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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and Recommendation regarding the death of Grace

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Pursuant to section 46B of the *Coroners Act 1993* (the Act), I provide this report on the findings and recommendation of Local Court Judge Elisabeth Armitage, Territory Coroner, dated 27 June 2024, regarding the death of Grace (the Deceased) (Attachment A refers).

The report includes the response to the recommendation of the Territory Coroner from Commissioner Michael Murphy APM, Northern Territory Police, and Ms Susan Bowden, Chief Executive Officer (CEO) of the Department of Education and Training (DET) (Attachments B and C refers, respectively).

The Deceased, a 14-year old girl, died at approximately 1.27 pm on 28 January 2022 at her family home in Darwin. The cause of death was suicide by self-inflicted gunshot to the chest.

Recommendations of the Coroner

At paragraphs 94 to 99 of the Coronial Findings, the Coroner made the following formal recommendations in regards to the death of the Deceased:

> '94. **I recommend** that the Department of Education ensure that there is appropriate policy, guidelines and training in all schools incorporating best practice following any disclosure of suicidality or suicidal thoughts by a student, including but not limited to, risk assessment, safety planning, follow up or referrals and communication to appropriate persons. Consideration should be given as to whether a policy similar to the NSW *Management of Sucidiality in Students* policy should be adopted.
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> 95. **I recommend** that NT Police embed in appropriate general orders, and any other applicable policy and training, clear directions as to the circumstances in which it is mandatory to immediately notify the forensic pathologist of a death and provide an opportunity for their attendance at a scene, in person or via videolink.

NORTHERN TERRITORY GOVERNMENT

96. **I recommend** that the NT Police amend the appropriate general orders, and any other applicable policy and training, to identify deaths in which it is mandatory for Police to attend autopsies and, guidance as to any discretion (if any).

97. **I recommend** that NT Police amend the appropriate general orders, and any other applicable policy and training, to address fingerprinting of deceased persons for forensic purposes including for comparative purposes.

98. **I recommend** that NT Police establish and maintain internal expertise in firearm crime scene reconstruction and ballistics, to have and maintain sufficient availability of appropriate external expertise.

99. **I recommend** that NT Police review and update appropriate general orders, and any other applicable policy and training, to reflect the Internal Broadcast *Prosecution Opinion Files – Coronial Investigations involving unsecured firearms* dated 1 December 2022.'

Response to Coroner's recommendation

A copy of the Coronial Findings was provided to Ms Karen Weston, former CEO, Department of Education, and Commissioner Murphy on 12 July 2024, in accordance with section 46A(1) of the Act.

A written response was received from Commissioner Murphy dated 2 October 2024, as required by section 46B(1) of the Act advising that:

1. In relation to recommendation 95 of the Coronial Findings – the Crime (Homicide and Serious Investigation) General Order (GO) has been sent out for consultation following review. It is expected to be Gazetted before the end of the year. It will include an amendment to mandate notification to a forensic pathologist whenever there is a child death or a death involving a firearm. On 25 August 2022 the Senior Principal Examiner of the Forensic Science Branch issued a direction mandating this notification for all child deaths under 18 and provided the notification steps and relevant contacts. This direction was disseminated to all Crime members and the relevant internal training document has been updated to reflect this direction.

   Training on this direction now includes presentations by the Coroner or the Deputy Coroner during courses for police investigators in order to address investigative concerns. Major Crime Detectives now reinforce the requirement to notify forensic pathologists as soon as possible in cases involving suspicious deaths – failures to notify a pathologist are uncommon in homicides or deaths which are clearly suspicious. The training package for police investigators is being updated to emphasise this new expectation.

2. In relation to recommendation 96 of the Coronial Findings – the new GO mandates police attendance at all autopsies involving any of the following circumstances:

   - a homicide;
   - a death where criminality has not been excluded;
   - a death involving a firearm; and
   - any death of a child.

3. In relation to recommendation 97 of the Coronial Findings – Police workflows have been updated to emphasise the need for fingerprints to be obtained from deceased individuals, especially in cases involving suspicious deaths. The Forensic Sampling and Examination GO mandates fingerprint confirmation for identifying deceased persons in all cases of suspicious death. This requirement has been reinforced to current investigators and is included in the Recruit and Detective training courses.

   The new GO (which is expected to be gazetted before the end of the year) will require members to obtain fingerprints in all cases involving dead children, firearm deaths, motor vehicle crashes and any deaths where criminality has not been excluded.

4. In relation to recommendation 98 of the Coronial Findings – Police now retain a team of members trained in firearm scene reconstruction and have also acquired a laser scanner to enhance the ability offered by this team. Police continue to maintain an ongoing relationship with NSW police and the Australian Federal Police (AFP) with a formal agreement (via a Letter of Exchange) in place to secure firearms identification assistance from the AFP.

5. In relation to recommendation 96 of the Coronial Findings – the new general order (which is expected to be gazetted before the end of the year) will require the preparation and submission of a prosecution file to the Director of Public Prosecutions when a prima facie case exists for charges of failure to adequately maintain storage or safekeeping requirements contrary to section 46 of the *Firearms Act 1997* (NT) arises. This aspect has also been incorporated into the Detective training programme.

A written response was received from Ms Bowden, dated 3 October 2024, as required by section 46B(1) of the Act, advising that:

1. DET accepts the Coroner's recommendation and notes the comments which preceded it, all of which will be considered through the implementation of the recommendation.

2. To implement the recommendation, DET is:

   - using a holistic approach in viewing a child within their school, family and broader context;

   - implementing resources that DET has developed since the Deceased's death, which include tools and advice for practice professionals who respond to suicide risk in schools, including a suicide practice guide for schools, family-inclusive practices and parental consent in accessing professionals;

   - routine audits of the professional records of department staff who provide inclusion and wellbeing support services to schools to support ongoing practice improvements in record keeping; and

   - ongoing promotion of available quality assured training in suicide prevention and mental health support through the department's partnership with Be You and other communication channels for schools.

I am satisfied that the CEO of DET and the Police Commissioner have considered the recommendations of the Territory Coroner and that they are taking necessary steps to implement the recommendations.

DATE: 26 NOVEMBER 2024

MARIE-CLARE BOOTHBY

26 / 11 /2024