IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

CORONER'S FINDINGS

*Section 34 of the **Coroners Act 1993***

I, Elisabeth Armitage, Coroner, having investigated the death of **a 47 year old Aboriginal female (the deceased)** and without holding an inquest, find that she was born on **9 August 1974** and that her **death occurred on 17 January 2022, at a bush camp approximately 200 metres from the intersection of Calytrix Road and Vanderlin Drive, Karama in the Northern Territory.**

Introduction

1. The deceased was born in Darwin and grew up with her family in Maningrida. She married and with her first husband she had four children. She separated from her husband in early 2015.
2. Later in 2015 the deceased met her partner, and they formed a relationship. Her partner also grew up in Maningrida. He had five children from a previous relationship. That relationship was plagued by domestic violence and ended following a domestic violence incident in early 2015.
3. The deceased and her partner lived between Pirlangimpi, Tiwi Islands and Darwin. Their relationship was also beset by domestic violence.
4. The deceased passed away at a bush camp near the intersection of Calytrix Road and Vanderlin Drive in Karama on 17 January 2022. Her partner reported her death to police but claimed to have no knowledge as to how she sustained the injuries that caused her death.

Cause of death

1(a) Disease or condition leading directly to death: **Multiple blunt force injuries**

Other conditions present but not regarded (or provable) as contributing to death were: acute alcohol intoxication

Following and autopsy, Forensic Pathologist Dr Marianne Tiemensma, commented:

Comments

- The 47-year old adult female was reportedly found unresponsive by her partner in the early morning hours of 17/01/2022.
- Post-mortem examination showed extensive blunt force trauma, involving the head and face, torso, and pelvis, with multiple defensive injuries present, and the presence of thin translucent fluid and sand in the vagina, suggestive of sexual activity.
- Toxicological analysis showed high blood and vitreous alcohol concentrations (0.29%). Expected symptoms and signs that may be encountered at this level of intoxication include loss of muscle coordination, balance disturbances, stupor, loss of orientation, and amnesia.

Older injuries

- Two healing lacerations, with granulation tissue and skin re-epithelization, were seen on the anterior aspect of the right knee.
- Superficial, healing, linear scratches were seen on the dorsal aspect of the left hand.
- A healing "U"-shaped laceration was seen in the right mid-frontoparietal region.

Fresh injuries

a. A displaced fracture of the left mandible was present.
b. A closed fracture of the right distal radius was present.
c. A horizontal laceration (15 mm x 2 mm) with surrounding dried blood, with sand embedded in the wound, was present on the right antero-lateral aspect of the forehead, above the right eyebrow.
d. A horizontal laceration (21 mm x3 mm), with an adjacent abrasion, with sand embedded in the wound, was present on the left antero-lateral aspect of the forehead, above the left eyebrow.
e. The left cheek was covered with abrasions.
f. Vertical lacerations were present on the anterior and posterior aspect of the helix of the left ear (measuring up to 26 mm x 2 mm).
g. A fresh scalp laceration (18 mm x 3 mm) with blood oozing from the edges and present in the surrounding hair, was present over the mid-posterior parietal area (vertex) of the head.
h. The superior and posterior aspects of the left shoulder and the thoracic and lumbar areas of the back were covered with superficial abrasions.
i. A fresh abrasion (30 mm x 8 mm) was present on the posterior aspect of the right shoulder.
j. A horizontal laceration (62 mm x 2 mm) was present on the right thoracic area of the back.
k. A fresh laceration (17 mm x 10 mm), with sand embedded in the wound, was present on the postero-lateral aspect of the right hip.
l. Linear abrasions covered the medial aspect of the left inner thigh.
m. Abrasions covering an area of 50 mm x 50 mm were present on the lateral aspect of the left thigh.
n. A vertical laceration (24 mm x 2 mm) was present on the anterior aspect of the left shin.

On subcutaneous dissection, multiple internal bruises and large areas of soft tissue haemorrhage were evident, with blood oozing from the muscles and soft tissues. These included:

- Large multi-focal scalp contusions on the top, sides, and back of the head.
- Large area of soft tissue haemorrhage on the right lateral aspect of the chest.
- Multiple, focal bruises covering the dorsal aspects of both hands, forearms, upper arms, and shoulders.
- Diffuse soft tissue bruising covering the back and buttocks.
- Multi-focal contusions involving both lower limbs.

Police investigation

5. A coronial investigation by police found suspicious circumstances surrounding this death.

A history of domestic violence concerns and injuries suffered by the deceased

6. There were numerous reports of domestic violence perpetrated on the deceased by her partner during the relationship. The police system records 12 domestic violence incidents between

December 2016 and August 2020, and one reciprocal DVO which expired on 21 February 2020. The police memo indicates, "A number of police interactions are recorded between 2016 and 2020 which indicate the partner had issues with jealousy in regard to the deceased and would physically harm or threaten to physically harm her on a number of occasions". However, there were no convictions recorded in relation to the incidents. Further details of the police interactions are summarized as follows:

- **1 December 2016** at 3.45pm: the deceased contacted police requesting to go to a safe house because her partner was heavily intoxicated and she was scared of him. Police were dispatched at 3.51pm and attending members spoke to the deceased. They noted her to be "very intoxicated". She said she wanted her boyfriend locked up because she didn't want him around anymore. When asked why she didn't want him around she replied "just cause". Police spoke to her partner who denied any arguing, and said she was drunk and talking in a bad way. Police recorded: verbal argument only, nil violence, nil children, nil orders in place, nil need for Police DVO. Police took the deceased into protective custody on the basis that she did not have anybody to look after her. She was noted to have pain in her right arm, and she said she fell down a week ago.

