CITATION: *Inquest into the deaths of Michael Shane Chisholm, Aaliyaha Jane Webb and Julian Thomas Chisholm [2013] NTMC 006*

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0087/2012, D0088/2012 & D0089/2012
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DELIVERED AT:	Darwin
HEARING DATE(s):	19-22 March 2013
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Killing of children, suicide, police response to child welfare complaint, grief counsellor.**

REPRESENTATION:

Counsel Assisting:	Ms Elisabeth Armitage
Counsel for the Northern Territory Police:	Dr Ian Freckleton QC and Ms Elizabeth Reed

Judgment category classification:	B
Judgement ID number:	[2013] NTMC 006
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0087, 88, 89/2012

In the matter of an inquest into the deaths of

MICHAEL SHANE CHISHOLM,
AALIYAHA JANE WEBB
JULIAN THOMAS CHISHOLM.
BETWEEN 21 - 22 MAY 2012
AT 178 LEANYER DRIVE, LEANYER

FINDINGS

(15 May 2013)

Mr Greg Cavanagh SM:

Introduction

1. Master Julian Thomas Chisholm was born on 5 March 2008. He was four years old when he died. Julian's sister, Miss Aaliyaha Jane Webb, was born on 14 December 2003. She was 8 years old when she died. Both children were suffocated to death by Mr Michael Shane Chisholm, who was 23 years old, having been born on 10 November 1988. Michael was Julian's father, and a father figure to Aaliyaha. After taking the children's lives, Michael committed suicide by hanging. The trauma and grief caused by these deaths to the Mothers, Fathers, family and loved ones of the deceased was palpable during the inquest and is acknowledged. My deepest sympathy is extended to them all.

2. The bodies of Julian, Aaliyaha, and Michael were located by police at Michael's home, 178 Leanyer Drive, Leanyer, at 8:10 am on Tuesday 22 May 2012. Julian and Aaliyaha were found deceased, lying side by side in a double bed. Michael was found deceased under the elevated house. There

was a carefully tied noose around his neck carefully attached to a beam under the house. His body was deliberately concealed behind sheets which were hung from a clothes line.

3. A "suicide note" in Michael's handwriting and baring his palm print was located on the back verandah table, next to Michael's watch. In it Michael wrote "I can't go and leave them behind". A second note book was located in the third bedroom which contained some of Michael's further writings. An entry in the notebook included the following: "I've been thinking about killing myself", "I can't leave Julian and Aaliyaha", and "my mind is already made up. I'm sick of all of this."

4. All the evidence at the scene, including the autopsy results, was consistent with the content of the notes. I find that Michael, with premeditation and planning, killed each child and then hanged himself.

5. I heard evidence from witnesses who saw Julian, Aaliyaha and Michael in the days before their deaths. On Monday 21 May, Michael was seen near the front gate of his house between 1:30 and 2 pm. Between approximately 2 and 2.30 pm Michael and Aaliyaha were seen on the back verandah. This was the last known sighting. I accept the evidence of those sightings as both credible and reliable.

6. In the inquest I heard evidence from the pathologist, who attended the scene and conducted the autopsies, in the hope that it would assist me determine times of death. Although, the pathologist was unable to provide an opinion as to the times of death she did consider that the level of decomposition observed in Michael was not consistent with recent death, certainly he must have been dead for several hours by the time she saw him. The pathologist fairly conceded, however, that if there was evidence of a reliable eyewitness sighting, then any opinion she formed from pathology should cede to that evidence.

7. According to the pathologist, the children's death scene appeared peaceful. There was no evidence of a struggle and no defensive or other injuries. No alcohol or other drugs were located in their blood samples. It was the pathologist's opinion that each child had died by suffocation in their sleep. She also considered it likely that each child lapsed quickly into unconsciousness, and so, would not have suffered. I accept those opinions.

8. The evidence did not establish what time each child fell asleep on Monday 21 May 2012. Further, although it might be unlikely, I cannot exclude the possibility that the children had an afternoon sleep, and so it is possible that they died earlier than their evening bedtime.

9. Regrettably, the available evidence does not allow me to determine a precise time of death for either Julian or Aaliyaha. I find that the children died sometime between 2.30 pm on Monday 21 May 2012 and the early hours of Tuesday 22 May 2012.

10. As to Michael, shortly before dawn on Tuesday 22 May 2012 a neighbour heard a loud sound, similar to the sound of a chair scraping on concrete. Although an upturned, plastic chair was located adjacent to Michael's body it is not possible for me to conclude with any degree of satisfaction, that the sound heard by the neighbour was caused by the plastic chair. The noise might equally have come from another cause or from another nearby house. Further, the timing of the noise was inconsistent with the pathologist's opinion of non-recent death based on observed decomposition. Accordingly, the evidence of the noise does not assist me to determine the time of Michael's death.

11. Tragically for Michael's family, Michael's eldest brother Kirk also committed suicide by hanging. He died on 22 October 2001 when he was 18. It is possible that Michael planned to end his life on the same day of the month as Kirk. While there is some intuitive force to this theory, I do not

elevate it above speculation, and it does not assist me to narrow the time of death.

