigation file of satisfactory quality will be submitted to the Coroner within 6 months from the date of death.

(iii) I recommend that the Director General for the Department of Health introduce an Adolescent Health Service within NT Department of Health.

Conclusion

55. The death of this young girl was tragic. There is some irony in the fact that her physical and mental health continued to deteriorate despite the spotlight which was being shone upon her community (and her) by NT government agencies, the Australian government, and the media. The sad lead up to her self-inflicted death is a reminder of the commonly difficult life circumstances for Aboriginal young people in Central Australia, and the continued responsibility of both the Aboriginal and wider community to maintain its efforts to improve these circumstances.

Dated this 4th day of June 2009.

_____

GREG CAVANAGH
TERRITORY CORONER