  On 2 December 2016 at 1.53am the deceased presented at RDH ED which records: "Fell 1/52 ago while intoxicated. Painful swollen right distal forearm since then. Neurovascularly intact. Full ROM of wrist and digits. No pain on pronation/supination. Above elbow ulnar gutter done with Dynacast. Fracture Clinic referral 7-10 days".

- **8 December 2016** at 7.33am: HB contacted police to report that her niece (the deceased) had been hit by her boyfriend (the partner) and is bleeding and then terminated the call. When the operator called HB back, she advised that the partner had kicked the deceased in the hand [likely call taker misunderstood hand for head] punched her in the face, and she is bleeding from the mouth. The operator spoke to the deceased on the phone, and she reported that her partner had been jealousing her and then punched her in the mouth and she fell to the ground. The result text indicates: "FVP1 (family violence participant) and FVP2 have been in a relationship for several months and are currently residing together at Knuckey Camp. They have no children together and no children residing with them. There are no previously recorded violence incidents between these parties and no DVO's. Police attended Knuckey Camp and spoke to FVP2 (the deceased) who was moderately intoxicated. She said she had just been arguing with her partner (FVP1) as he was jealous of her talking to other men. She said she was fine now and he had left so she did not need police. She had a split lower lip however it was not bleeding and did not appear fresh. She denied that the injury was caused by her partner and continued to state that they were just arguing and that he was gone now so she did not need police. Police were unable to locate her partner. Police returned to Knuckey later that afternoon and were still unable to locate him. Follow up required: FVP1 to be located and VOE (version of event) obtained. [There is no further follow up documented.]

- **29 September 2018** at 3.36pm: Police attended Thorngate Road camp in response to a 000 call in which the caller stated that the partner had been hit on the head with a rock by the deceased. On arrival, both participants FVP1 (the deceased, intoxicated) and FVP2 (the partner, intoxicated) advised they had been watching the grand final and, as they both support opposite teams, they were teasing each other, and he fell and hit his head. Members left the area and returned a short time later as both participants were arguing about the footy again and it appeared the deceased was threatening her partner. Police took the deceased into custody under s128 on the basis that she may commit offences or be unable to care for herself. Parties separated, nil violence, nil witnesses, nil CCTV, DVO options explained, declined support link referrals, nil children at

location. NFPAR (no further police action required) request matter be finalised.

- **9 November 2018** at 8.35am: the deceased contacted police reporting that she had locked herself in the bathroom for over 2 hours, she is very scared, and that people are screaming and swearing at her. She said the POI's (persons of interest) are her partner, and her aunty. The call taker could hear a disturbance in the background during the call and could hear the POI shouting at her to "open the door". Police attended the location and spoke to the deceased who was now alone. She said that her aunty was at the location earlier and swore at her and she didn't like it, so she went and sat in the bedroom and called police. She did not provide any details about her aunty, her surname/where she was from/whether she was family. Recorded by police as nil domestic disturbance as reported. Matter to be finalised.
- **15 November 2018** at 8.40am: Palmerston Hospital contacted police to make a mandatory report. The nurse reported that the deceased had attended hospital overnight stating that her partner punched her in the jaw but later said it was an accident. She also had a haematoma and bruise under her eye which she said was from a fall. The male POI was also at the hospital with a broken arm, possibly separately brought in by police. Police members were tasked to attend Palmerston Hospital. Police spoke with the deceased who had been discharged and was waiting for a bus outside. She said that she had been at Knuckey Camp and got into an argument with her partner. She said they were drunk and jealousing each other and pushed each other. She said her partner slipped and his hand accidentally struck her lip. She elaborated that her partner is never violent, it was an accident and they had apologised, and they embraced afterwards. Police located the partner at Knuckey Camp, and he said they were drinking and got into a jealousy argument, they wrestled and then the deceased stumbled. He tried to break her fall but struck her lip by accident. They said sorry and that was it. Other occupants stated that the couple were drunk and jealousing and the deceased fell on the slab outside. Nil children present. DV options given, and noted this is the couple's first DV incident. Nil weapons or threats, minor injuries, nil complaint forthcoming by either party.
- **23 November 2018** at 4.20am: the deceased came into custody at 10.20pm after being apprehended at Knuckey Lagoon. She refused breath analysis. The Custody Sergeant reported that she woke up distressed from sleep and was experiencing chest pains. The custody nurse attended, assessed her and an ambulance was called. Of note, she had a swollen eye and when asked about the injury she said she could not remember. She was transported to hospital (see hospital entry below). Nil alert added until further information comes to hand.