12. As with the children, on the available evidence it is not possible for me to determine a precise time of death. I find that Michael died sometime between 2.30 pm on Monday 21 May 2012 and the early hours of Tuesday 22 May 2012, and that his death followed those of the children.

13. Michael shared the parenting of Julian and Aaliyaha with their mother, Ms Roxanne Lee. Michael generally had care of the children from Friday afternoons until Sunday evenings. On the weekend immediately preceding their deaths, Michael requested to have the children for an additional night (the Sunday night). Ms Lee understood that Michael would deliver the children to school and day-care on the Monday morning and she would collect them from care in the afternoon. However, when Ms Lee went to collect the children she discovered they had not been to school or day-care that day. She notified family members that the children were missing, and she tried to ring Michael and raise him at his house without success.

14. Ms Lee armed herself with relevant documents and went to Berrimah Police Station to report her concerns. She briefly spoke to a Constable on the TUFF phone and again in person on the doorstep of the station. She attempted to show him her documents which included an affidavit and photos of bruising on Aaliyaha which she attributed to Michael. However, as the station was officially closed, her documents were not fully examined and she was told to go home and report the matter by phone to police communications. This police response was contrary to training and procedure which required officers to "attempt to resolve the matter at the first point of contact". Ms Lee should have been taken inside and her documents should have been properly considered.

15. As Ms Lee's documents were not properly considered the attending Constable did not appreciate that Ms Lee's concerns extended to possible

harm to her children. Instead he proceeded on the basis that her concerns related to possible removal only.

16. The same Constable received her call and entered information from it onto the Call Centre computer system known as iCAD. The information Ms Lee provided ought to have been prioritised as a "child welfare" matter, to be attended to "promptly" as required by a level 2 grading, but was incorrectly entered as a "welfare check" and was prioritised as "routine", a level 3 grading which permitted a delayed response.

17. The information entered into iCAD was considered by the Sergeant in charge of the Call Centre who was also responsible for allocating police resources. He identified the matter as one concerning "child welfare" but did not correct the electronic records to reflect this. As no "safety issues" were disclosed in the recorded information, he considered the matter to be a low priority grade 2 and allocated police resources accordingly.

18. On two occasions, at 7.24 pm and 8.03 pm, the Sergeant attempted to dispatch police to conduct a check on the children however no vehicles were available. By 10.20 pm the Sergeant determined that, on the information provided to him, it was too late to attend the premises. He rang Ms Lee and told her that police would attend the following morning.

19. Both the Constable and Sergeant agreed that had they been aware of the photos attached to Ms Lee's affidavit, her complaint would have been dealt with differently. The Sergeant told me that he would have upped the matter to a "Grade 1", requiring an immediate response. He then could have allocated police resources outside the area of complaint to ensure timely police attendance. I have no doubt that if police members had considered all the information in Ms Lee's possession when she first attended Berrimah Police Station to report her concerns, police would have promptly attended and entered the premises to sight the children.

20. During the course of this extremely sad inquest, police mistakes were readily admitted and failings were identified. However, I do not consider that any of these played a causative role in the tragedy. Whether events might have been different if there had been a more timely attendance is entirely unknown. The Northern Territory Police Service has reflected on the lessons to be learned. I endorse the changes made to the Call Centre child welfare Standard Operating Procedures and I have made further recommendations in the hope that other families might be spared from a similar tragedy.

21. Ms Elisabeth Armitage appeared as Counsel Assisting and Dr Ian Freckleton QC appeared for the Northern Territory Police. The deaths were investigated by Detective Senior Constable Anastacia Cutler. I received into evidence her detailed and thorough investigation brief and additional documents. I also heard evidence from forensic pathologist Dr Jane Vuletic, Ms Lina Sigar, Ms Jodie Porter, Ms Samantha Geriakos, Ms Irene Tsimbidakis, Ms Villalyn Casabuena, Mr Stewart Chisholm, Ms Nicole Chisholm, Ms Zoe Webb, Ms Roxanne Lee, and biologist Ms Joannah Lee. I heard from the following police witnesses, Detective Senior Constable Anastacia Cutler, Senior Constable Pauline Setter, Constable First Class Kirsty Ray, Constable First Class Nathan Lawrence, Sergeant Shane Humphries and Senior Sergeant Craig Ryan.

22. Pursuant to section 34 of the 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;

23. 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."

24. 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."

Relevant circumstances surrounding the death

Background

25. Michael is survived by his parents, Mrs Villalyn (Lyn) Chisholm Casabuena and Mr Alexander Stewart Chisholm, his younger sister Nicole Chisholm, and his older brother Leigh Chisholm. Michael's eldest brother, Kirk Chisholm, died on 22 October 2001 when he committed suicide by hanging while suffering from schizophrenia.

26. Michael was born in Brisbane, Queensland, and moved with his family to Darwin in 1994 when he was 6 years old. He attended Wulagi Primary School and Sanderson High School.

27. When Michael was 12 years old his parents separated and he then lived between their households.

28. Michael met Ms Roxanne Lisa Lee when they were both 17 years old and working at Lenard's Chicken, Casuarina Square. Michael was in year 12 but left school soon after the relationship started to obtain full time employment to support Ms Lee and her daughter, Aaliyaha.

29. Michael obtained an apprenticeship with Skyline Painting and trained to be a house painter like his father. Michael was working for Stefan Nadev of All Trades Building and Renovations Pty Ltd until the day of his death.

30. The children, Aaliyaha and Julian, are survived by their mother Ms Roxanne Lisa Lee and Aaliyaha's father, Mr Shannon Stephen Webb.

31. Ms Lee and Mr Webb were living together at Casuarina as a family unit with their daughter Aaliyaha, born 10 December 1988, until 2006. At about the time their relationship ended, Ms Lee formed a new relationship with Michael.

32. Michael, Ms Lee and Aaliyaha lived together as a family unit from February 2006. Michael was a father-figure to Aaliyaha. They stayed with family members until moving into a Territory Housing unit at 1/1 Timpson Court, Gray.

33. In January 2008 Aaliyaha started school at Gray Primary School.

34. On 5 March 2008 Julian was born. Michael, Ms Lee, Aaliyaha and Julian continued to live together as a family unit in Gray until December 2009.

35. On 2 December 2009 Ms Lee and Michael had an argument that escalated to violence. Michael damaged the car in which Ms Lee and the children were passengers. Ms Lee later described the incident in an affidavit prepared for custody proceedings dated 15 January 2010. Ms Lee described fearing for

her and her children's safety and she took the children to Queensland to live with her father.

36. On 2 December 2009 Michael reported all three as missing persons to the Northern Territory Police Force. Ms Lee contacted the police to explain her side of the story and confirmed that they were all safe and in Queensland. Ms Lee permitted telephone contact between Michael and the children.

37. In December 2009 Michael commenced recovery and custody proceedings. On 18 January 2010 the Federal Magistrates Court ordered Ms Lee to return Julian to the Northern Territory and ordered shared parental responsibilities for Julian. In response to the order, Ms Lee and both children returned to Darwin and soon after they started living at 7 Kapool Crescent, Malak. Ms Lee enrolled Aaliyaha in Wanguri Primary School.

38. On 24 July 2010 Michael assaulted Ms Lee's boyfriend, Mr Jason Taylor.

39. In December 2010 Michael had an extended period of care of both children and in early 2011 moved them to Howard Springs Primary School and day care. According to Miss Lee this was without her knowledge or permission. Ms Lee recovered the children on 11 February 2011 with some police involvement.

40. On 23 March 2011 Michael was convicted for aggravated assault on Mr Taylor and sentenced to 8 months imprisonment, suspended forthwith on an 18 month Good Behaviour Bond.

41. The custody proceedings for both children continued with Michael alleging that they were neglected by Ms Lee and that her activities placed them at risk. Ms Lee denied the allegations and contended that Michael suffered from unpredictable mood swings and was, on occasions, violent. The custody dispute was prolonged and unresolved at the time of the deaths.

42. Michael discussed his heartfelt concerns for the children with family and friends. In early 2012 he shared his despair and sense of hopelessness about his prospects for custody with his sister and mother. He told them he had given up and that he could not pay his mounting legal bills. Michael's work colleagues, family and friends told police that Michael appeared depressed. His brother and sister encouraged him to see a doctor. The evidence indicates that he did not act on this advice.

43. On 4 May 2012 Michael's mother travelled to the Philippines with her new husband. Michael sent her a text message on 14 May stating "I wish you were here so I could talk to you. I am sick of feeling like shit. My own family don't even care except you". Michael's mother responded "Hi Darling, I'm so glad you text me. Please try not feeling alone because you are not. We will always be there for you until the end of our breath and that includes Mario. He loves you like his own son, believe me he is so concern to all my children but most to you. Time flies so quickly, so don't worry for all you know we'll be home again. Okey darling, take care always and say our hello to the kids. We love you so much and goodnight for now, bye."

44. On 16 May 2012 Michael's sister travelled to Brisbane for a wedding and was due to return on 22 May 2012. Her partner, Chris, was away working. Michael had the house to himself.

The last known sightings of Michael and the children

45. During 2012 and by consent, Michael shared the parenting of Julian and Aaliyaha with their mother, Ms Lee. Michael generally had care of the children from Friday afternoons until Sunday evenings.

46. In accordance with this arrangement, on the afternoon of Friday 18 May 2012, Michael picked up Aaliyaha and Julian from school and day care and took them home to 178 Leanyer Drive.

47. At 5.13 pm Michael was served with a statement of claim for victims of crime compensation in the amount of $10,484.55.

48. At about the same time Michael's father, Mr Stewart Chisholm, visited Michael and the children. He gave Michael an incorrectly addressed outstanding bill from his family court lawyer for $10,000. Michael did not discuss the statement of claim he had just received with his father. Mr Chisholm described Michael as quiet and down. Michael told his father that he was taking the children to the movies. Later, police found movie tickets for the Avengers screening at Casuarina at 8.37 pm.

49. On Saturday 19 May 2012 a neighbour heard Michael and the children playing in their backyard pool. At 10 pm that night they went to Steven Pedlar's house on McMillans Road and Michael borrowed a computer game from his friend. Mr Pedlar thought all three appeared normal, happy and healthy.