  Hospital entry RDH: 44-year-old living in Darwin, was brought in from the watch house with acute onset sharp left sided chest pain. Swollen right eye also noted, unable to open eye. On further questioning, she states she cannot remember what happened, but someone likely assaulted her as she remembers her partner yelling at someone not to touch her.
- **8 January 2019** at 10.09pm: JC (highly intoxicated) contacted police requesting that people be locked up. She didn't want to answer questions and was not forthcoming with information. Police members attended Knuckey Camp and spoke with persons at the location who advised that the deceased and her partner were drunk, had been causing trouble and had both decamped upon police arrival. Police located both parties nearby highly intoxicated. She was screaming and lying on the bitumen. She had a blood lip and some grazes on her elbows and when asked how she sustained the injuries she said that her partner had kicked her, and they had both been arguing over jealousy issues. She then said she had not been assaulted by her partner and that she had fallen over

drunk causing the grazes to her elbows and injury to her lip. She did not require medical treatment (minor injury) and then walked back to her house. The partner advised that they had an argument but said he had not assaulted her, and she had fallen over drunk. He was agitated and angry about being questioned. He was taken into protective custody to separate the parties and prevent any offences occurring. Nil current or previous DVO's between parties. Nil offences established due to varying story from P1 and nil independent witnesses. S41 DVO considered but deemed not necessary. Nil children present/involved.

- **19 January 2019** at 9.32pm: an anonymous male contacted police reporting that the deceased and her partner were physically fighting (pushing, shoving and punching), they were intoxicated, and children were present. Police members attended a house in Knuckey Camp and spoke to her on arrival. She said they had been consuming alcohol, both were intoxicated, and they returned to their house in Knuckey Camp. A verbal argument began, and she left the location and went to another house where police were called. She said she did not want to stay at Knuckey Camp and wanted to be driven to Dickward Drive into the care of family. Police complied and took her to that address. They returned and spoke to her partner who provided no further information. Parties separated, no further action required.
- **13 February 2019** at 7.01pm: the deceased contacted police reporting that her partner is bleeding on road and then hung up. The call taker phoned back, and she advised that he is coming back, that he hurt her hand, she didn't require St John Ambulance and is okay now. She wants him charged and he is walking towards her. Police members attended Dickward Drive two hours later and reported nil disturbance at location upon arrival. Members tried calling the deceased numerous times but there was no answer. Messages were left. The deceased was not linked to the Dick Ward Drive address and there were nil further calls received regarding this matter. At this stage members reported being unable to establish whether an assault had occurred and requested the matter be finalised pending further information coming to hand. At 9.54pm members reported being called back to location for a drunk person, the deceased. Members spoke to the owner of a unit who stated that the deceased was drunk and annoying them at the unit. The unit owner said that the deceased had not been assaulted and does not know why she would ring up and say that. The partner was also at the location and confirmed there was no assault that she was just drunk and annoying people. The deceased decamped prior to police arrival. Nil assault as reported. No further action required.
- **19 February 2019** at 9.26pm: PW contacted police reporting that the partner was beating the deceased and asked for an ambulance as she thinks she has broken ribs. Police members attend the location and heard a female screaming in distress and a big crashing noise coming from upstairs. Members rushed into the residence and were told that the couple were upstairs and he was beating her. Due to the dim light members had their flashlights out. As police got partly up the stairs the partner approached the police from the top with no shirt on and blood on his body. Due to the low light, height disadvantage and members being unable to see his hands, one of the members, fearing serious harm, drew his taser and painted him. Verbal directions were given to him to face the wall and place his hands behind his back. He complied with those directions and was handcuffed to ensure everyone's safety until the circumstances could be clarified. The deceased came out from the bedroom. The partner said that he was not assaulting her. He said they were wrestling. He had scratches on his left chest/shoulder area but nothing to explain the blood on his body. He was placed into the back of the police van, and she was spoken to out in the car park area. A small laceration was observed above her left eyebrow and she had significant swelling above her left eye. She said that her partner had not assaulted her and that they were both wrestling with

each other. She was assessed by St John Ambulance but declined to attend Palmerston Hospital. Due to concerns for both parties, an attending officer contacted a Senior Sergeant who authorised reciprocal, non-harm DVO's. The deceased and her partner were both served with the orders, and he was taken to another location to spend the night with family. Neither party was willing to provide a statement to police. The Nationally Recognised DVO's were for a period of 12 months with conditions not to: cause harm or attempt or threaten to cause harm, cause damage to property or attempt or threaten to cause damage, intimidate or harass or verbally abuse. A statement from one of the police members records that that officer accessed the police promis system and identified the recent involvements between the couple.

- **21 February 2019** at 10.45pm: a caller reported that a male is assaulting a female at a service station. The caller took the victim, the deceased, inside and she said no to SJA (St John Ambulance). There are three males outside a nearby church and two males (the partner and his brother) at the service station. Nil injuries. Police members attended the location. She was very intoxicated and stated she had an argument with her partner. He said that she had been arguing with everyone walking past. His grandmother was present, and she said that the deceased is too drunk, and no one can control her. The partner left with his grandmother. The deceased was taken into protective custody. Police noted that there was a current non-harm DVO in force, however no breach has been identified.
- **6 June 2020** at 4.19am: at Pirlangimpi Community a police member reported observing the deceased on the road outside a residence yelling and screaming abuse. The member approached the female who continued to yell and scream loudly abusing an unknown person. Pirlangimpi Night Patrol attended shortly after and assisted the reporting member to convey her to a family residence in community. She was heavily intoxicated at the time and had been drinking at the local social club. She was banned from the social club and issued an infringement notice for disorderly behavior.
- **16 July 2020** at 10.26am: an anonymous caller contacted police reporting that a male was dragging a female into the bush at Leanyer Waterpark and SJA was possibly required. Police members attended and after extensive patrols located the couple suspected of being involved. They were mildly intoxicated with nil injuries. They were spoken to separately. Police ascertained that there had been a verbal argument between the couple over the partner's pay. The deceased tried to walk out into the road. The partner took hold of her and pulled her away from the road. He then walked away. They were happy to remain together, and the issue was resolved. Nil children involved. Not as reported. Support Link Referral offered but declined. Nil offences.
- **15 August 2020** at 6.57pm: RP contacted police reporting that the partner is fighting with the deceased and others at Pirlangimpi Community. Members are currently off duty and unable to contact complainant on mobile. Downgraded job as no further calls and limited information. At 8.00am on 20 August a Sergeant attended at a home in Pirlangimpi Community and spoke to AK (FVP, family violence participant) and her daughter MR (FVP). Situation: Both AK and MR wanted to speak with the deceased about why she was swearing and bad-mouthing AK. When they knocked on the door the deceased came out and started to yell and swear at both AK and MR. The deceased is said to have been jealous over AK and believes that she is trying to see her partner. All the women had their say and both AK and MR walked back to their residence. Police spoke to all parties who gave the same version of events. Verbal argument, nil injuries, no children involved, no grounds to take out a police DVO, advice given regarding DVO's, nil DVO's, Support Link Referral declined.

7. These interactions sadly provide examples of specific and systemic Police failings to appropriately respond to domestic violence incidents, for example:

    - In most instances there is nothing to indicate that attending members were aware of or accessed the partner's history of domestic incidents with his previous partner or his growing history of incidents with the deceased. To the contrary there are occasions where the history of DV is incorrectly minimized.
    - There is nothing in the available recorded material to indicate that attending members were aware of or accessed the deceased's history as a domestic violence victim.
    - Where incidents were reported by third parties/witnesses police failed to obtain statements from those persons at the time or later. Had statements been taken there may have been sufficient evidence to support a DVO or criminal charges, particularly on the occasions when the deceased was injured. On occasions witnesses were spoken in the presence of the partner.
    - Where the initial complaint to 000 was not repeated by the deceased to attending police sometimes recorded the incident as 'not as reported' and seemingly accepted implausible explanations.
    - Police seemingly failed to apply a DV lens to the relationship.
    - Police seemingly failed to build rapport with the deceased.
    - Police appeared to discount the deceased's complaints due to her intoxication.
    - It is not clear that BWV was used appropriately.
    - On occasions police failed to identify the person most in need of protection, resulting in the deceased being taken into custody perhaps, on reflection, inappropriately.
    - Police seemingly accepted implausible explanations provided by the partner for incidences and injuries. There were instances of apparent collusion with the partner and misdirection by him.
    - Instances of coercive control (especially jealousing) were not clearly identified as DV and were seemingly minimized.
    - On occasions injuries to the deceased were overlooked or minimized by attending police.
    - The police failed to conduct risk assessments in relation to the deceased's welfare.
    - Support link referrals were discussed on some occasions but were overlooked on others.
    - DVOs were not taken out when they perhaps should have been.
    - On occasions there was delay between report and police response.

8. There were potentially other incidents of domestic violence that went unreported and doubtful explanations appear to have been accepted by health personnel. There is no evidence of social work support being offered to the deceased. For example:

    - **6 March 2017** (Pirlangimpi Community Health Centre): nurses were called to home by the partner as the deceased had fallen, was unable to move, and had suffered a soft tissue injury. She had reportedly fallen on slippery concrete. No alcohol or drugs. On 8 March she was CareFlighted to Darwin with her partner as escort.
    - **30 December 2019** (Pirlangimpi Community Health Centre): the deceased presented after feeling dizzy and needing to sit down on the road. She said there had been verbal

abuse this morning by her partner so she left the house and was walking around town when the whiteness of a car made her dizzy. She denied any injuries, no headache, orientated, walked to clinic (was crying) denied any shortness of breath or chest pain. Denied any recent alcohol and no gunga, occasionally smokes cigarettes, was left to sleep but when checked for review had left clinic.