50. On Sunday 20 May 2012 Michael took Aaliyaha and Julian to the Sky City Casino for breakfast at the Sunset Restaurant. They left at 10.38 am.

51. At 3.35 pm Michael sent a text message to Ms Lee, "Was just calling to see if the kids can stay here tonight. There's a uniform here already". Ms Lee responded at 3.59 pm, "Sorry for the late reply my phone was on silent for some weird reason. That should be fine if there's a uniform there. I've got an essay I'm working on atm anyway." As per previous arrangements Ms Lee understood that Michael would drop the children to school and day care the next day, and she would collect them in the afternoon.

52. Another neighbour heard the children in the pool at about 7.30 pm and at about 8 pm they went to the Hibiscus Shopping Centre, Leanyer where Aaliyaha collected a pizza from Pizza King. The pizza box was later located at the house.

53. Little is known about the children and Michael's movements on Monday 21 May 2012. The children did not go to school or day care. A female who has not been identified was seen at the gate of the premises in the morning. Michael was seen near the front gate between 1:30 and 2 pm. Between approximately 2 and 2.30 pm Michael and Aaliyaha were seen and heard on the back verandah by a neighbour, Ms Irene Tsimbidakis, who was hanging out her clothes. The neighbour described them singing together. This was the last known sighting. I accept that evidence as both credible and reliable.

54. Ms Lee became aware that her children had not been delivered to school or day care when she went to collect them in the afternoon. She became worried and notified family members that the children were missing. She tried to call Michael and Aaliyaha but neither answered their phone. Ms Lee went by Michael's house and called out and beeped her horn. The gate was locked (which was not unusual) but she was unable to raise anybody. She told me that normally the children would come out to her, and even though his car was in the driveway she thought perhaps they were out ot Michael had taken them away.

Ms Lee attended Berrimah Police Station

55. Previous experience informed Ms Lee that she would likely get a better outcome from police if she had documentation proving her relationship with the children and the custody arrangements. She went home and collected the documentation that she thought was relevant, including birth certificates and her family proceedings affidavit, and drove to Berrimah Police Station to report her concerns.

56. Ms Lee arrived after 6.30 pm and the station was closed. She used a TUFF phone at 6.43 pm, and spoke briefly to Constable Nathan Lawrence, who then came and spoke to her on the front steps of the station. Ms Lee spoke to the Constable for a few minutes. She told him that Michael was the biological father of Julian but not Aaliyaha, that he had visitation rights, and

that he had not returned the children or taken them to school. Ms Lee tried to show Constable Lawrence her documents. Constable Lawrence looked at the birth certificates but not at her affidavit or the attached photos of bruising to Aaliyaha which Ms Lee attributed to Michael.

57. From the conversation, Constable Lawrence understood that Ms Lee didn't know where the children were, and she wanted police to check on them to see if they were okay. Constable Lawrence did not appreciate that Ms Lee had concerns about possible harm to the children and it is not clear to me whether those concerns were orally communicated.

58. Constable Lawrence told Ms Lee that police couldn't remove the children but they could do a welfare check. As the station was closed, Constable Lawrence told Ms Lee to go home and report the matter by phone to police communications on the police 131444 number.

59. The police response at Berrimah Police Station was contrary to police training, best practice, and the Police Customer Service Charter and Service Delivery Standards. Police officers are expected to "attempt to resolve the matter at the first point of contact". In this case, both the Constable and his supervising Sergeant agreed in evidence that Ms Lee should have been taken inside, her documents should have been properly considered, and her complaint taken then and there. She should not have been sent away to make a phone call.

60. As Ms Lee's documents were not properly considered, the attending Constable did not appreciate that there was an alleged history of harm to Aaliyaha. Had this history been understood, it was conceded by the Constable and Sergeant that their response to the complaint would have been different.

Ms Lee reported the matter on the police assistance line

61. Ms Lee drove back to Michael's house and again tried to raise a response without success. She then drove to a service station for fuel and phoned the police number.

62. Constable Lawrence was working in the Call Centre and took Ms Lee's call at 6.55 pm. He entered information from the call onto the Call Centre computer system known as iCAD. I listened to the call. Ms Lee reiterated the care arrangements between herself and Michael, reported that the children had not been delivered to school or day care, that Michael was not answering his phone, the gate fence was locked, and his house appeared empty although his car was there. In the call Ms Lee did not mention concerns of harm.

63. Constable Lawrence recorded the information provided in the call and informed Ms Lee, "We can't physically take the children off him but we can observe if they're, you know if he has them and stuff like that but you'll have to refer this to the courts." Ms Lee asked if she would get a call back and Constable Lawrence advised her that she would.

64. From the conversations on the doorstep and on the phone, Ms Lee understood, and felt reassured, that police would conduct a welfare check on her children that evening and would call back with the results of that check.

The call centre and police response

65. Each call received by the Call Centre is entered into the computer and prioritised for police response. There are 5 national levels of prioritisation which are used throughout Australia. Grade 1 requires an urgent response. Grade 2 requires a prompt response, as soon as possible. Grade 3 is considered routine, police are to attend when a unit is available and delay is permitted. Grade 4 requires police action but not attendance. Grade 5 requires neither police action nor attendance.