- **24 March 2020** (Pirlangimpi Community Health Centre): the partner called the clinic to say the deceased had fallen today at about midday whilst hunting. Difficult to understand mechanics of injury. Said she "fell standing up straight". She said she didn't feel pain at the time. Later she went to the club at about 7.00pm this evening and whilst sitting she noticed "bad" pain. Reports having had 3 cans of mid strength beer this evening, denies other drugs/Kronic. Brought to clinic by clinic vehicle. Swelling ++ compared to right knee. 5cm piece bruise noticed. Area not hot or red. May need x-ray, for tonight strap, analgesia and crutches, non-weight bare. Review tomorrow.
- **7 September 2021** (Pirlangimpi Community Health Centre): the deceased presented for review of right wrist pain. Recent visit to Darwin, had fall while intoxicated. Right forearm swelling for one week after fall. Did not seek medical advice. Right forearm with small amount of swelling at site of pain, nil erythema or skin changes, nil bruising, not warm to touch, full range of movement in wrist, mild pain on supernation, nil fluctuance or induration, mild tenderness on palpation.
- **20 December 2021** (Royal Darwin Hospital): the deceased presented to ED with an infected scalp laceration following a fall whilst intoxicated 2 days ago. Social history – from Pirlangimpi originally but has been staying in Darwin with her partner and family for past 1-2 weeks. Reports falling 2/7 ago whilst intoxicated, head strike on concrete footpath. Nil loss of consciousness at time, full recollection of events, partner witnessed, nil other injuries sustained, nil nausea/vomiting since, no fevers, increasing pain and discharge from wound over previous 24 hours, nil analgesia prehospital and declining on review, keen to go home. U-shaped laceration over right frontoparietal region of scalp, approx. 1.5cm from end of end, purulent discharge, tender, no surrounding erythema/cellulitis, no palpable haematoma/collection.

The couple move to Darwin and camp at Karama

9. In early December 2021, the partner travelled from Pirlangimpi to Darwin to attend a medical appointment, however there is no record of him attending the hospital. A few weeks later he was joined by the deceased, who travelled in by ferry. They stayed with friends and family at a bush camp near the intersection of Calytrix Road and Vanderlin Drive in Karama. An older relative, a 'mother' to the deceased, was also staying at the bush camp.
10. On Sunday 16 January 2022, at around 10.00am, they purchased two bottles of Yellow Tail chardonnay from the Karama shops and returned to the bush camp to consume it. They were later joined by the deceased's son, who had two bottles of Johnny Walker that he had stolen from the Karama shops earlier that day. They drank together. At around 5.00pm other persons joined the group to consume alcohol including KW, CF, KF, EC, MM, EP and CW.
11. KW told police that she had seen the couple intoxicated and they started arguing over jealousy issues. The deceased tried to walk away, but her partner grabbed her by the arm and pulled her back to camp then started slapping her across the face. The deceased told him to leave her alone. The deceased went and sat down next to one of the females in the group. The deceased told the female she wanted to leave and go somewhere else.
12. A close relative of the deceased, CF, was interviewed by police at about 5pm on 17 January 2022 and he reported that he had seen the couple at Karama shops on the morning of 16 January 2022. They were drinking and arguing, and the partner slapped the deceased on her cheek. Back

at the bush camp he said that they were growling at each other, and they took off their clothes. This made CF and others feel ashamed, so he and some others left the bush camp.

13. KF, EC, MM, and CW were at the bush camp at about 5pm. Members from that group said they were having fun drinking and there were no problems. KF, EC and MM all left because it was raining. CW said the couple were arguing when she left at 5pm, but she said that they always argue when they are drunk. When CW left the deceased was "good," not injured.

14. EP was at the camp for a short period of time and he thought everyone seemed happy. He left at about 6 or 6.30pm.

15. When KW left the camp, he said the partner was yelling at the deceased to leave too. The 'mother', who is old, was in her tent and sober.

16. After the rest of the group left, the 'mother' saw or heard the couple punching and pushing each other. She saw or heard the partner push the deceased to the ground and she heard the deceased calling out for help.

17. Several hours later the partner noticed that the deceased was unresponsive, not breathing and had no pulse. He woke the 'mother' and said to her, "might be finished" and left the camp to get help.

18. He attended a nearby unit complex and asked a female resident to call an ambulance. The female resident was an off-duty paramedic. She asked what had happened and whether there had been any fighting. He stated "she isn't waking up properly" and disclosed there had been fighting "earlier part". The female resident said she would call an ambulance and told him to wait on the street to flag it down.

19. He left the unit complex and made his way down the alley connecting Vanderlin Drive and Mistletoe Court where he attended another residence because there were people there that he knew. A male at that location said that he would call an ambulance.

20. At approximately 12.35am (17 January 2022) the partner flagged down a police vehicle that had been at a residence nearby on an unrelated matter. He told the police members he needed an ambulance for his wife. He got into their vehicle and guided them to the bush camp.

The police investigation

21. On their arrival at the camp, police members located the deceased lying unresponsive on a mattress. She was wearing a long floral skirt hitched up to her waist line with no top. They noted a small laceration above her right eyebrow and a small amount of blood on her lips. CPR was commenced.

22. At 12.48am St John Ambulance arrived. Paramedics noted she was topless, and her skirt was up around her waist. They saw a 2.5cm laceration above her left eye which had been bleeding but which was now dry, a 1cm laceration above her right eye, and a 1cm laceration on her left tibia. Her chest was soft, suggestive of trauma, possibly associated with CPR. Her temperature was "unreadably low". No assistance could be offered and she was declared deceased at 12.52am on 17 January 2022.