66. “Child welfare” matters are coded 423 and automatically generate a grade 2 response. However, Constable Lawrence incorrectly entered Ms Lee’s complaint as a “welfare check” under code 424 which automatically generated a grade 3 response. The mistake was not picked up by Constable Lawrence because he also failed to open and consider the Standard Operating Procedures. Had he done so, he would have been directed to, and could hyperlink through to, code 423 for child matters. I accept Constable Lawrence did not follow the correct procedure and he made mistakes through human error.

67. The information entered into iCAD was considered by the Sergeant in charge of the Communication Centre, Shane Humphries. The Sergeant was responsible for considering complaints and allocating police resources. Sergeant Humphries told me that although the matter was entered as a “welfare check”, from the information provided he dealt with the matter as a “child welfare” matter of a low-level grade 2 priority. He told me that he allocated resources accordingly, and attempted to dispatch police at 7.24 and 8.03 pm however no vehicles were available. The electronic records confirm these dispatch attempts. I accept Sergeant Humphries evidence that he did deal with the matter as a low-level grade 2, but it would have been better had he corrected the electronic records on the night to reflect this. Understandably, his failure to do so gave rise to concerns in the minds of the grieving families.

68. By 10.00 pm that night no police had attended the location to conduct the Welfare Check. At 10.20 pm Sergeant Humphreys phoned Ms Lee. He told her that police were not available that night and a check would be conducted in the morning. Sergeant Humphries told Ms Lee “You’re not showing us anything that’s saying that there’s a major concern for their safety, you’re just asking us to look at them”. Ms Lee responded, “Well I have no idea where they are” and “what classifies as a safety issue because that would actually put me at knowing anything about them”.

69. Sergeant Humphries appeared to be of the view that this conversation was an opportunity for Ms Lee to express any additional relevant safety concerns she might have. As she did not do so, he felt further justified in delaying the matter until the following morning. Ms Lee, however, explained that she felt "text-booked". She thought Sergeant Humphries was there to deliver a message, the decision had been made, and it would be futile to try and convince him to change position.

70. I accept that each person had divergent perceptions of this conversation. Objectively, while Ms Lee could have rejected Sergeant Humphries statements and voiced her concerns about possible harm or "safety issues", she was never actually asked what her concerns were. I accept that Ms Lee felt shut down, and did not perceive this call to be an opportunity to further explain her complaint. Indeed, when he reflected on the call, Sergeant Humphries agreed that he should have asked open questions in order to afford Ms Lee a better opportunity for communicating her concerns.

71. Police powers to enter premises are strictly limited. Section 126 (2A) of the *Police Administration Act* provides that a police member may enter a place if he believes on reasonable grounds, that (a) a person at the place has suffered, is suffering or is in imminent danger of suffering personal injury at the hands of another person, or (b) a contravention of a *Domestic and Family Violence Act* order (DV order) has occurred, is occurring or is about to occur.

72. In this case there was no DV order and Sergeant Humphries was not aware of any information which could give rise to a reasonable belief that personal injury to the children had or was likely to occur. He was of the opinion that had police attended, they could call out from the locked boundary, but there was insufficient information to justify a forced entrance. Accordingly, taking into account the information known to Sergeant Humphries, I do not

criticise him for delaying any further response until the following morning. Ultimately, however, these discussions or justifications are not to the point.

73. If Ms Lee's complaint had been processed in person at Berrimah Police Station, as it should have been, her documents would have been considered. The documents contained photos of bruising on Aaliyaha which Ms Lee attributed to Michael. Both Constable Lawrence and Sergeant Humphries agreed that had they been aware of those photos Ms Lee's complaint would have been handled differently. Sergeant Humphries readily admitted he would have categorised it as a grade 1 matter requiring immediate attention. He could then have accessed additional police resources outside Casuarina to respond.

74. In my view the photos, taken in conjunction with the non-return of the children, their failure to attend school, the non-answered phone calls and the non-responsiveness at the home, would have justified a forced police entry. However, what the outcome might have been had there been an entry on Monday night is entirely unknown.

The crime scene

75. The bodies of Julian, Aaliyaha, and Michael were located by police when they attended at Michael's home, 178 Leanyer Drive, Leanyer, at approximately 8:10 am on Tuesday 22 May 2012.

76. By the Tuesday morning, the children had not been seen by their mother since Friday afternoon and the police cannot be criticised for jumping the locked fence to make further enquiries.

77. Michael was located deceased under the elevated house. There was a noose around his neck attached to a beam under the house, tied with considerable care. His body was deliberately concealed behind sheets which were hung from a clothes line. Julian and Aaliyaha were found deceased, lying side by side in a double bed in the upstairs second bedroom.

78. Neither the bodies nor scene was interfered with, save to confirm that all were deceased. A crime scene was established and the bodies remained in situ until the attendance of the Major Crime Squad and the forensic pathologist. The scene was photographed and 66 items were seized for further examination.

79. Those items included the gate lock, the sheets and pegs from the clothes line concealing Michael's body, the noose, the pillows and sheets in the bedroom where the children were located, glasses, a wallet belonging to Michael, a Nokia mobile phone, a Samsung mobile phone, a HP laptop, notebooks, swabs of liquids in glasses around kitchen and bedroom, swabs from XXXX bottles and items inside the house, box of "cilex" anti-biotic medication and a bottle of Nurofen children liquid medication.

80. The mobile phones and computer were examined by the Computer Crime Unit. The laptop contained information belonging to Nicole Chisholm and she confirmed it was hers. There was nothing of relevance to the investigation on the laptop. The Nokia phone belonged to Aaliyaha and the Samsung belonged to Michael. There were text messages of relevance on the Samsung phone between Michael and Ms Lee concerning the additional Sunday night arrangement for the children and Michael's mood state (referred to above).

81. There were no illicit substances located at the crime scene or any tools of ingestion. Although Michael's toxicology results indicated traces of cannabinoids, it did not appear to have been consumed at the crime scene.

82. The pillows and pillow cases on the children's bed were examined. They revealed DNA consistent with being used by Julian, Aaliyaha and Michael and other unidentified DNA. It was not possible for the biologist to provide an opinion as to how long the DNA had been present and she could not assist with better identifying the method of suffocation.

83. As at 22 May 2012, Michael's combined bank accounts contained $27.94. His Master Card was de-activated. There was no cash located at his home. Evidence established he owed $800 in rent, $10,000 in legal bills and $10,485.55 for victims of crime compensation.

84. Significantly, a "suicide note" in Michael's handwriting and baring his palm print was located on the back verandah table, together with Michael's watch. In it Michael wrote "I can't go and leave them behind". A second note book, in which many of Michael's fingerprints were identified, was located in the third bedroom. It contained further writings by Michael. An entry in the form of an undated letter to his deceased brother included the following: "I've been thinking about killing myself", "I can't leave Julian and Aaliyaha", and "my mind is already made up. I'm sick of all of this."

The autopsies

85. Autopsies were carried out by Dr Jane Vuletic on each of the deceased throughout 23 May 2012.

86. As to Julian , Dr Vuletic concluded-

(i) The deceased was a 4 year old boy who was found dead in bed with his sister. His father was found hanging in the same house. Homicide by suffocation and /or poisoning was suspected at the time of post mortem examination.

(ii) At autopsy the significant findings included the following:

(a) White plume in nostrils,

(b) Pulmonary congestion and oedema,

(c) Epicardial petechial haemorrhages.

(iii) Samples of blood and gastric contents were taken at autopsy for toxicological analysis which revealed no evidence of alcohol or drugs.

(iv) The post mortem findings were <u>consistent with death due to suffocation</u>.

(v) There was no indication of trauma.

(vi) There was no natural disease which contributed to or caused the death.

87. As to Aaliyaha , Dr Vuletic concluded-

(i) The deceased was an 8 year old girl found dead in bed with her brother. Her father was found hanging in the same house. Homicide by suffocation and /or poisoning was suspected at the time of post mortem examination.

(ii) At autopsy the significant findings included the following:

(a) Eyelid, facial and conjunctival petechiae,

(b) Pulmonary congestion and oedema,

(c) White plume in nostrils,

(d) Epicardial petechial,

(e) Left parietal scalp haemorrhages,

(f) Focal myocarditis.

(iii) Samples of blood and gastric contents were taken at autopsy for toxicological analysis which revealed no evidence of alcohol or drugs.

(iv) The post mortem findings were <u>consistent with death due to suffocation</u>.

(v) The myocarditis is incidental and not likely to have contributed to death.

88. According to the pathologist, the children's death scene appeared peaceful. There was no evidence of any additional injuries to either child. There was no evidence of a struggle and no defensive injuries. No alcohol or other drugs were located in their blood samples. It was the pathologist's opinion that each child had died by suffocation in their sleep. She also gave evidence that she considered it likely that each child lapsed quickly into unconsciousness, and so, would not have suffered. I accept those opinions.

89. As to Michael, Dr Vuletic concluded-

(i) The deceased was a 23 year old male who was found hanging in the laundry of his home. Two children were also found deceased in bed.

(ii) At autopsy the significant findings included the following:

(a) Rope around neck

(b) Neck abrasion

(c) Eyelid and conjunctival petechiae,

(d) Pulmonary congestion and oedema,

(e) Anterior and posterior hypostasis,

(f) Features of decomposition.

(iii) Samples of blood were taken at autopsy for toxicological analysis which revealed the presence of cannabis metabolites and a small quantity of alcohol which may have arisen after death.

(iv) The post mortem findings were consistent with death by neck compression due to hanging. There were no markings or injuries to indicate the involvement of another person in the death and no significant pre-existing medical conditions were identified.

90. I accept Dr Vuletic's opinion that Michael died by neck compression due to hanging.

An attempt to determine a time of death

91. In the inquest I heard further evidence from the pathologist in the hope that it would assist me to determine more precise times of death.

92. Dr Vuletic was unable to provide an opinion as to the times of death of the children. Dr Vuletic said that there was no test that could determine the times of death. Further, possible indicators varied considerably between deaths and so were unreliable.

93. The evidence did not establish what time each child fell asleep on Monday 21 May 2012. Whether Michael kept to normal child bedtimes on this night is not known. Further, I cannot exclude the possibility that the children had an afternoon sleep and so might have died earlier than their evening bedtime; however I do note that an afternoon nap was considered most unlikely by Ms Lee.