23. The partner spoke to police members at the scene. He said he had been drinking with other family members at the camp earlier in the night and an incident occurred with his wife. He said that she had hit him to the back of the head which caused him to pass out and when he woke up a few hours later he found her lying on the ground. He moved her to the mattress and went to sleep and when he woke later noticed something was wrong and went to get help.

24. One police member paid particular attention to the partner's appearance and noted that there was no blood or injuries on his hands. However, neither the police nor paramedics checked his head to determine whether there was any injury that might corroborate (or potentially refute)

his version that he had been knocked unconscious by a blow to the head.

25. The Crime Scene Examination Unit conducted an initial examination of the body. They noted a laceration on her forehead and shin, as well as possible bruising on her back, a possible bald spot on her head, and a small clump of hair under or behind her. However, they could not identify a preliminary cause of her death. There was no obvious signs of a disturbance noted, however, sticks and a broken rake were collected. The crime scene was held open so that it could be examined in daylight after the autopsy.

26. The partner told police that the laceration on her head had occurred when she fell over drunk at the Karama shopping centre on the previous Tuesday or Wednesday.

27. Police members conveyed the partner and the 'mother' to the Berrimah police station to obtain statements. When police informed the partner that she was deceased, he became emotional and said that the ambulance did not get to her fast enough. He said that he wished to end his own life now that she was dead.

28. Police commenced his audio statement at 3.10am. The partner made no admissions to assaulting the deceased and denied doing so when asked directly. He said he arrived in Darwin on 1 December 2021 for treatment for a broken jaw but left the hospital to go drinking. He said he did not know what had caused her death and when asked about the injury to her eyebrow, said she had fallen over at Karama shops the preceding Tuesday or Wednesday when she was drunk. The interviewing member noted a small injury to his left knee. He said that he had fallen over on the bitumen. Police also saw injuries on his neck and forehead that appeared to be several days old. His injuries were photographed, and his clothes and swabs were taken. The audio statement was concluded at 4.15am and he agreed to speak with police again the following day if they had any further questions. He was then conveyed by police to a family member's residence.

29. The 'mother' provided a statement at 3.26am that same morning. She said she had fallen asleep at about 4 pm the previous afternoon and didn't know anything about what had happened until she was woken by the partner. She was spoken to again on 19 January 2022. This time she said she was in her tent and saw or heard a "fair fight" between the couple. She said that the deceased sang out for help. She said she saw the partner push the deceased over and he also fell over. She said the deceased went to the mattress and he walked away.

Police learn of the autopsy findings

30. An autopsy was conducted at 9.30am and extensive blunt force trauma was identified involving the head, face, torso and pelvis, with multiple defensive injuries present. Swabs were taken at autopsy (hand/fingernail swabs and genital swabs). The genital swabs tested negative to a presumptive test for semen. The other items appear not to have been tested.

31. Police members from the Major Crime Squad and Crime Scene Examination Unit attended the autopsy. A case note of their attendance at autopsy, reads in part:

> *EXTERNAL:*
>
> *Lacerations to the L and R eyebrows*
> *Laceration to the rear of L ear*
> *Laceration to the R hip*
> *The deceased found to be covered +++ in sand and sand evident under fingernails, as though she had been rolling / laying in the sand, or possibly dragging / crawling along the ground.*
>
> *INTERNAL:*

Sand possible semen in vagina, however nil other apparent injuries to the area
Extensive bruising to numerous parts of the deceased body (virtually all areas), including defensive injuries to the both forearms / wrists
Broken jaw
Multiple fractured ribs (not likely to be the result of CPR)
Broken pelvis
Bruising to internal organs

OPINION: Tiemensma was of the opinion that the deceased died as a result of multiple blunt force trauma injuries, likely sustained during a prolonged attack on the deceased by one or more person/s. Nil indication the death was the result of one specific injury, but rather the cumulative effect of numerous ones.

32. It was clear to the police who attended the autopsy that the deceased had been the victim of a violent, vicious and prolonged attack.

33. One of the attending officers notified the Officer in Charge, Major Crime, of the autopsy findings at about 11am. However, it was decided that the partner would not be arrested in relation to the death as there was a corroborating witness to **his** version of events and a significant gap in the timeline leading up to death. The only additional version police had at that stage was the 'mother's' and on that first version she said she was asleep. I am perplexed as to how this could be construed as corroborating the partner.

34. In any event, because of this decision, the investigating team was directed to focus on the other people who were identified as being present in the camp prior to her death. As discussed earlier, some of those witnesses stated that they observed the couple arguing and witnessed him slapping her earlier that day. This was not neutral evidence, it pointed to the partner being a recent perpetrator of physical violence against the deceased.

35. Police held a briefing at about 3pm. It was their combined view there was only marginal evidence to support a charge of assault against the partner (referencing the slap at Karama shops earlier in the day), and although he was a suspect in her death, there was insufficient evidence to arrest him for her death. It is not clear whether they accessed and, if so, what weight they gave, to his domestic violence history against the deceased, or his history of violence with his previous partner.