94. I note that Ms Lee attended the premises twice during the early evening of 21 May 2012, between approximately 6 and 6.30 pm. Although she rang, called out and beeped her horn, the children did not appear. She told me that normally they would run out to greet her. However, Ms Lee also noticed that unusually the louvers were closed and it appeared no-one was home.

95. Although urged to do so by Counsel for the Police, I decline to make any finding as to possible times of death based on this evidence. In my view there are alternate, plausible reasons not excluded by the available evidence, as to why the children may not have responded. These include possibilities such as, they were not at home (although as they were not seen by anyone I think this unlikely), they did not hear Ms Lee because windows were closed and other distractions such as tvs or air conditioners were on, or they were discouraged or prevented from going to their mother by Michael.

96. Regrettably, the available evidence does not allow me to determine a precise time of death for either Julian or Aaliyaha. I find that the children died sometime between 2.30 pm on Monday 21 May 2012 and the early hours of Tuesday 22 May 2012, and that they died before Michael.

97. As to Michael, Dr Vuletic referred me to her observations of decomposition. She considered them consistent with death possibly occurring during the Sunday night/ Monday morning, and certainly not recent to the time she saw the deceased at about 9 am on 22 May 2011. However, Dr Vuletic readily and fairly conceded that if there was evidence of a reliable eyewitness sighting, then any opinion she formed from pathology would cede to that evidence.

98. As noted above, I accept the evidence of Ms Irene Tsimbidakis, that she saw Michael and Aaliyaha between 2 and 2.30 pm on Monday 21 May 2012. Accordingly, I conclude that Michael died after that time but at least several hours before he was observed by Dr Vuletic.

99. I heard evidence from another neighbour, Ms Samantha Gerakios. She heard a loud sound, similar to the sound of a chair scraping on concrete, shortly before dawn on Tuesday 22 May 2012. A plastic, upturned, chair, with Michael's footprints on it, was located adjacent to Michael's body. The beam from which Michael hung himself was approximately two metres high. It seems likely that Michael stood on the chair to tie the rope to the beam, and that the chair up-turned at or shortly before the time Michael took his own life.

100. However, it is not possible for me to conclude with any degree of satisfaction, that the sound heard by the neighbour was caused by the plastic chair. The noise might equally have come from another cause or from another nearby house. Further, the timing of the noise was inconsistent with Dr Vuletic's evidence that death was not recent to 9 am. Accordingly, the evidence of the noise does not assist me to determine the time of Michael's death.

101. Tragically for Michael's family, Michael's eldest brother Kirk also committed suicide by hanging. He died on 22 October 2001 when he was 18. It is clear from Michael's writings that he was thinking about Kirk when he was planning his own death. It is possible that Michael planned to end his life on the same day of the month as Kirk. This would point to Michael ending his life in the morning hours of 22 May 2012. However, this remains purely speculative and so does not assist me to narrow the time of death.

102. As with the children, it is not possible on the available evidence for me to determine a precise time of death. I find that Michael died sometime between 2.30 pm on Monday 21 May 2012 and the early hours of Tuesday 22 May 2012, and that his death followed those of the children.

Further observations on responses to issues arising from this inquest

103. Individual officers and Senior Officers in the Northern Territory Police Service frankly admitted that mistakes in procedures had been made. I am assured and accept that steps have been taken to reinforce police processes to ensure similar mistakes are avoided in the future.

104. In particular I note the following police responses as attested to by Acting Assistant Commissioner Crime, Richard Bryson, in his statement dated 20 March 2013-

(i) The responsibility of Call Centre Operators to go into and work through the Standard Operating Procedures has been reinforced by clear instructions and the placement of large red signs at each computer designed to provide a constant reminder to "CHECK YOUR SOPS".

(ii) Standard Operating Procedure 423 - Child Welfare has been amended to include an additional paragraph designed to assist operators to ensure they elicit relevant information from callers, as follows-

WELFARE CONCERNS

Specific details of caller's main concern/s (asked by open-ended question), eg neglect, cruelty, violence, sexual, significant accident, removal from jurisdiction, or something less serious.

105. I considered the limits on the power of police to enter premises in response to child welfare concerns. Under the current legislation police have no powers of entry unless they have reasonable grounds for believing there has or will be either personal injury or a contravention of a DV order. The information recorded in iCAD concerning Julian and Aaliyaha was likely to have been insufficient to justify uninvited police entry on the evening concerns were raised.

106. Children are particularly vulnerable. In my view, one of the lessons to be learned from this inquest is that additional police powers of investigation for child welfare matters are necessary. To this end, Counsel for the Police suggested an amendment to section 126 of the *Police Administration Act* which would empower a police member to enter a place if, he believed on reasonable grounds, it was necessary to do so in order to evaluate whether there was a serious imminent risk to the welfare of the child.

107. The phrase "welfare of the child" is broad and so would include physical and psychological welfare. A failure to return a child following an access visit might put a child at psychological risk and might justify police entry to check on the child's well-being. As for all powers, decisions would be made on a case by case basis, taking into account all the known and relevant circumstances.

108. I am persuaded that a limited broadening of police powers, justified by child welfare concerns, is warranted.

109. The children's family raised with me their concerns about insufficient support and communication following this tragedy. Their concerns were numerous. They particularly identified concerns surrounding the timing of, necessity for, and the accuracy of information given to them about, the autopsies. Personal items of the children were not returned and insufficient explanation was given. They were not told of the suicide note or its contents. In the hours, days and months following their traumatic loss, they were left feeling unsupported and misinformed.

110. In my findings on 9 June 2011 in the Inquest into the death of Nicholas Edward Spring, I recommended that provision be made for a Grief Counsellor. While I am confident that Coroners Constables and investigating officers do their best, they are not professionally trained to deal with grief, and investigating officers have a myriad of competing priorities and duties which necessarily mean the needs of grieving family members cannot

normally take precedence. Dedicated Grief Counsellors are widely recognised as integral to the coronial jurisdiction across Australia and can provide professional liaison and a conduit for information and concerns between families, the Coroner's Office, and investigating police. The loss of a loved one is hard enough. The trauma of loss is compounded when the process is taken over by a coronial investigation. The concerns of Ms Lee and her family deserve close consideration and, in my view, re-consideration of provision for a Grief Counsellor is warranted.

Findings

111. Michael Shane Chisholm killed Julian Thomas Chisholm and Aaliyaha Jane Webb by suffocation. He then killed himself by hanging. The circumstances surrounding the deaths, including the weekend activities with children, Michael's writings, and the care taken with the noose and concealment of his body, satisfy me that the deaths were premeditated and planned.

112. On the evidence of his family and friends I find it likely that Michael Shane Chisholm was feeling overwhelmed by his circumstances, including concerns for the welfare of the children, unresolved and drawn out custody proceedings, and accumulating debts that he could not repay. I find it likely that he was suffering from undiagnosed depression when he took the children's lives and his own.

113. All the deaths occurred between 2.30 pm on Monday 21 May 2012 and the early hours of Tuesday 22 May 2012. Michael Shane Chisholm's death followed those of the children.

114. I find no causal connection between the police response and the deaths. Whether or not the outcome might have been different if police had responded earlier is entirely unknown.

Formal Findings

115. Pursuant to section 34 of the Act, I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the deceased adult was Michael Shane Chisholm born on 10 November 1988 at Brisbane, Queensland. Mr Chisholm resided at 178 Leanyer Drive, Leanyer, in the Northern Territory of Australia.

(ii) The time and place of death was between 2.30 pm on 21 May 2012 and the early hours of 22 May 2012 at 178 Leanyer Drive, Leanyer, in the Northern Territory of Australia.

(iii) The cause of death was suicide by hanging. .

(iv) Particulars required to register the death:

1. The deceased adult was Michael Chisholm.

2. Michael Chisholm was employed as a house painter.

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 Jane Vuletic on 23 May 2012.

5. Mr Norman's parents are Ms Villalyn Chisholm Casabuana and Mr Stewart Alexander Chisholm.

116. Further, pursuant to section 34 of the Act, I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the deceased female child was Aaliyaha Jane Webb, born 14 December 2003. Miss Aaliyaha Webb resided at

7 Kapool Crescent, Malak in the Northern Territory of Australia.

(ii) The time and place of death was between 2.30 pm on 21 May 2012 and the early hours of 22 May 2012 at 178 Leanyer Drive, Leanyer, in the Northern Territory of Australia.

(iii) The cause of death was killing by suffocation.

(iv) Particulars required to register the death:

1. The deceased female child was Aaliyaha Jane Webb.

2. The deceased was a student at Anula Primary School.

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 Jane Vuletic on 23 May 2012.

5. The deceased female child's parents are Ms Roxanne Lisa Lee and Mr Shannon Stephen Webb.

117. Further, pursuant to section 34 of the Act, I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the deceased male child was Julian Thomas Chisholm, born 5 March 2008. Master Julian Chisholm resided at 7 Kapool Crescent, Malak in the Northern Territory of Australia.

(ii) The time and place of death was between 2.30 pm on 21 May 2012 and the early hours of 22 May 2012 at 178 Leanyer Drive, Leanyer, in the Northern Territory of Australia.

(iii) The cause of death was killing by suffocation.

(iv) Particulars required to register the death:

1. The deceased male child was Julian Thomas Chisholm.

2. The deceased was an infant in day care.

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 Jane Vuletic on 23 May 2012.

5. The deceased male child's parents are Ms Roxanne Lisa Lee and Mr Michael Shane Chisholm (deceased).

Recommendations

118. I recommend that consideration be given to amending section 126(2A) of the *Police Administration Act* by inserting paragraph (ba) as follows:

> (2A) A member of the Police Force may, by reasonable force if necessary, enter a place if he believes, on reasonable grounds, that:
>
> .....
>
> (ba) it is necessary to do so in order to evaluate whether there is a serious imminent risk to the welfare of a child,
>
> .....

119. I recommend that consideration be given to the employment of a dedicated Grief Counsellor to be available to assist families whose loss is subject to a coronial investigation. Consideration should also be given to such a position having a broader role in respect of other deaths under police investigation.

Dated this 15th day of May 2013.

GREG CAVANAGH
TERRITORY CORONER