The partner commits suicide

36. On the morning of 17 January 2022, the partner travelled to Casuarina Square with some family members, and then to Nightcliff foreshore. They noticed that he was quiet and distant. The group sat drinking alcohol near the Rapid Creek foot bridge for a number of hours. He mentioned to one of the people he was drinking with that he wished to end his life. At around 8.00pm the group travelled to Knuckey Lagoon camp and the partner walked to House 22, the residence of the deceased's family, where he was observed to be upset and crying. He later walked to House 20 and went to sleep on the balcony. Sometime prior to 7.30am on 18 January 2022 he made his way to the outskirts of the camp alongside the Stuart Highway and hung himself using his shirt tied to a tree branch. He was discovered by a male driving outbound along the Stuart Highway. Police were contacted at 7.30am.

37. Meanwhile, at 8.30am on 18 January 2022, the Major Crime Squad held a briefing with all members attached to the investigation. The Officer in Charge was informed of the witness who had provided a statement that the partner had assaulted the deceased earlier at the Karama Shopping Centre and it was decided to arrest him for that assault.

38. At the conclusion of the briefing at approximately 9.20am, the Officer in Charge was informed there had been a death by hanging 400 metres from Knuckey Lagoon camp. The body was

identified as the partner who had been declared deceased at 7.47am. A crime scene was established, and no suspicious circumstances were identified. At 9.25am members of the Major Crime Squad attended Knuckey Lagoon.

Relevant postmortem findings of the partner

39. Dr Marianne Tiemensma conducted a postmortem examination on the partner on 18 January 2022 and her opinion as to his cause of death was self-inflicted hanging.

40. Significantly, Dr Tiemensma found no injury consistent with his account of being struck on the back of the head and knocked unconscious by the deceased.

Issues:

Police did not contact the forensic pathologist for advice or request her to attend the crime scene

41. As at January 2022 the relevant police General Order, Coronial Investigations and Inquests, provided at [83] that,

> *Prior to an autopsy being conducted, it is imperative that the Pathologist is properly briefed on the circumstances surrounding the death and any additional information police may have regarding the possible cause of death.*

42. The current police General Order, Crime (Homicide and Serious) Investigation, which was approved on 22 November 2022 now provides at [113] that,

> *In addition to controlled examination of the deceased in the mortuary, a forensic pathologist may be available to attend a scene and undertake an initial inspection of the deceased prior to removal from the scene. This opportunity should be provided to the forensic pathologist in appropriate circumstances and the pathologist determine the value or otherwise of attending. Police can then assist the pathologist in attending the scene as being of value to the investigation.*

43. When police examined the scene, they did not identify any very significant injuries and found no obvious cause of death.

44. Under the General Order, as it then was, there was no expectation that police would contact the forensic pathologist to provide an opportunity for her to attend the scene. Under the current General Order, the forensic pathologist is to be consulted and given an opportunity to visit and inspect the crime scene. If the forensic pathologist had been afforded that opportunity, police would likely have been alerted much earlier to the extensive blunt force trauma suffered by the deceased. That knowledge would likely have assisted their lines of enquiry, particularly when questioning the partner and the 'mother' later that morning, and it should have given rise to greater suspicion of him.

Police did not arrest (section 123 *Police Administration Act 1978*)

45. However, even without the benefit of the attendance of the forensic pathologist police knew:

- There was fresh blood and lacerations on the deceased's face and leg, and her entire body was covered in sand.
- The partner denied assaulting her but admitted to arguing with her and claimed she had assaulted him and knocked him unconscious.
- At 9.30am the postmortem examination identified extensive blunt force and defensive

injuries.

- The partner was the last to see her alive and discovered her deceased.
- The partner had scratches on his face and chest.
- The partner indicated to police that he would "never hurt his wife" which was an obvious lie when compared to the history of domestic violence.
- The account he gave was unconvincing.

46. Additionally, given his complaint of a significant blow to the head resulting in prolonged unconsciousness, as a duty of care police should have requested that he be assessed by paramedics. If police had confirmed that he did not have a head injury, this lie would have been identified.

47. Section 123 of the *Police Administration Act 1978* provides a power of arrest where a police officer believes on reasonable grounds that a person has committed, is committing or is about to commit an offence. In this instance, a reasonable belief may have been reached to arrest the partner for an offence if police had properly understood and given appropriate weight to his domestic violence history, had better understood the extent of her injuries at the scene, had identified his lie about having been knocked unconscious, and if they had properly understood that the 'mother's' evidence (at that time) was neutral rather than corroborative of his account.

48. Alternatively, if appropriate consideration and weight had been given to his history, a reasonable belief may have been reached following the receipt of the autopsy findings at 11am on 17 January, and/or on receipt of the statement from CF at 5.41pm on 17 January in which he provided evidence of the earlier assault at the shops. An arrest at any of these points of time would have reduced the risk of him absconding or interfering with evidence or witnesses, provided an opportunity for him to be fairly tried, and may have prevented his suicide, at least in the circumstances in which it occurred.

49. Except for the partner, the police have never identified any other person as being of interest concerning the deceased's passing.

Comment

50. I believe that offences were committed in connection with the death of the deceased and, but for the death of her partner, in accordance with section 35(3) Coroners Act I would have reported my belief to the Commissioner of Police and the Director of Public Prosecutions.

51. As I have made adverse comments concerning some police attendances, NT Police was provided with an opportunity to consider and respond to those comments. NT Police advised that:

    - With the introduction of SerPro it is now easier for police to access a 'DFV History report' which provides members with information as to whether a person has any history of Domestic Violence Orders and the parties to those orders, however, it remains difficult to access DVF occurrences in a timely way when police are on the road using iphones or ipads.
    - A direction has been given to police that they are not to make an entry 'Not as reported'. Instead, they are to enter what is reported.
    - NT Police have developed a 'DV Dashboard' which is currently undergoing testing. The Dashboard is linked to SerPro and will allow proactive monitoring of trends in DV.

52. NT Health were also invited to comment but did not consider it necessary to do so.

53. On the evidence available I am satisfied that the deceased is one of the 82 Aboriginal women in the killed in the Northen Territory since the year 2000 in the context of domestic violence

referred to *Inquests into the deaths of Miss Yunupingu, Ngeygo Ragurrk, Kumarn Rabuntja and Kumanjayi Haywood* [2024] NTLC 14.

54. In the *Inquests into the deaths of Miss Yunupingu, Ngeygo Ragurrk, Kumarn Rabuntja and Kumanjayi Haywood* common issues arising in the context of domestic violence deaths were identified and considered. Many of those common issues are evident in the circumstances surrounding this deceased's experience of domestic violence and her death. Her circumstances provide additional evidence of the following:

    - Domestic violence is under reported.
    - The role of alcohol in increasing the probability, frequency and severity of domestic violence.
    - The prevalence of coercive control and jealousing as a form of domestic violence.
    - That for a variety of reasons, many women remain in a relationship with an abusive partner and don't 'just leave'.
    - That for a variety of reasons, after making a report to police it is not uncommon for a victim to refuse to repeat the complaint or make a statement to attending police.
    - It was not uncommon for Police responses to be inadequate. On occasions in the deceased's story there is evidence: of occasional delay, that little was known of their respective domestic violence histories, that sometimes police appeared to struggle to identify the person most in need of protection and sometimes misidentified the primary perpetrator, that sometimes police appear to have been seduced or manipulated by the perpetrator (collusion) when he appeared more sober or reasonable, that there was little or no rapport building, that no risk assessments were conducted, and there were occasions when no referrals were offered.

55. Had a full inquest been conducted it is likely further common issues may have been identified. It is not known, for example, whether the deceased accessed supports such as safe houses, and whether they assisted her or turned her away, and it is not known how her children have been affected. Equally it is not known whether the partner had any access to programs or supports to assist him to recognize and change his abusive behaviours. Or whether either of them accessed alcohol rehabilitation.

56. It is not possible to hold an inquest into every death. As Territory Coroner, my functions are set out in section 4A of the *Coroners Act 1993*. While I am required to investigate all reportable deaths, I must also administer the coronial system efficiently. Following the recent lengthy inquest into the deaths of four Aboriginal women who died because of domestic violence, and considering the commonality of many issues, I do not consider it to be desirable to hold an inquest in this case. I have decided not to hold an inquest because under section 16(1) of the *Coroners Act 1993* I am satisfied that the investigations into the death disclose the time, place and cause of death and the relevant circumstances concerning the death. Additionally, the circumstances do not require a mandatory inquest because the deceased was not, immediately before death, a person held in care or custody, and the death was not caused or contributed to by injuries sustained while the deceased was held in custody, and her identity is known.

57. However, because this death is tragic, because this deceased had a history of exposure to domestic violence, because she did not always get the response and support she deserved, and because her death should not be forgotten, overlooked or ignored, I am publishing these anonymized findings.

58. I am of the view that many, if not all, the recommendations made in the *Inquests into the deaths of Miss Yunupingu, Ngeygo Ragurrk, Kumarn Rabuntja and Kumanjayi Haywood* [2024] NTLC 14 are relevant and applicable to this death. On the particular facts in these findings these two recommendations are clearly apt:

Recommendation 5: *Evidence-based alcohol intervention strategy*

To reduce the victimization of Aboriginal people, particularly women and children, the NT Government should develop and enforce an evidence-based strategy to reduce alcohol availability, taking into account that alcohol increases the frequency and severity of DFSV and reducing alcohol availability has a significant impact on reducing DFSV.

Recommendation 11: *PARt training*

The NT Government should specifically fund, and NT Police should provide PARt training to all current NT police officers, auxiliaries and new recruits as well as JESCC staff, including police and auxiliaries.

Formal Findings

59. The formal findings that I make are:

    a. The identity of the deceased was, born on 9 August 1974 at Darwin in the Northern Territory.

    b. The time of death was 12.52am on 17 January 2022. The place of death was 200 metres northeast of Calytrix Road and Vanderlin Drive, Karama, in the Northern Territory.

    c. The cause of death was multiple blunt force injuries.

    d. The particulars required to register the death have been reported to the Registrar, Births, Deaths and Marriages.

    e. The death was reported to the Coroner by the Police.

    f. The cause of death was confirmed by the Forensic pathologist Dr Marianne Tiemensma.

    g. The deceased's mother and her father are identified.